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

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SC Court of Appeals

Appellate Case No. 2017-001367

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

v.

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

RECORD ON APPEAL

Volume I of II

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FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF YORK

JUDGMENT IN A CIVIL CASE

IN THE COURT OF COMMON PLEAS

CASE NO. 2011 CP-46-04508

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

PLAINTIFF(S)

South Carolina Department of Social Services

DEFENDANT(S)

Submitted by: Patrick J. Frawley	Attorney for : ☐ Plaintiff ☒ Defendant or ☐ Self-Represented Litigant

FILED-RECEIVED
2017 MAR 31 AM 9:40
DAVID HAMILTON
C.C.C.P. & G.S.
YORK COUNTY, S.C.

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.

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

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

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

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

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

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.
Additional Information for the Clerk : Order for Summary Judgment

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)
Defendant	Plaintiff	$N/A
		$
		$

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.**

For, M Kimbell — 3063 — 3/30/17

Circuit Court Judge | **Judge Code** | **Date**

For Clerk of Court Office Use Only

This judgment was entered on the 31 day of Mar, 2017 and a copy mailed first class or placed in the appropriate attorney's box on this 31 day of Mar, 2017 to attorneys of record or to parties (when appearing pro se) as follows:

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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 [redacted] a minor, Plaintiff, vs. South Carolina Department of Social Services, Defendant.	)	**ORDER FOR SUMMARY JUDGMENT** Case No.: 2011-CP-46-04398

FILED-RECEIVED
2017 MAR 31 AM 9:40
DAVID HAMILTON
C.C.C.P.&G.S.
YORK COUNTY, SC

This matter came before the Court on March 13, 2017, upon the Motion for Summary Judgment of Defendant ("DSS"). Representing the parties were: Whitney B. Harrison and Eve S. Goodstein for Plaintiff; and, Patrick J. Frawley for DSS. Based on the record presented, the memoranda of law submitted, and the arguments of counsel, I make the following findings and conclusions.

FACTUAL/PROCEDURAL BACKGROUND

Owen [redacted] was born [redacted] to Kayla Lythgoe, then 19 years old, and Michael [redacted] then 18 years old. On December 4, 2009, when Owen was twelve weeks old, his parents took him to Piedmont Medical Center ("PMC") in Rock Hill for medical attention. According to the parents, Owen experienced an episode after feeding where he cried out, became limp, and was unresponsive, although breathing. On December 5, 2009, PMC physicians transferred Owen to Levine Children's Hospital ("Levine"), a part of the Charlotte-Mecklenburg Hospital Authority ("CMHA"), in Charlotte for further care and evaluation. The following day, December 6, a CT scan by CMHA staff revealed two areas on Owen's brain of subdural hematoma, which raised suspicions of a non-accidental injury to Owen. Levine then notified the York County office of DSS that the child may have been the victim of non-accidental trauma.

DSS received an intake on December 6, 2009, at 5:01 p.m., reporting that a two-month old baby with two subdural hematomas had been admitted to the hospital, raising the possibility of non-accidental trauma. The corresponding report went on to indicate that the parents' behavior with the child had been "appropriate." (*See* DSS Intake Summary.) An "on-call" case worker Chandra Tyler responded to the hospital by 7:45 p.m. She had face-to-face meetings with the

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parents of the child, the paternal grandparents, a paternal uncle, and an unnamed nurse. (*See* DSS Case Dictation ("Dictation"), pp. 309-311.) Ms. Tyler provided the parents with the DSS Brochure 3034. They were also provided the handbook entitled *Child Protective Services: A Guide For Parents*, advising them of the DSS procedure in Child Protective Services ("CPS") cases and of their right to representation by counsel. Both parents signed for the material, acknowledging receipt of it. (*Id.*, p. 311; *see also*, DSS Brochure 3034 (Feb. 03) and signed Acknowledgement.) Ms. Tyler also had the parents sign a Safety Plan, pursuant to which the parents agreed to follow medical advice of the hospital, and not to remove the child from the hospital until the child was medically discharged. (Dictation, p. 309; *see also*, DSS Safety Plan (12/6/09).)

The morning of December 7, 2009, Ms. Tyler and her supervisor, Lola Sutherland, had a staffing with the assessment case worker to whom the case was being assigned, Dirvondra Hill, and her supervisor Krista Hinnant. (Dictation, pp. 305-307; Deposition of Lola Sutherland ("Sutherland Deposition") p. 27, line 19 to p. 28, line 20; Deposition of Krista M. Hinnant ("Hinnant Deposition") p. 39, line 20 to p. 40, line 11; Deposition of Dirvondra Hill ("Hill Deposition") p. 12, lines 9-17; DSS Case Transfer and/or Case Staffing form 3062 (December 7, 2009).) In the initial staffing, it was discussed that Owen had two subdural hematomas, that the hospital social worker and a nurse had concerns that the injuries were the result of non-accidental trauma, but no doctor was saying that injuries were non-accidental, and that the child was ready for discharge from the hospital. (Dictation, p. 307.)

After the initial staffing and accepting the transfer of the case from the on-call caseworker Tyler, DSS Assessment Supervisor Hinnant and Assessment Caseworker Dirvondra Hill had a second staffing that same morning with DSS Legal. (Dictation, pp. 307-308; Hinnant Deposition, p. 39, line 20 to p. 40, line 6; p. 41, lines 6-11; DSS Case Transfer and/or Case Staffing Form 3062, Legal Staffing (December 7, 2009).)

Later that morning, DSS supervisor Krista Hinnant contacted Levine Children's Hospital social worker Laura McDowell, inquiring into whether doctors thought the trauma was non-accidental. (Dictation, p. 305.) McDowell told Hinnant that she would speak with the doctors and report back to her. (*Id.*)

Hinnant spoke with a second social worker, Laura Newmark, at approximately 11:50 a.m., who told Hinnant that she was the social worker who had been working with the [redacted] that she had spoken with the pediatric staff, and that they could not determine whether the child's

injuries were accidental or not. (*Id.*, p. 304.) She told Hinnant that, although the family had no clear history of trauma, the hospital could not rule out trauma, but that there were no obvious findings of abuse or neglect, and that the hospital mostly had concerns about lack of supervision. (*Id.*) Newmark further stated that Dr. Cheryl Courtland was working with the child, and that Dr. Courtland could not determine if the injuries were accidental or not at that point in time. (*Id.*)

Hinnant staffed the matter with the DSS legal department, and authorized the discharge of the child to the care of his parents. (Dictation, pp. 303-304; Hinnant Deposition p. 31, line 18 to p. 32, line 19, p. 33, lines 3-17.) Dirvondra Hill attempted an unannounced home assessment with the child later December 7, but found no one at home. (Dictation, p. 308; Hill Deposition, p. 10, line 16 to p. 12, line 6.) Ms. Hill followed up with attempted unannounced home visits on December 8 and 10, but found no one at home. (Dictation, pp. 301-302.) Ms. Hill sent a "home attempt" letter to Michael [redacted] and Kayla Lythgoe, indicating her unsuccessful attempts to visit the home, and scheduled a home visit for December 21 at 9:00 a.m. (Hill Deposition, p. 35, line 6 to p. 36, line 6; Hill letter to [redacted] Lythgoe (undated).)

Ms. Hill sent criminal records check inquiries to the York County Sheriff's Department on December 16, 2009, requesting records for Michael [redacted] Kayla Lythgoe, and Charlotte Williams, the maternal grandmother. (*Id.*, p. 300.)

On December 17, Ms. Hill went to the home unannounced, encountering Lythgoe, the mother. Lythgoe was about to leave for work, so the visit was short. She told Ms. Hill that the child was out with the grandmother while Lythgoe worked, and could not give a phone number at which she could be reached. (*Id.*, p. 299-300.) Ms. Hill presented Lythgoe with a third Safety Plan, which Lythgoe signed. Lythgoe acknowledged having received the "home attempt" letter from DSS. She and Ms. Hill agreed to a meeting December 21 at 9:00 a.m., in order for Ms. Hill to inspect the home and meet all members of the household. *Id.*

On December 17, Ms. Hinnant spoke with a Lt. Miller of the York County Sheriff's Department, who told Hinnant the Department had received the law enforcement inquiry, but needed additional information. Hinnant provided the additional information to Lt. Miller. (Dictation, p. 298.)

On December 21, Ms. Hill met with Michael [redacted] Kayla Lythgoe, and Owen, at the [redacted] on December 21. (Dictation, pp. 297-298.) Ms. Hill read the allegations of the report and received a history from the mother and father of what had happened leading up to the child's hospitalization. (*Id.*) Ms. Hill noted that the home was ". . . warm and organized in the

living room," and observed that the child was on the floor with the father, describing the child as ". . . vibrant lying on his back on a blanket kicking his feet and arms laughing and smiling as his father interacted with him." (*Id.*, p. 298.) In dictation, Ms. Hill states that she presented a fourth Safety Plan, which the parents signed. (*Id.*) However, Defendant has been unable to locate a written copy of the Plan.

On January 4, 2010, Krista Hinnant and Ms. Hill staffed the case, intending to get all medical records, follow up with the December 16 law enforcement inquiry, and assess the grandmother Charlotte Williams' home. (Dictation, pp. 296-297; DSS Case Transfer and/or Case Staffing form 3062 (January 4, 2010).)

On January 11, 2010, Michael [redacted] and Kayla Lythgoe took their son to Piedmont Medical Center, and the nurse with whom they spoke, Elizabeth Super, later told Ms. Hill that she observed multiple bruises to the body, left leg, left hand, chest, and face of the child. (Dictation, p. 290.) The mother explained that the child had been "normal" on the previous day, but the next morning was having seizures, and the parents apparently attempted to attribute the bruises to the child scratching himself. (*Id.*) The child was transferred to Levine Children's Hospital ICU, actively seizing, in critical condition, on a ventilator. (*Id.*, pp. 289-291.) CT scans were performed at PMC and Levine, which revealed up to five new areas of brain bleeds for the child, which were different from the two he had in December. Skeletal CT scans were done, and showed no fractures. (*Id.*) At one point Owen was taken off of life support, based on medical opinion that he could not survive, and he was moved to a Rock Hill hospice. Nevertheless, he did recover, but has severe, permanent brain damage, and vision problems. He has been in the custody of the maternal grandparents.

Law enforcement was notified and investigated the situation. Authorities administered a polygraph test to the father, Michael [redacted] and he confessed to having injured the child. He has pled guilty to criminal charges, and is incarcerated. Michael [redacted] has never admitted to inflicting the injury to Owen that resulted in the first hospitalization, which is the incident investigated by DSS. Kayla Lythgoe passed a polygraph test, indicating that, apparently, she neither abused the child, nor was aware that the father had abused him.

STANDARD OF REVIEW

Summary judgment is appropriate only when there is no genuine issue of material fact, and judgment is warranted 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

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(Ct.App.1999); Rule 56(c), S.C.R.C.P. Further, the evidence and all reasonable inferences therefrom are viewed in the light most favorable to the non-moving party. *Helms Realty, Inc. v. Gibson-Wall Co.*, 363 S.C. 334, 611 S.E.2d 485 (2005); *Med. Univ. of S.C. v. Arnaud*, 360 S.C. 615, 602 S.E.2d 747 (2004).

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).

The non-moving party need only submit a mere scintilla of evidence to withstand a summary judgment motion where the standard of proof is by a preponderance of the evidence. *Hancock v. Mid-South Management Co., Inc.*, 381 S.C. 326, 673 S.E.2d 801 (2009). The meaning of the "scintilla of evidence rule" is ". . . that there must be some evidence arising out of the testimony which elucidates the issues of fact, and which enables the jury to form an intelligent conclusion. It does not authorize the admission of speculative, theoretical, and hypothetical views." *Crawford v. Town of Winnsboro*, 205 S.C. 72, __, 30 S.E.2d 841, 849 (1944) (emphasis in original), cited with approval in *Radcliffe v. Southern Aviation School*, 209 S.C. 411, 420, 40 S.E.2d 626, 630 (1946).

A party seeking summary judgment has the burden of clearly establishing, with use of the record properly before the court, the absence of a triable issue of fact. *Stanford Fire Ins. Co. v. Marine Contracting and Towing*, 301 S.C. 418, 392 S.E.2d 460 (1990).

DISCUSSION/ANALYSIS

The South Carolina Tort Claims Act ("Act"), codified at S.C. Code Ann. §§15-78-10 through 220 (1976, as amended), is a limited waiver of governmental immunity. *See, e.g., Staubes v. City of Folly Beach*, 331 S.C. 192, 204, 500 S.E.2d 160, 167 (Ct. Ap. 1999). The remedy provided by the Act is the exclusive civil remedy available for any tort committed by a governmental entity, such as DSS, its agents or employees, so long as they act within the scope of their official duties, and did not commit actual fraud, actual malice, intent to harm, or a crime involving moral turpitude. *See, e.g.*, S.C. Code Ann. §§15-78-20(b), 15-78-70(b) (1986 as amended), 15-78-200 (1997 as amended); *Huggins v. Metts*, 371 S.C. 621, 624, 640 S.E.2d 465,

466 (Ct. App. 2007). The provisions of the Act establishing limitations upon, and exemptions from, liability of a governmental entity must be liberally construed in favor of limiting liability. *Id.*, §§15-78-20(f), 15-78-200; *Staubes, supra*, 331 S.C. at 205, 500 S.E.2d at 167.

A governmental entity such as DSS is not liable for a loss resulting from responsibility for, or duty to, any student, patient, prisoner, inmate, or client of the governmental entity, except when the responsibility or duty is exercised in a *grossly negligent manner*. This includes supervision, protection, control, confinement, or custody of an individual. *Id.*, §15-78-60(25) (1986 as amended) (Emphasis added.)

Gross negligence is the intentional, conscious failure to do something which one ought to do or the doing of something one ought not to do, and as the failure to exercise slight care. *See, e.g., Etheredge v. Richland School District One*, 341 S.C. 307, 310, 534 S.E.2d 275, 277 (2000); *Clyburn v. Sumter County District Seventeen*, 317 S.C. 50, 53, 451 S.E.2d 885, 887 (1994); *Staubes, supra*, 331 S.C. at 204, 500 S.E.2d at 167. It has also been defined as a conscious failure to exercise due care. *Staubes*, 331 S.C. at 204, 500 S.E.2d at 167. While gross negligence is ordinarily a mixed question of law and fact, when the evidence supports but one reasonable inference, the question becomes a matter of law for the Court. *Etheredge, supra*, 341 S.C. at 310, 534 S.E.2d at 277 (2000); *Clyburn, supra*, 317 S.C. at 53, 451 S.E.2d at 887.

If a defendant has exercised at least slight care, the fact that it might have done more is not controlling, and the defendant is not chargeable with gross negligence. *Etheredge, supra*, 341 S.C. at 312, 534 S.E.2d at 278; *see also, Clyburn, supra*, 317 S.C. at 53-54, 451 S.E.2d at 888.

In *Clyburn, supra*, the Court affirmed a grant of summary judgment in suit brought by high school student for injuries sustained in a knife attack by a non-student assailant, while on a school bus. In an incident prior to the one at issue, the School District did not seek criminal charges against the same assailant who was responsible for the incident before the Court. The Court acknowledged this fact, but recited those steps that the School District did take to prevent a further attack. The Court concluded that the only reasonable inference to be drawn from those facts was that the School District had exercised slight care, and was not grossly negligent as a matter of law.

DSS staff must consider numerous policy and procedure dictates in making judgments pertaining to action plans in individual cases. These are expounded by statute, and in DSS's Human Services Policy and Procedure Manual ("Manual"). They must be considered as a whole,

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and not in isolation, when evaluating DSS's performance.[1] Plaintiff has made reference to a number of those dictates in assigning fault to DSS.[2] The "slight-care" standard requires consideration of these policies and procedures, since they necessarily affect the actions of DSS staff in specific cases. However, in the end, the issue before Court is whether the actions DSS did undertake meet the standard of "slight care." Those actions are described in the factual background given above.

In this case, the summary-judgment-standard requires that DSS demonstrate the absence of a factual issue concerning the exercise of "slight care." While the record may raise inferences of factual issues concerning "simple negligence", that is not controlling. DSS need only show from the entire record that it met the standard of slight care in this case. Based on the entire record, I conclude that DSS has carried the burden of showing that it exercised slight care in this tragic fact situation. Thus, DSS is entitled to summary judgment as a matter of law.

Therefore, it is ordered that the motion for summary judgment be granted, and that Plaintiff's Complaint be dismissed with prejudice.

AND IT IS SO ORDERED.

March 29, 2017

S. Jackson Kimball
Special Circuit Court Judge
York County

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[1] DSS's Human Services Policy and Procedure Manual ("Manual"), cited by Plaintiff in opposition to this motion, is relied upon by DSS staff in making decisions concerning plans for the protection of children. The Manual contains the following guideline, among the many policy statements that direct how a case is to be handled.

> • **When parents (or caregivers) are unable or unwilling to fulfill their responsibilities to provide adequate care and to keep their children safe, CPS has the mandate to intervene.** Both laws and good practice maintain that interventions should be designed to help parents protect their children in the *least intrusive manner possible.* Interventions should build on the family's strengths and address the factors that contribute to the risk of maltreatment. Reasonable efforts must be made to maintain child safety and keep the children with their families except when there is significant risk to child safety. *Referral to court and removal of children from their families should only be done when it is determined that children cannot be kept safely in their own homes.* (Bold-underline in original; italics added.)

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

#7

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 [redacted]	Carolinas Medical Center	Department of Social Services South Carolina

PLAINTIFF(S) DEFENDANT(S)

Submitted by: The Court

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

DISPOSITION TYPE (CHECK ONE)

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

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

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

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

☐ **STAYED DUE TO BANKRUPTCY**

☐ **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 (RULE 59(e) MOTION)

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.
E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.

S/S. Jackson Kimball — **Special Circuit Court Judge**

3063 — **Judge Code**

5/23/2017 — **Date**

CPFORM4Cm
SCCA SCRCP Form 4C (Revised 2/17)

For Clerk of Court Office Use Only

This judgment was entered on **May 24, 2017**, and a copy mailed first class or placed in the appropriate attorney's box on **May 24, 2017**, to attorneys of record or to parties (when appearing pro se) as follows:

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Duane Michael Shaw PO Box 36250 Rock Hill, SC 29732

Patrick John Frawley PO Box 489 Lexington, SC 29071-0489

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

David Hamilton

Court Reporter

David Hamilton - Clerk of Court

Court Reporter:

E-Filing Note: In E-Filing counties, the date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgement to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

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)
) IN THE COURT OF COMMON PLEAS
COUNTY OF YORK)

FILED-RECEIVED
2017 MAY 24 AM 8:19
DAVID HAMILTON
C.C.P. & G.S.
YORK COUNTY, SC

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

Plaintiff,

vs.

South Carolina Department of Social Services,

Defendant.

ORDER

(RULE 59(e) MOTION)

Case No.: 2011CP4604508

This matter came before the Court on May 18, 2017, upon Plaintiff's motion pursuant to Rule 59(e), SCRCP, asking the Court to reconsider, alter, or amend the Court's Order dated March 30, 2017, filed March 31, 2017. Representing the parties were: S. Randall Hood for Plaintiff; and, Patrick J. Frawley for Defendant South Carolina Department of Social Services ("DSS").

The purpose of Rule 59(e), SCRCP, is to request the trial judge to ". . . reconsider matters properly encompassed in a decision on the merits." *Arnold v. State*, 309 S.C. 157, 420 S.E.2d 834 (1992) (citations omitted). A party cannot use a motion to reconsider, alter or amend a judgment to present an issue that could have been raised prior to the judgment, but was not. *See Johnson v. Sonoco Products Co.*, 381 S.C. 172, 672 S.E.2d 567 (2009); and, *Poch v. Bayshore Concrete Products/South Carolina, Inc.*, 386 S.C. 13, 686 S.E.2d 689 (Ct. App. 2009). The present motion essentially asks the Court to reconsider its ruling on the matters presented at the original hearing on DSS's summary judgment motion.

Plaintiff's argument is based on the premise that in the exercise of 'slight care', and as the only proper action, DSS was compelled to remove the minor Plaintiff from his home, and place him in temporary protective care, before the severe permanent injury inflicted by his father. Plaintiff's argument requires a finding that such action would have been compelled if DSS had exercised 'slight care' at different phases of its investigation process. Reviewing the record assembled both prior to, and subsequent to, the child's injury reveals no evidence that more diligent investigation would have produced evidence dictating immediate removal as the only appropriate action at the time.

It has been said that "[a] motion for summary judgment is akin to a motion for a directed verdict . . . ." *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). The summary judgment standard is said to "mirror" the standard for a directed verdict. *Baughman, supra*, 306 S.C. at 115, 410 S.E.2d at 545. That comparison is appropriate in this instance. There is a lack of evidence in the record dictating that DSS's only option was to seek immediate removal of the minor Plaintiff from his parents prior to his tragic injury.

Thus, upon reviewing 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 ruling in the prior Order.

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

AND IT IS SO ORDERED.

May 23, 2017

S. Jackson Kimball
Special Circuit Court Judge
York County

#2

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

Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen [redacted] a minor, Plaintiff(s)

vs.

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

CIVIL ACTION COVERSHEET

11-CP - 46- 04508

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

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

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

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

DOCKETING INFORMATION (*Check all that apply*)

***If Action is Judgment/Settlement do not complete*

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

NATURE OF ACTION (*Check One Box Below*)

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

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

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

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

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

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

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

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

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

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

Submitting Party Signature: _____ **Date:** 1/30/11

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

FOR MANDATED ADR COUNTIES ONLY

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

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

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

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

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

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

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

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

    b. Requests for temporary relief;

    c. Appeals

    d. Post Conviction relief matters;

    e. Contempt of Court proceedings;

    f. Forfeiture proceedings brought by governmental entities;

    g. Mortgage foreclosures; and

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

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

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

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

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

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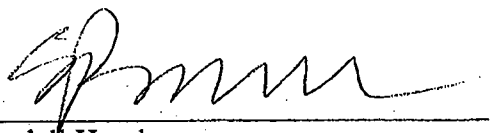
DAVID HAMILTON
C.C.C.P.& G.S.
YORK COUNTY, SC

TO: THE DEFENDANTS IN THE ABOVE NAMED ACTION

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

[SIGNATURE PAGE TO FOLLOW]



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Rock Hill, South Carolina

November 30, 2011

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

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

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

PARTIES

Plaintiffs

1. Plaintiff Elizabeth Hope Rainey, ("Rainey") is a citizen and resident of York County, South Carolina and is the duly appointed guardian ad litem of the minor child, Owen [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 [redacted] SCDSS is sued pursuant to the South Carolina Tort Claims Act which makes the employing entity liable for the torts of its employees (S.C. Code Ann. §15-78-70) and pursuant to the South Carolina Children's Code (S.C. Code Ann. § 63-1-10 et. seq.). Plaintiff alleges all employees of SCDSS were acting within the course and scope of their official duties in relation to this claim.

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

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

Kayla Lythgoe and Michael [redacted]

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 [redacted]

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

but by virtue of the history of the parents, one of the two of them was the only possible source of Owen [redacted] 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 [redacted] and ensured that Owen [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 [redacted]

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 [redacted] to ascertain how Owen [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 [redacted] safety from December 8, 2009 until January 11, 2010.

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

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 [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 [redacted] be a happy, healthy child today.

FOR A FIRST CAUSE OF ACTION
(Negligence - CMC)

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

33. While Owen [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 [redacted] back to the person who hurt him in the first place, Michael [redacted]

35. CMC agents and employees had a duty to Owen [redacted] to place him back into an abusive and terribly dangerous environment and breached that duty to Owen [redacted] and were thereby negligent, careless, grossly negligent, reckless and acted in violation of the duties owed to decedent in that they committed one or more of the following acts of omission or commission, any or all of which were departures from the duty owed to the minor Plaintiff:

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

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

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

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

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

f. in failing to adequately communicate the condition and safety needs of Owen [redacted] 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 [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 [redacted] was safe after SCDSS was notified of a potential harm to Owen [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 [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 [redacted] in December 2009 and January 2010. If the person who perpetrated negligent acts in regard to Owen [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 [redacted]

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

44. SCDSS, York County Sheriff's Department and YC voluntarily undertook an investigation of suspected abuse of Owen [redacted] and therefore owed Owen [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 [redacted] was abused.

46. SCDSS, York County Sheriff's Department and YC agents and employees breached their duties to Owen [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 [redacted] could be safely discharged into the care of his parents Kayla Lythgoe and Michael [redacted]

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

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

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 [redacted] and ensured the minor Plaintiff was not at risk of further injury at the hands of one of his parents, and specifically, Michael [redacted]

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 [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 [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 [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 [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 [redacted] in December 2009 and January 2010. If the person who perpetrated negligent acts in regard to Owen [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 [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 [redacted] injuries. The Children's Code imposes a duty on Sheriff Bryant and York County Sheriff's Department employees and agents to Owen [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 [redacted]

56. Agents and employees of Bryant (through York County Sheriff's Department) breached that duty to Owen [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 [redacted] to consider or determine whether or not Owen [redacted] could be safely protected from his parents Kayla Lythgoe and Michael [redacted]

b. in failing to adequately investigate and/or recognize or adequately consider the fact that Owen [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 [redacted] were harming Owen [redacted]

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

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

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

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

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

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

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

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

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

herein verbatim, and further alleges:

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

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

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

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

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

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

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

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

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

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

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

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

Rock Hill, South Carolina

November 30, 2011

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

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

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

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

3. I have reviewed the medical records of Owen [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 [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 [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 [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 [redacted] and the South Carolina (York County) Department of Social Services records of Owen [redacted] The factual basis of my opinions may be supplemented at a later time.

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

[SIGNATURE PAGE TO FOLLOW]

GEORGE W. SAVARESE, Ph.D., LCSW

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

Notary Public

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

My Commission expires: 5/26/2012

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

EDUCATION

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

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

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

ADMINISTRATIVE EXPERIENCE

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

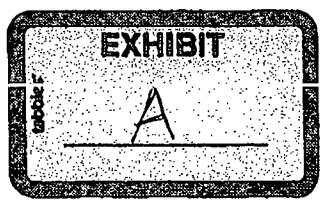
Executive Clinical Director. Founded and direct a private psychosocial services consultation organization which provides psychosocial risk and resource management services in a variety of clinical, medical, and forensic markets; Direct the strategic planning, organizational and program development, research,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

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

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

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

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



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

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

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

ACADEMIC EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TRAINING EXPERIENCE

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

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

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

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

CLINICAL EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESEARCH EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

OTHER EXPERIENCE

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

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

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

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

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

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

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

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

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

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

VOLUNTARY ACTIVITIES

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

PUBLICATIONS

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

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

MEMBERSHIPS/CERTIFICATIONS/LICENSES

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

STATE OF SOUTH CAROLINA)) COUNTY OF YORK)	IN THE COURT OF COMMON PLEAS SIXTEENTH JUDICIAL CIRCUIT Civil Action No.: 2011-CP-46-04508
Elizabeth Hope Rainey, as the appointment Guardian ad Litem to Owen [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.	**ANSWER OF THE DEFENDANT SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES**

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

00 44

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 [redacted], 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 [redacted] 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 [redacted] 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.

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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

00 50

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF YORK)	SIXTEENTH JUDICIAL CIRCUIT
Elizabeth Hope Rainey, as the appointment Guardian ad Litem to Owen [redacted] a minor,)	Civil Action No.: 2011-CP-46-04508
Plaintiff,)	
vs.)	**CERTIFICATE OF SERVICE**
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.)	

I, Rachelle G. Brown, a paralegal with the law firm of Davis, Frawley, Anderson, McCauley, Ayer, Fisher & Smith, LLC, do hereby certify that I have this date served a copy of the following documents upon the counsel named below, by placing a copy in the United States Mail, postage prepaid and return address clearly indicated to the address below:

COUNSEL SERVED:

S. Randall Hood, Esquire
Jordan Calloway, Esquire
Lara Pattis Harrill, Esquire
McGOWAN, HOOD, & FELDER, LLC
1539 Health Care Drive
Rock Hill SC 29732

Duane M. Shaw
Nathan J. Sheldon
SHAW LAW FIRM
1169 Ebenezer Road
Rock Hill, SC 29732

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

Monteith Powell Todd, Esquire
Sowell Gray Stepp & Laffitte, LLC
PO Box 11449
Columbia SC 29211

DOCUMENTS:

ANSWER OF DEFENDANT SCDSS

SCDSS' FIRST SET OF INTERROGATORIES TO PLAINTIFF

SCDSS' FIRST REQUEST FOR PRODUCTION TO PLAINTIFF

Rachelle G. Brown

Rachelle G. Brown

Lexington, South Carolina
January 9, 2012

STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS

Elizabeth Hope Rainey, as the appointment Guardian ad Litem to Owen [redacted] a minor,
☐ Plaintiff

v.

South Carolina Department Of Social Services, Et Al.
☒ Defendant.

CASE NO.

2011-CP-46-04508

MOTION AND ORDER INFORMATION FORM AND COVER SHEET

Plaintiff's Attorney:	Defendant's Attorney:
S. Randall Hood, Bar No.	Patrick J. Frawley, Bar No. 2118
Address:	Address:
McGowan, Hood, & Felder, LLC	Davis Frawley, LLC
1539 Health Care Drive, rockHill SC 29732	PO Box 489, Lexington SC 29071-0489
phone: 803-327-7800 fax: 803-328-5656	phone: 803-359-2512 fax: 803-359-7478
e-mail: rhood@mcgowanhood.com other:	e-mail: pat@oldcourthouse.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:45 minutes Court Reporter Needed: ☒ YES / ☐ NO

SECTION II: Motion/Order Type

☒ Written motion attached
☐ Form Motion/Order
I hereby move for relief or action by the court as set forth in the attached proposed order.

Signature of Attorney for ☐ Plaintiff / ☒ Defendant — December 29, 2016 Date submitted

SECTION III: Motion Fee

☒ PAID – AMOUNT: 25.00
☐ EXEMPT: (check reason)
☐ 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: _____

SCCA/233 (11-03)

☐ MOTION FEE COLLECTED: _____
☐ CONTESTED – AMOUNT DUE: _____

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF YORK)	SIXTEENTH JUDICIAL CIRCUIT
Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen [redacted] a minor,)	Civil Action No.: 2011-CP-46-04508
Plaintiff,)	**SCDSS'S NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT**
vs.)	
South Carolina Department of Social Services,)	
Defendants.)	

TO: S. RANDALL HOOD, JORDAN CALLOWAY, DUANE M. SHAW, AND NATHAN J. SHELDON, ATTORNEYS FOR THE PLAINTIFF ELIZABETH HOPE RAINEY, AS THE APPOINTED GUARDIAN AD LITEM TO OWEN [redacted] A MINOR:

YOU WILL PLEASE TAKE NOTICE that the Defendant South Carolina Department of Social Services, by and through its undersigned attorneys, will move before the presiding Judge of the York County Court of Common Pleas, of the Sixteenth Judicial Circuit, on the tenth day after service hereof, or as soon thereafter as Counsel may be heard, at the York County Courthouse, in York, South Carolina, or such other site as the Court may designate, for an Order granting this Defendant summary judgment as to the Plaintiff's claims against it, and dismissing those claims. This motion is the same Motion filed by this Defendant September 9, 2013, a clocked-in copy of which is attached hereto, which was withdrawn during the stay imposed while the Plaintiff appealed the dismissal of the co-Defendant Charlotte-Mecklenburg Hospital Authority. This motion is made on the grounds that there is no genuine issue of material fact but that this Defendant, through its agents and employees, exercised at least slight care and

beyond in its investigative efforts and handling of the matter subject of this action between the December 6, 2009 intake report received by this Defendant and the January 11, 2010 injury sustained by the minor child Owen [redacted] and was not grossly negligent as a matter of law. This motion is made on the further grounds that there is no evidence that the injury to the child that triggered the December 6, 2009 intake report was the result of any act or omission of the father of Owen [redacted] such that this Defendant should have had adequate cause to suspect that the father, Michael [redacted] would willfully and criminally injure the child January 11, 2010.

This motion is based upon the pleadings in this matter, documents produced through discovery, including this Defendant's case dictation and case file, depositions of the parties and witnesses, statutes, case law, rules of court, regulations, memoranda submitted by counsel, and such other and further authority as the Court may deem appropriate.

DAVIS FRAWLEY, LLC

By: _____

Patrick J. Frawley
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
December 29, 2016.

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

FILED-RECEIVED
2013 SEP -9 AM 10: 31

Elizabeth Hope Rainey, as the appointment ad Litem to Owen [redacted], a minor,
☐ Plaintiff

v.

South Carolina Department Of Social Services, Et Al.
☒ Defendant.

CASE NO.
2011-CP-46-04508

MOTION AND ORDER INFORMATION FORM AND COVER SHEET

Plaintiff's Attorney:	Defendant's Attorney:
S. Randall Hood, Bar No. Address: McGowan, Hood, & Felder, LLC 1539 Health Care Drive, rockHill SC 29732 phone: 803-327-7800 fax: 803-328-5656 e-mail: rhood@mcgowanhood.com other:	Patrick J. Frawley, Bar No. 2118 Address: Davis Frawley, LLC PO Box 489, Lexington SC 29071-0489 phone: 803-359-2512 fax: 803-359-7478 e-mail: pat@oldcourthouse.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: 45 minutes Court Reporter Needed: ☒ YES / ☐ NO

SECTION II: Motion/Order Type

☒ Written motion attached
☐ Form Motion/Order
I hereby move for relief or action by the court as set forth in the attached proposed order.

Signature of Attorney for ☐ Plaintiff / ☒ Defendant SCDSS — September 5, 2013 Date submitted

SECTION III: Motion Fee

☒ PAID – AMOUNT: 25.00
☐ EXEMPT: (check reason)
☐ 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: _____

SCCA/233 (11-03)

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF YORK) SIXTEENTH JUDICIAL CIRCUIT

FILED-RECEIVED
2013 SEP -9 AM 10:31
DAVID HAMILTON
C.C.P.S.

Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen [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.

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

SCDSS'S NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT

TO: S. RANDALL HOOD, JORDAN CALLOWAY, DUANE M. SHAW, AND NATHAN J. SHELDON, ATTORNEYS FOR THE PLAINTIFF ELIZABETH HOPE RAINEY, AS THE APPOINTED GUARDIAN AD LITEM TO OWEN CARDUFF, A MINOR:

YOU WILL PLEASE TAKE NOTICE that the Defendant South Carolina Department of Social Services, by and through its undersigned attorneys, will move before the presiding Judge of the York County Court of Common Pleas, of the Sixteenth Judicial Circuit, on the tenth day after service hereof, or as soon thereafter as Counsel may be heard, at the York County Courthouse, in York, South Carolina, or such other site as the Court may designate, for an Order granting this Defendant summary judgment as to the Plaintiff's claims against it, and dismissing those claims. This motion is made on the grounds that there is no genuine issue of material fact but that this Defendant, through its agents and employees, exercised at least slight care and beyond in its investigative efforts and handling of the matter subject of this action between the December 6, 2009

intake report received by this Defendant and the January 11, 2010 injury sustained by the minor child Owen [redacted] and was not grossly negligent as a matter of law. This motion is made on the further grounds that there is no evidence that the injury to the child that triggered the December 6, 2009 intake report was the result of any act or omission of the father of Owen [redacted] such that this Defendant should have had adequate cause to suspect that the father, Michael [redacted] would willfully and criminally injure the child January 11, 2010.

This motion is based upon the pleadings in this matter, documents produced through discovery, including this Defendant's case dictation and case file, depositions of the parties and witnesses, statutes, case law, rules of court, regulations, memoranda submitted by counsel, and such other and further authority as the Court may deem appropriate.

DAVIS FRAWLEY, LLC

By: _____

Patrick J. Frawley
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
September 5, 2013.

00 59

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF YORK)
) SIXTEENTH JUDICIAL CIRCUIT
Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen [redacted], a minor,) Civil Action No.: 2011-CP-46-04508

Plaintiff,

vs. CERTIFICATE OF SERVICE

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

Defendants.

FILED-RECEIVED
2013 SEP -9 AM 10:03
DAVID HAMILTON
CLERK OF COURT

I, Rachelle G. Brown, a paralegal with the law firm of Davis Frawley, LLC, do hereby certify that I have this date served a copy of the following documents upon the counsel named below, by placing a copy in the United States Mail, postage prepaid and return address clearly indicated to the address below:

COUNSEL SERVED:

S. Randall Hood, Esquire
Jordan Calloway, Esquire
Lara Pattis Harrill, Esquire
McGOWAN, HOOD, & FELDER, LLC
1539 Health Care Drive
Rock Hill SC 29732

Duane M. Shaw
Nathan J. Sheldon
SHAW LAW FIRM
1169 Ebenezer Road
Rock Hill, SC 29732

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

Monteith Powell Todd, Esquire
Sowell Gray Stepp & Laffitte, LLC
PO Box 11449
Columbia SC 29211

DOCUMENTS: **SCDSS'S NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT**

Rachelle G. Brown

Rachelle G. Brown

Lexington, South Carolina
September 5, 2013

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF YORK)	SIXTEENTH JUDICIAL CIRCUIT
Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen [redacted] a minor,)	Civil Action No.: 2011-CP-46-04508
Plaintiff,)	
vs.)	**CERTIFICATE OF SERVICE**
South Carolina Department of Social Services,)	
Defendant.)	

I, Rachelle G. Brown, a paralegal with the law firm of Davis Frawley, LLC, do hereby certify that I have this date served a copy of the following documents upon the counsel named below, by placing a copy in the United States Mail, postage prepaid and return address clearly indicated to the address below:

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1539 Health Care Drive
Rock Hill SC 29732

Duane M. Shaw
Nathan J. Sheldon
SHAW LAW FIRM
1169 Ebenezer Road
Rock Hill, SC 29732

DOCUMENTS: **SCDSS'S NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT**

Rachelle G. Brown

Lexington, South Carolina
December 29, 2016.

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF YORK)	SIXTEENTH JUDICIAL CIRCUIT
Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen [redacted] a minor,)	Civil Action No.: 2011-CP-46-04508
Plaintiff,)	**MEMORANDUM IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT**
vs.)	
South Carolina Department of Social Services,)	
Defendants.)	

The Defendant South Carolina Department of Social Services (hereinafter "SCDSS") offers the following Memorandum in Support of its Motion for Summary Judgment, filed January 4, 2017.

This case arises out of physical abuse of a four-month-old minor child on January 11, 2010 by his father, and whether SCDSS was grossly negligent in its investigation of a December 6, 2009 intake report involving the same child. There is no genuine issue of material fact with regard to what occurred between the December 6, 2009 intake report and the January 11, 2010 injury, with the sole issue to be determined being whether the actions of SCDSS in responding to the intake and conducting its investigation amounted to at least slight care, and were not grossly negligent as a matter of law.

I. FACTUAL BACKGROUND.

Owen [redacted] was born [redacted] to Kayla Lythgoe, then 19 years old, and Michael [redacted] then 18 years old. On December 4, 2009, when Owen was twelve weeks old, his parents took him to Piedmont Medical Center (hereinafter "PMC") in Rock Hill for medical attention. On December 5, 2009 PMC physicians transferred

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Owen to Levine Children's Hospital (hereinafter "Levine") at Charlotte-Mecklenburg Hospital Authority ("CMHA") in Charlotte for further care. The following day, December 6, a CT scan by CMHA staff revealed a subdural hematoma, which raised suspicions of a non-accidental injury to Owen. Levine then notified the York County office of SCDSS that the child may have been the victim of non-accidental trauma.

SCDSS received an intake December 6, 2009, at 5:01 p.m., reporting that a 2-month old baby with two subdural hematomas had been admitted to the hospital, raising the possibility of non-accidental trauma, although the report went on to indicate that the parents' behavior with the child had been "appropriate." *See*, SCDSS Intake Summary, attached hereto as Appendix "A." On-call case worker Chandra Tyler responded to the hospital by 7:45 p.m., having face-to-face meetings with the parents of the child and collaterals—the paternal grandparents, a paternal uncle, and an unnamed nurse. *See*, SCDSS Case Dictation, attached hereto as Appendix "B" (hereinafter "Dictation"), pp. 309-311.[1] Ms. Tyler provided the parents with the DSS Brochure 3034 and the handbook entitled *Child Protective Services: A Guide For Parents*, advising them of the SCDSS procedure in Child Protective Services (CPS) cases and their right to representation by counsel, which both parents signed for, acknowledging receipt. *Id.*, p. 311; *see also*, DSS Brochure 3034 (Feb. 03) and signed Acknowledgement, attached hereto as Appendix "C." Ms. Tyler also had the parents sign a Safety Plan, pursuant to which the parents agreed to follow medical advice of the hospital, and not to remove the child from the hospital until the child was medically discharged. Dictation, p. 309; *see also*, SCDSS Safety Plan (12/6/09), attached hereto as Appendix "D." The nurse Ms. Tyler spoke with seemed unaware of a CPS call, and thought that Ms. Tyler was at the

[1] Case Dictation is read from back to front, with the first entry with Action Date 12/6/09 appearing on page 311, at the end of Appendix "B," and the most recent entry with Action Date 1/11/10—the day after the child's second injury—appearing on page 288.

hospital to relieve the sitter who was present in the room with the child. *Cf.*, Dictation, p. 310, bottom paragraph ("The nurse seemed confused and said that they had no known concerns of non accidental trauma and that the social worker was not supposed to be calling for those reason [sic], but was to call to get DSS approval to remove the sitter for Owen's room.").

The morning of December 7, 2009 Ms. Tyler and her supervisor, Lola Sutherland, had a staffing with the assessment case worker to whom the case was being assigned, Dirvondra Hill, and her supervisor Krista Hinnant. *See, e.g.*, Dictation, pp. 305-307; Deposition of Lola Sutherland (January 10, 2013)(hereinafter "Sutherland Deposition," excerpts attached hereto as Appendix "E"), p. 27, line 19 to p. 28, line 20; Deposition of Krista M. Hinnant (January 10, 2013)(hereinafter "Hinnant Deposition," excerpts attached hereto as Appendix "F"), p. 39, line 20 to p. 40, line 11; Deposition of Dirvondra Hill (January 14, 2013)(hereinafter "Hill Deposition," excerpts attached hereto as Appendix "G"), p. 12, lines 9-17; SCDSS Case Transfer and/or Case Staffing form 3062 (December 7, 2009), attached hereto as Appendix "H." In the initial staffing, it was discussed that Owen had two subdural hematomas, that the hospital social worker and a nurse had concerns that the injuries were the result of non-accidental trauma, but no doctor was saying that injuries were non-accidental, and that the child was ready for discharge from the hospital. Dictation, p. 307.

After the initial staffing and accepting the transfer of the case from the on-call caseworker Tyler, SCDSS Assessment Supervisor Hinnant and Assessment Caseworker Dirvondra Hill had a second staffing that same morning with SCDSS Legal. *See,* Dictation, pp. 307-308; Hinnant Deposition, p. 39, line 20 to p. 40, line 6; p. 41, lines 6-11; SCDSS Case Transfer and/or Case Staffing Form 3062, Legal Staffing (December 7,

2009), attached hereto as Appendix "I." Later that morning, DSS supervisor Krista Hinnant contacted Levine Children's Hospital social worker Laura McDowell, inquiring into whether doctors thought the trauma was non-accidental. Dictation, p. 305. McDowell told Hinnant that she would speak with the doctors and report back to her. *Id.* Hinnant spoke with a second social worker, Laura Newmark, at approximately 11:50 a.m., who told Hinnant that she was the social worker who had been working with the [redacted] family, that she had spoken with the pediatric staff, and that they could not determine whether the child's injuries were accidental or not. *Id.*, p. 304. She told Hinnant that, although the family had no clear history of trauma, the hospital could not rule out trauma, but that there were no obvious findings of abuse or neglect, and that the hospital mostly had concerns about lack of supervision. *Id.* Newmark further stated that Dr. Cheryl Courtland was working with the child, and that Dr. Courtland could not determine if the injuries were accidental or not at that point in time. *Id.*

Hinnant staffed the matter with the DSS legal department, and authorized the discharge of the child to the care of his parents. Dictation, pp. 303-304; Hinnant Deposition p. 31, line 18 to p. 32, line 19, p. 33, lines 3-17. Dirvondra Hill attempted a home assessment with the child later December 7, but found no one at home. Dictation, p. 308; Hill Deposition, p. 10, line 16 to p. 12, line 6. Ms. Hill followed up with attempted home visits December 8 and 10, but found no one at home. Dictation, pp. 301-302. Ms. Hill sent a "home attempt" letter to Michael [redacted] and Kayla Lythgoe, indicating her unsuccessful attempts to visit the home, and scheduled a home visit for December 21 at 9:00 a.m. *See*, Hill Deposition, p. 35, line 6 to p. 36, line 6; Hill letter to [redacted] Lythgoe (undated), attached hereto as Appendix "J."

Ms. Hill sent criminal records check inquiries to the York County Sheriff's Department December 16, 2009 for Michael [redacted] Kayla Lythgoe, and Charlotte Williams, the maternal grandmother. *Id.*, p. 300; Appendix "K," attached hereto.

Ms. Hill finally caught someone at home for a home visit and face-to-face interview with the mother, Lythgoe, on December 17. Dictation, pp. 299-300. Lythgoe was about to leave for work, so the visit was short; but she told Ms. Hill that the child was out with the grandmother while Lythgoe worked, and could not give a phone number at which she could be reached. *Id.*, p. 299. Ms. Hill presented Lythgoe with a third Safety Plan, which Lythgoe signed, and, after Lythgoe acknowledged having received the "home attempt" letter from DSS, she and Ms. Hill agreed to a meeting December 21 at 9:00 a.m., for Ms. Hill to inspect the home and meet all members of the household. *Id.*

On December 17 Ms. Hinnant spoke with a Lt. Miller of the York County Sheriff's Department, who told Hinnant the Department had received the law enforcement inquiry, but needed additional information. Hinnant provided the additional information to Lt. Miller. Dictation, p. 298.[2]

Ms. Hill met with Michael [redacted] Kayla Lythgoe, and the child at the [redacted] home on December 21. Dictation, pp. 297-298. Ms. Hill read the allegations of the report and received a history from the mother and father of what had happened leading up to the child's hospitalization. *Id.* Ms. Hill noted that the home was "warm and organized in the living room," and observed that the child was on the floor with the father, describing the child as "vibrant lying on his back on a blanket kicking his feet and arms laughing and smiling as his father interacted with him." *Id.*, p. 298. Ms. Hill presented a fourth Safety Plan, which the parents signed. *Id.*

[2] The criminal records check came back negative for Kayla Lythgoe and Michael [redacted] but indicated that the maternal grandmother, Charlotte Williams, had a criminal domestic violence conviction in her history. Hinnant Deposition, p. 92, line 14 to p. 94, line 16.

On January 4, 2010, Krista Hinnant and Ms. Hill staffed the case, resolving to get all medical records, follow up with the December 16 law enforcement inquiry, and assess the grandmother Charlotte Williams' home. Dictation, pp. 296-297; SCDSS Case Transfer and/or Case Staffing form 3062 (January 4, 2010), attached hereto as Appendix "H."

On January 11, 2010, Michael [redacted] and Kayla Lythgoe took their son to Piedmont Medical Center, and the nurse they spoke with—Elizabeth Super—later told Ms. Hill that she observed multiple bruises to the body, left leg, left hand, chest, and face of the child. Dictation, p. 290. The mother explained that the child had been "normal" on the previous day, but the next morning was having seizures, and the parents apparently attempted to attribute the bruises to the child scratching himself. *Id.* The child was transferred, actively seizing, to Levine Children's Hospital ICU, in critical condition, on a ventilator. *Id.*, pp. 289-291. CT scans were performed at PMC and Levine, which revealed up to five new areas of brain bleeds for the child different from the two he had in December. Skeletal CT scans were negative for fractures. *Id.* At one point the child was taken off of life support, with doctors opining that he was terminal, and he was moved to a Rock Hill hospice; but the child did recover, but he has permanent brain damage and vision problems. He has been in the custody of the maternal grandparents.

Law enforcement got involved, administered a polygraph test to the father, Michael [redacted] who confessed to having injured the child. He has pled guilty to criminal charges, and is currently incarcerated. The mother, Kayla Lythgoe, passed her polygraph, indicating, apparently, that she neither abused the child nor was aware that the father had abused him. The father has never admitted injuring the child resulting in the

first hospitalization, however, which is the incident the Plaintiff argues should have alerted SCDSS that the father was a potential safety threat to the child.

II. DISCUSSION.

A. Pleadings.

This matter was started with the filing of a Summons and Complaint in York County on December 1, 2011, naming SCDSS as a Defendant, along with Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Medical Center, Bruce Bryant, as the Sheriff of York County, the York County Sheriff's Department, and York County, and alleging that the Plaintiff was the duly appointed Guardian ad Litem for Owen [redacted] a minor, born [redacted] to Kayla Lythgoe and Michael [redacted] of York County, and that Owen [redacted] had been hospitalized at Levine Children's Hospital, in Charlotte, North Carolina on December 4, 2009 for injuries that were suspected to be non-accidental trauma, that the York County office of SCDSS was alerted by medical social workers from the hospital that the injuries may have been non-accidental, but the hospital released the child to its parents on December 8, 2009, and that the child was again admitted to the hospital January 11, 2010 for more serious injuries that resulted from physical abuse by the father, which injuries have left the child permanently injured. The Complaint alleges that the various Defendants failed to fulfill their respective duties owed the child, with SCDSS being accused of, essentially, failing to adequately investigate the report and failing to protect the child from further injury at the hands of his father after having received the report. The claims against all of the Defendants are couched as negligence causes of action, with an additional cause of action against all Defendants being called a "Necessaries Claim," being brought on behalf of the maternal grandparents, who now

00 69

have custody of the child, for medical and life care expenses for the child's life. The Summons and Complaint were served upon SCDSS December 8, 2011.

SCDSS answered January 9, 2012, interposing a qualified general denial, asserting, in part, that SCDSS received an intake report at 5:01 p.m. on December 6, 2009, responded to the Charlotte hospital by 7:45 p.m. the same day, and conducted an appropriately thorough and timely investigation, and took appropriate steps to protect the child, given the information that was available at the time. SCDSS also alleged affirmative defenses sounding in intervening negligence of third parties, South Carolina Tort Claims Act defenses under *S.C. Code Ann.* §15-78-60(1), (2), (3), (4), (5), (12), (20), (23), and (25), and §15-78-120(b) as a bar to punitive damages.

B. Summary Judgment Standard.

Summary Judgment is appropriate and should be granted if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. *See, e.g., Hancock v. Mid-South Management Co., Inc.*, 381 S.C. 326, 329, 673 S.E.2d 801, 802 (S.Ct. 2009); *Lanier Construction Company, Inc. v. Bailey & Yobs, Inc.*, 384 S.C. 275, 278, 681 S.E.2d 909, 911 (S.C. App. 2009). Summary Judgment is completely appropriate when a properly supported motion sets forth facts that remain undisputed or are contested in a deficient manner. *Lanier*, 384 S.C. at 278, 681 S.E.2d at 911. Supporting and opposing affidavits shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated thereon. SCRCP Rule 56(e). In determining whether any triable issues of fact exist, the evidence and all inferences which can be reasonably drawn from the

evidence must be viewed in the light most favorable to the nonmoving party. *E.g.*, *Hancock*, 381 S.C. at 329-330, 673 S.E.2d at 802; *Strother v. Lexington County Recreation Comm'n*, 332 S.C. 54, 504 S.E.2d 117 (1998).

In cases applying the preponderance of the evidence burden of proof, the non-moving party is only required to submit a mere scintilla of evidence in order to withstand a motion for summary judgment. *Hancock*, 381 S.C. at 330, 673 S.E.2d at 803. However, under South Carolina case law, the meaning of the "scintilla of evidence rule" is *not* that, if there is *any* relevant testimony, amounting to a scintilla, it must be left to the jury to determine its force and effect; rather, "[t]he meaning of the rule is that there must be some *evidence* arising out of the testimony which elucidates the issues of fact, and which enables the jury to form an intelligent conclusion. It does not authorize the admission of speculative, theoretical, and hypothetical views." *Crawford v. Town of Winnsboro*, 205 S.C. 72, __, 30 S.E.2d 841, 849 (S.Ct. 1944) (emphasis in original). *Cited with approval* in *Radcliffe v. Southern Aviation School*, 209 S.C. 411, 420, 40 S.E.2d 626, 630 (S.Ct. 1946). *See also, Radcliffe*, 209 S.C. at 421, 40 S.E.2d at 630 ("[if] it be conceded that there may be deduced by a process of unusual *finesse* of reasoning that there is a scintilla of evidence * * * nevertheless there is another rule, more founded upon common sense and reason, to the effect that when only one reasonable inference, not just one inference, but one reasonable inference, can be deduced from the evidence, it becomes a question of law for the court, and not a question of fact for the jury." (emphasis in original)).

The remedy provided by the South Carolina Tort Claims Act is the exclusive civil remedy available for any tort committed by a governmental entity, its employees, or its agents, so long as they act within the scope of their official duties, and did not commit

actual fraud, actual malice, intent to harm, or a crime involving moral turpitude. *See, e.g., S.C. Code Ann.* § 15-78-20(b), 15-78-70(b) (1986 as amended). Provisions establishing limitations upon and exemptions from liability of a governmental entity must be liberally construed in favor of limiting liability. *S.C. Code Ann.* §§ 15-78-20(f), 15-78-200 (1997 as amended).

C. Gross Negligence Standard.

The South Carolina Tort Claims Act, codified at *S.C. Code Ann.* §§15-78-10 through -220 (1986 as amended), is a limited waiver of governmental immunity. *See, e.g., Staubes v. City of Folly Beach*, 331 S.C. 192, 204, 500 S.E.2d 160, 167 (Ct. Ap. 1999). The remedy provided by the South Carolina Tort Claims Act is the exclusive civil remedy available for any tort committed by a governmental entity such as SCDSS, its agents or employees, so long as they act within the scope of their official duties, and did not commit actual fraud, actual malice, intent to harm, or a crime involving moral turpitude. *See, e.g., S.C. Code Ann.* §§15-78-20(b), 15-78-70(b) (1986 as amended), 15-78-200 (1997 as amended); *Huggins v. Metts*, 371 S.C. 621, 624, 640 S.E.2d 465, 466 (Ct. Ap. 2007). Provisions of the South Carolina Tort Claims Act establishing limitations upon and exemptions from liability of a governmental entity must be liberally construed in favor of limiting liability. *Id.* §§15-78-20(f), 15-78-200; *Staubes,* cited *supra,* 331 S.C. at 205, 500 S.E.2d at 167. A governmental entity such as SCDSS is not liable for a loss resulting from responsibility or duty, including but not limited to supervision, protection, control, confinement, or custody of any student, patient, prisoner, inmate, or *client* of the governmental entity, except when the responsibility or duty is exercised in a grossly negligent manner. *Id.* §15-78-60(25) (1986 as amended) (emphasis added).

South Carolina Courts have defined gross negligence in a number of ways: as the intentional, conscious failure to do something which one ought to do or the doing of something one ought not to do, as the failure to exercise slight care, *e.g.*, *Etheredge v. Richland School District One*, 341 S.C. 307, 310, 534 S.E.2d 275, 277 (2000); *Clyburn v. Sumter County District Seventeen*, 317 S.C. 50, 53, 451 S.E.2d 885, 887 (1994); *Staubes*, cited *supra*, 331 S.C. at 204, 500 S.E.2d at 167, and as a conscious failure to exercise due care. *Staubes*, 331 S.C. at 204, 500 S.E.2d at 167. While gross negligence is ordinarily a mixed question of law and fact, when the evidence supports but one reasonable inference, the question becomes a matter of law for the Court. *Etheredge*, 341 S.C. at 310, 534 S.E.2d at 277 (2000); *Clyburn*, 317 S.C. at 53, 451 S.E.2d at 887.

If a Defendant has exercised at least slight care, the fact that it might have done more does not negate the fact that it did exercise slight care and was not grossly negligent. *Etheredge*, 341 S.C. at 312, 534 S.E.2d at 278. *See also*, *Clyburn*, 317 S.C. at 53-54, 451 S.E.2d at 888 (in affirming Court of Appeals affirmation of lower Court grant of summary judgment in suit brought by high school student for injuries sustained in knife attack by a non-student assailant on a school bus, South Carolina Supreme Court, while acknowledging the student's argument that the School District had not brought a criminal action against the assailant after an earlier incident, enumerated those steps that the School District had taken to avert a further attack, and concluded that the only reasonable inference to be drawn from those facts was that the School District, at the very least, had exercised slight care, and was not grossly negligent as a matter of law).

D. SCDSS was not Grossly Negligent.

There is no genuine issue of material fact but that SCDSS exercised at least slight care and beyond in its investigative efforts and handling of this matter from the time it

received the intake report on December 6, 2009 through the January 11, 2010 injury sustained by Owen [redacted] at the hands of his father, and was not grossly negligent as a matter of law. The on-call caseworker, Ms. Tyler, responded quickly after receiving the intake report December 6, 2009, spoke with the parents and paternal extended family at the hospital, as well as hospital personnel. Ms. Tyler also had the parents enter into a Safety Plan after providing them with the SCDSS Brochure, advising them of their rights. The following morning Ms. Tyler and her supervisor, Lola Sutherland, staffed the case with the Assessment Supervisor Krista Hinnant and the Assessment Caseworker who was to take over the case, Dirvondra Hill; and Hinnant and Hill later that morning staffed the case again with SCDSS Legal. Ms. Hinnant had conversations with Hospital Social Workers to determine if the child's injuries indicated non-accidental trauma, and was able to get no doctor to opine that the child's injuries were the result of anything other than an accidental occurrence. With the hospital indicating that the child was medically ready for discharge and no indication from the health care professionals that the injuries were the result of non-accidental trauma, Ms. Hinnant consulted again with DSS legal, and told the hospital to release the child to his parents.

Hill attempted a home visit unsuccessfully on December 7, 8, and 10, then sent a letter to the parents scheduling a home visit for December 21 at 9:00 a.m.; despite that scheduling, Hill made another attempt at a home visit December 17, and was able to find the child's mother at home, and confirmed the December 21 meeting. At the December 21 home visit—Ms. Hill's *fifth* attempt at the home visit—the child and father interacted well and the home appeared to not be a threat to the child. Dictation, pp. 297-298.

The Plaintiff's claim against SCDSS is made with total 20-20 hindsight, asserting that the caseworker, Ms. Hill could have done more, or done it more quickly, or reached

different conclusions from what she saw. They will argue that Krista Hinnant should have spoken to one more hospital social worker, or another doctor or nurse before concluding that, with no medical opinion that the injury was the result of non-accidental trauma, she should never-the-less have had DSS take custody of the child. Yet all of those arguments are asserting a simple negligence standard, attempting to impose a qualitative analysis of the acts or omissions of SCDSS, when the South Carolina Tort Claims Act imposes a quantitative analysis. *S.C. Code Ann.* §15-78-60(25) imposes a gross negligence standard on the Plaintiff's claim; and in order to prevail, the Plaintiff must prove that SCDSS failed to exercise even slight care in its efforts in investigating Owen [redacted] case. *Etheredge v. Richland School District One*, 341 S.C. 307, 310, 534 S.E.2d 275, 277 (2000); *Clyburn v. Sumter County District Seventeen*, 317 S.C. 50, 53, 451 S.E.2d 885, 887 (1994); *Staubes*, cited *supra*, 331 S.C. at 204, 500 S.E.2d at 167 While in retrospect, SCDSS perhaps could have done more, or done things more quickly, or done them better; but the fact that SCDSS did not do all things the way the Plaintiff would assert does not detract from the fact that it did, through its caseworkers and supervisors, exercise beyond slight care. The SCDSS Case Dictation alone catalogs the level of care that SCDSS went to, and it exceed slight care. SCDSS is not grossly negligent as a matter of law. *Etheredge*, 341 S.C. at 312, 534 S.E.2d at 278. *See also*, *Clyburn*, 317 S.C. at 53-54, 451 S.E.2d at 888.

Owen [redacted] injuries are tragic, but SCDSS did not strike the blows that injured the child, and there was nothing that SCDSS did or failed to do that could have prevented the injuries. The father, Michael [redacted] who admitted injuring his son, had no criminal record. There was no indication that he was the author of the child's injuries from the December 6 intake report. There is no evidence that the Plaintiff has come

forward with indicating that Michael [redacted] inflicted the December 6 injuries to the child. SCDSS sought a medical opinion that the December 6 injuries were the result of non-accidental trauma and received no such opinion. SCDSS was only thirty-six days into its investigation when Owen was injured a second time on January 11, still within its 45-day investigative period, with no red flags having been raised by the mother of the child or the maternal grandmother, who were in closer proximity to Michael [redacted]

There is no genuine issue of material fact but that SCDSS did exercise at least slight care and beyond in its efforts to respond to the December 6 intake report and investigation. As a matter of law SCDSS is not grossly negligent, and is entitled to Summary Judgment and dismissal of the Plaintiff's action.

E. No Evidence of the Cause for the December 6, 2009 Injury.

There is no evidence that the injury to Owen [redacted] that triggered the December 6, 2009 intake report to SCDSS was the result of any act or omission of the father of Owen [redacted] such that SCDSS should have had adequate cause to suspect that the father, Michael [redacted] would willfully and criminally injure his son January 11, 2010.

III. CONCLUSION.

For the foregoing reasons argued above, the Defendant SCDSS is entitled to an Order of this Court granting the SCDSS Motion for Summary Judgment.

DAVIS FRAWLEY, LLC

By: _____

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ATTORNEYS FOR THE DEFENDANT
SOUTH CAROLINA DEPARTMENT OF
SOCIAL SERVICES

Lexington, South Carolina
March 7, 2017.

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HR1590-R01 | South Carolina Department of Social Services | 12/16/2010 15:01

Intake Summary w/Supplemental Person

Intake ID: 0001293788 **Intake Name: [redacted] Michael**

Secion (A) - Intake Decision

Intake Date: 12/06/2009 **Intake Time:** 17:01:00 **Intake Worker:** Cook Patricia
Intake Decision: Accepted/Approved **Intake Reason:** CPS Investigative Assessment
Reason Text:

Assigned Supervisor: Sutherland, Lola P **Case ID:** 0001113743 **Case Name:** Lythgoe, Kayla
Collateral Contact: none reported Oncall worker: Chandra Tyler
Referred to Law Enforcement: Supervisor Signature:

Section (B) - Address

Type: Household
Address: [redacted]

Directions to Address

Telephone Numbers

Type: Cell Phone
Number: (803) 280-3048 ext:

Section (C) - Persons Involved

Person ID	Last Name. First	DOB/AGE	Sex	Relationship	Caregiver	Role	Race	Language
0001545390	Lythgoe, Kayla	[redacted]		Birth Parent		Alleged Perpetrator	White	English
0001545391	Williams, Charlotte	[redacted]		Grandparent		Non-Perpetrator	White	English
0001545389	[redacted] Michael	[redacted]		Birth Parent		Alleged Perpetrator	White	English
0001545398	[redacted] Owen	[redacted]		Birth Child		Alleged Victim	White	English

Sectio (D) - Allegation

Client Abuse/Neglect Issues Related to this Intake

TOH Physical Neglect

Incident Address: **Incident Date:** **Incident Time:**

Incident Phone:

Allegations/Concerns

R/S 2 month old male baby has 2 wubdural hematoma (sizes 3 mm and 2 mm). R/S there is a Fatx Subdural Hematoma which raises the possiblity of none accidental trauma. R/S parents behavior has been appropriate w/the child.

Section (E) - This Section not used by APS

Section (F) - Victims Unique Attributes

Person ID	Last Name, First	Sex	In Imminent Danger	Need Medical Treatment	Need Medical Evaluation
0001545398	[redacted], Owen	Male			

Section (G) - Alleged Perpertrators unique Attributes

Person ID	Last Name, First	Sex	Degree of Dangers to Workers
0001545390	Lythgoe, Kayla	Female	
0001545389	[redacted], Michael	Male	

Section (H) - Report Risk Factors

Client Characteristics
Baby is 2 months old.[redacted] Baby was intially admitted to Piedmont Medical on 12-4-09 and was transferred to CMC Main (Levine Children's Hospital). R/S CT scan shows 2 subdural hematomas (sizes 3mm and 2 mm). R/S there is a fatx subdural

Environmental Factors
no known stressors. CM did not see the home

Caretaker Characteristics
Parents were observed to be apporpriate and concerned. Parents took the baby for medical treatment on 11-28, 12-2 and 12-4. No mental, physical, spouse abuse known at this time. No known prior CPS history. Parents reside w/ maternal GM and they all

Social/Economic Factors
Both parents are employed and live together. No known marital financial problems noted at this time.

Facility Operating Practices
are the primary caregiver of the child.

Additional Risk Factors
hematoma which raises the possiblity of no accidental trauma. No other children in the home. CM was informed of no prior physical/mental delinquency.

Section (I) - Risk Tag Information

Child Protective Services

Overall Rating:	Medium
Seriousness:	High
Age:	High
Frequency:	Low
Accessibility of Alleged Perpetrator:	Low

Section (J) - Screening Information

Was the alleged perpetrator a caretaker of the child or action in Loco Parentis as defined by Section 20-7-490(5)? Yes

If No, is the person responsible negligent in protecting the child?

Is there a specific allegation of abuse/neglect that meets the legal definition? Yes

Section (K) - Services History

Section (K-1) - Intake History

SCDSS 0467

Intake ID	Program	Date	Worker	Intake Name	Decision	Risk Rating
0001309860	Child Protective Services	5/11/2010	Seepersaud Bobby	Bryson, Deborah	Accepted/Approved	Medium
0001299692	Child Protective Services	2/5/2010	Sexton Edward	Lythgoe, Kayla	Accepted/Approved	Medium

0001299682	Child Welfare Services (Non-CPS)	2/5/2010	Sexton Edward	Lythgoe, Kayla	Void - Created in Error	
0001293788	Child Protective Services	12/6/2009	Cook Patricia	[redacted], Michael	Accepted/Approved	Medium

Service (K-2) - Case History

Section (L) - Person Report

Person ID: 0001545390
Person Name: Lythgoe, Kayla
Role: Alleged Perpetrator
Relationship: Birth Parent
DOB/Age: [redacted]
Sex: Female
Military Branch:
Primary Race: White
Household Address: [redacted]

Person ID: 0001545391
Person Name: Williams, Charlotte
Role: Non-Perpetrator
Relationship: Grandparent
DOB/Age: [redacted]
Sex: Female
Military Branch:
Primary Race: White
Household Address: [redacted]

Person ID: 0001545389
Person Name: [redacted] Michael
Role: Alleged Perpetrator
Relationship: Birth Parent
DOB/Age: [redacted]
Sex: Male
Military Branch:
Primary Race: White
Household Address: [redacted]

Person ID: 0001545398
Person Name: [redacted] Owen
Role: Alleged Victim
Relationship: Birth Child
DOB/Age: [redacted]
Sex: Male
Military Branch:
Primary Race: White
Household Address: [redacted]

[redacted]

HRI600-R01 | South Carolina Department of Social Services | 12/16/2010 15:01

Reporter

Intake ID - 0001293788

Reporter Name: Kathy Harrison
Address: CMC Main
, NC

Phone: (704) 446-0069

Reporter Type: Hospital / Clinic
Call Reporter Back?
Confidentiality? Yes

Source:
see dictation

Collateral Contacts Suggested:
none reported
Tyler
Oncall worker: Chandra

Did Reporter Request Feedback?
Yes

SCDSS 0470

Dictation

HRC690-R01 | South Carolina Department of Social Services | 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen - [redacted]

Action Date: 1/11/2010 **Action Time:** 7:20 PM **Time Spent:** 1.00

Input Date: 1/12/2010 **Input Time:** 7:28 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:28:06 1/12/2010

Collateral Contact-Wesley Clement-optimist
Arrived at the hospital after 7pm to examine the child's eyes. He reported there was hemorrhaging and bleeding in the back of the eye.

AM 7:29:13 1/12/2010

Correction-Wesley Clement-Opthlalmologist

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen - [redacted]

Action Date: 1/11/2010 **Action Time:** 6:15 PM **Time Spent:** 0.75

Input Date: 1/12/2010 **Input Time:** 7:23 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

SCDSS 0288

AM 7:23:51 1/12/2010

Collateral Contact-Otwell Timmons(Doctor)
Child had CT Scan on December 5th and December 7th. Doctor showed case manager all three CT scans

for Owen. He pointed out on December 7th the brain tissue looked healthy-however on today there was more fluid, acute blood-brain cells have died(infraction)-there were no broken bones, there were multiple bruising in which babies don't get bruised there. Doctor was Dwight Bailey during the day-his phone number is (704)381-6100 page him if cant get in contact. Owen was taken to Piedmont Medical Center earlier this morning in which the baby was actively seizing and was airlift to Levine's. Don't know how long and when the incident occurred however the incident did happen within 24 hours-will not be able to detect until 72 hours. Doctor Timmons reported there was brain tissue dead and caused a stroke. Doctor informed case manager there was a history of head bleeds.

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen - [redacted]

Action Date: 1/11/2010 **Action Time:** 6:00 PM **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 7:22 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:22:30 1/12/2010

Collateral Contact-Heather Maykowski(Nurse)
CT Scan was performed at PMC and Levine's. Almost five areas (new ones) have formed-they are not the same hematomas as the last time the child was at Levine's about a month ago. Child was admitted today around 1pm or 1:30pm. Father went with Detective back to York County with Amanda Carter to get a polygraph test. There was no explanations from either parent-baby could have been dropped. An opthlalmologist will be here at 7pm to look at the baby's eyes to determine if there is bleeding behind the eye-he will be able to detect. The bone examinations were in-the test was negative as the test was negative in December 2009 when the child was there the second time. Nurse informed the CT scan are different from last time the child was there.

HRC690-R01 | South Carolina Department of Social Services | 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen - [redacted]

Action Date: 1/11/2010 **Action Time:** 5:45 PM **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 7:16 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:16:42 1/12/2010
Collateral Contact-Elizabeth Super(Nurse)
Nurse stated the family came in today and she observed multiple bruises to the body-left leg, left hand, chest, face-she stated the statements about the baby scratching himself-she was not buying it. Case manager inquired about the parents' statements-she stated the parents could not explain the injury-they stated they did not know how the child received the hematomas. She stated the mother said the child was normal on yesterday (Sunday). Mother checked on the child Monday morning around 5-6am and again at 10am and noticed the baby was having a seizure-child was making noises and having uncontrollable seizures-she took the child to Piedmont Medical Center in Rock Hill, SC.

Actions:

Face to Face with child/client

Recipients:

0001545391 - Williams, Charlotte - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 1/11/2010 **Action Time:** 5:15 PM **Time Spent:** 2.00

Input Date: 1/12/2010 **Input Time:** 7:15 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:15:23 1/12/2010

Face to Face with child/Client

FYI: Owen has acute bleed in the head actively seizing more than one bleed; multiple bruises chest, arm, cheek, and legs, actively seizing not a good sign, 2nd injury much more serious this time. Incubated ICU on a ventilator, critical condition, actively seizing. Child may not make it. Child was shaking uncontrollable and was taken to PMC before Levine's Children's Hospital(Charlotte, NC).

York County Detective Amanda Carter at the hospital was at the hospital earlier however was already gone when case manager arrived.

Arrived at Levine's Children's Hospital on January 11, 2010 at 5:15pm to speak with parents, doctor, social worker, and access Owen [redacted] Owen is on the Pediatric Intensive Care Unit 6th floor room 13. Outside the room was a nurse and doctor-informed case manager they were still getting information regarding the child. Case manager observed Owen [redacted] in the Pediatric Intensive Care Unit hooked up to a ventilator in critical condition with wires stuck to his head. There were multiple marks/bruises on the child's body-a red scratch on the child's leg, mark on his face, a scratch on his hand, a bruise on the chest. While case manager was at the hospital Owen did not have any active seizing. Case manager spoke with doctor and nurses regarding the child. Case manager was informed they did a CT scan however would not be able to tell until 72 hours to determine the swelling of the child's brain. At the time there was nobody in the hospital room with the child except a nurse. Kayla had left to get clothing, Michael left with York County Detective to get a polygraph, and the Grandparents went to get something to eat and will be back. Approximately thirty minutes later the Grandparents arrived back at the side of the bed of Owen-Case manager spoke to both of the Grandparents regarding the allegations. Case manager asked about Kayla's whereabouts-Mrs. Williams(Grandmother) stated they been left the hospital and Michael was suppose to have been at Moss Justice Center at 5:30pm-She called Kayla-Kayla stated they have not gotten to the Moss Justice Center because they got lost at the time it was around 7pm. Kayla spoke about making sure Michael's parents knew where they were going and they were on their way to the Moss Justice Center. Mrs. Williams did not know why Kayla was going to the Moss Justice Center and everybody at the hospital thought Michael was being transported by the detective. Kayla informed her mother she would be back at the hospital later-she did not mention a time she would be back. She knew Case manager needed to speak with her in regards to the incident that occurred with the child.

Actions:

Medical Contact

Recipients:

0001545389 - [redacted] Michael - [redacted]

Action Date: 1/11/2010 **Action Time:** 2:00 PM **Time Spent:** 0.50

Input Date: 1/11/2010 **Input Time:** 4:05 PM **Worker:** Sutherland, Lola

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 4:05:15 1/11/2010

ycso lt miller and lora newwark from levines, owen is in the hospital, sezing, has an acute bleed in head, more that one bleed, mutliple brusies chest, arm cheek, leg, detective carter at hospital, owen is actively seizing not a good sign, he is incubated icu on a ventilator, critical condition, parents and grandparents there, parents report no knowledge of injuries and bruises, much more serious this time the injuries, supervisor sutherland informed lora dss will not allow parents to take child, supervisor sutherland asked lora for clarification actively sezing not a good sign does this mean the child could die she stated yes, ycso contacted supervisor of case, supervisor checked capps and stated case is open, cw will be notified cw hill informed of phone call, cw hemphill sp parents cannot remove the child from the hospital, child to

go to relative,
call from lt miller 404pm, super stated injuries to lt miller per lora's call, child may die, child not to go to parents if child recovers,

HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Collateral Contact

Recipients:

0001545391 - Williams, Charlotte - [redacted]

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.75

Input Date: 1/12/2010 **Input Time:** 7:25 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:25:13 1/12/2010
Collateral Contact- Charlotte Williams-Mat. Grandmother

Mrs. Williams reported in November she observed the child to have a bruise on his head-she stated she took a picture of the bruise-Michael and Brian had the child and could not tell her how the child got the bruise on the child's head. The week prior to December 4, 2009 the child was crying a lot and the parents took the child to Sunshine Pediatrics and they informed the parents the child had a throat infection and it had gotten worse-child was taken to Riverview Medical Center and later taken to Piedmont Medical Center in which they performed test-Michael was watching the child when the baby went limb-Kayla had gotten off from work and Michael meet her at the door with the baby limb scratched out. Child was taken to Piedmont Medical Center then Levine's. It was determined the baby had bruising to the brain. Mrs. Williams stated there were no other incidents she could recall after wards until this weekend. Owen was at her home on Saturday and she observed looked like to be a scratch on the child's head-she placed the child in the light and observed a bruise about the size of a dime on the child's forehead. She stated she felt it and it was soft and full-she stated she observed the nurses and doctors last time checking the child like that. Michael was asked about the child's forehead in which he stated he did not know. He later stated the child sleeps in the crib by himself and he maybe hit his head on something. On Sunday, during child the child was sitting on Michael's lap and later placed in his carrier. When asked to hold the child-Michael would not allow her-When asked to have the child come to her home-Michael stated the baby was going home with them. Usually the baby would visit the home of the grandparents and the parents be happy about the grandparents caring for the child-however not this Sunday. Kayla arrived at the home later-in which she usually brings the baby with her-the baby was not with her-Asked where the baby was-the baby was left at the home with Michael-When asked why she didn't bring the baby-Kayla begin to get defensive against her and stated the baby can be with his father and does not always have to come with her. She stated Kayla was at the home to eat some chili because she loves her mother's chili. Received a phone call this morning as she and her husband were on their way to Columbia for a funeral in which her husband was going to do the eulogy.

Charlotte Williams information-dob [redacted] Address [redacted] phone number [redacted]. Has a son by the name of Aaron that lives in the home he is 12 years old. Family does not have any DSS history and no Criminal History. Have everything for the child that he will need. Has a playpen for the child however will need to get a crib for the baby-child has Medicaid.

Actions:

SCDSS 0293

Collateral Contact

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 7:26 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:26:11 1/12/2010
Collateral Contact-Larry Williams-Grandfather ([redacted])
Mr. Williams reported child was at church on Sunday with parents. Michael held the child the entire time and then placed the child in car seat. Michael usually don't want anything to do with the child. Would not allow allow Charlotte to hold the baby. Charlotte asked to keep the baby-Michael said No-Child going with him-They usually give the child to them and allow the child to go to their house. This was the first time-Michael has done this. Mr. Williams later reported Kayla should not be ruled out-She made a phone call to the house one night to get the baby because she was about to lose it.

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen - [redacted]

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 7:27 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:27:15 1/12/2010
Collateral Contact-Social Worker-Yvette
Case manager inquired about Medical Records for the minor child Owen [redacted] Case manager was informed she would need a release of information from the parents and they would not be able to give medical records to her tonight-they stop giving medical records at a certain thing-Case manager would need to get in contact with the hospital in the morning regarding receiving medical records.

HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Face to Face with child/client

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 7:31 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:31:12 1/12/2010

Safety plan-
Owen has acute bleed in the head, actively seizing, multiple bruises chest, arm, thighs, and legs, actively seizing not a good sign-2nd injury much more serious this time. Kayla and Michael will have No unsupervised contact with Owen [redacted] Owen [redacted] not go home with Kayla and Michael. Levine's Children's Hospital will contact York County Department of Social Services when minor child to be released/discharged. Both parents will comply with safety plan-failure will result in court intervention. Case manager Hill will follow up with ALL parties and request records, etc.

Parents never arrived back at the hospital-Case manager spoke with Charlotte Williams regarding the safety plan and hospital staff-A copy of the safety plan was placed in Owen's file.

Actions:

Telephone Contact

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.25

Input Date: 1/12/2010 **Input Time:** 8:05 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 8:05:15 1/12/2010

Telephone contact
Received telephone call stating Owen [redacted] still actively seizing and Michael [redacted] found guilty-He admitted to shaking the baby.

Actions:

Staffing With Supervisor

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 1/4/2010 **Action Time:** **Time Spent:** 1.00

Input Date: 1/7/2010 **Input Time:** 4:30 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 4:30:23 1/7/2010

Supervisor staffed case with Cm. See DSS Form 3062 in file.

HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

PM 4:49:46 1/12/2010

Current Situation:

Hospital cannot determine if hematomas are accidental or non-accidental. Concerns for lack of supervision. Charlotte babysits Owen. Baby is doing well. Crib and all baby supplies in home.

Recs:

Get all medical records
Follow up with Law Enforcement - What is their status?
Assess Grandmother's Home- Get incident Reports

Actions:

Face to Face with child/client

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/21/2009 **Action Time:** **Time Spent:** 1.25

Input Date: 1/12/2010 **Input Time:** 9:56 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 9:56:00 1/12/2010

Face to Face with Child/Client

Present at the home were Kayla, Michael, and Owen. Owen was on a blanket on the floor in which Michael was playing with the baby when case manager arrived. The family was expecting case manager at the home- in which case manager spoke with Kayla several days ago and sent a home attempt letter to the home. The home was warm and organized in the living room. Case manager read the allegations out to the family. Allegation-R/S 2 month old male baby has two subdural hematoma(sizes: 3mm and 2 mm). R/S there is a Fatx Subdural Hematoma which raises the possibly of no accidental trauma. R/S parents behavior has been appropriate with the child. Baby is 2 months -baby initiated admitted to PMC on December 4, 2009 and was transferred to CMC Main(Levine Hospital) R/S CT Scan shows two subdural hematoma-Case manager was informed of no prior physical/mental delinquency. Parents were observed to be appropriate and concerned. Parents took the baby for medial treatment on November 28, December 2 and December 4.

Kayla informed case manager the baby receive medical service at Sunshine Pediatrics in Rock Hill-child was taken there in which she was informed the child had a minor cold/throat infection in which the parents transported the child on Wednesday. Friday-the week before the child was sick-sleeping more eating less, crying more-pink(color of skin) and passed out there was not a response out of the baby-drove the baby to the ER-the baby grasped and screamed everything appeared normal. There was a concern with the baby's

red blood count in which it was low. The baby was taken to Levine's Children's Hospital the same day. Afterwards, the baby was fine and normal-eating normal, sleeping and a head scan was done-they could not find out what was going on with the baby. Case manager asked the parents have the baby been dropped-both parents stated no the baby have not been dropped. Case manager inquired about caregivers-parents Michael(father), Kayla(mother), and Grandparents. Child does not attend daycare. Case manager inquired about any other members that care for the baby-parents stated no. Case manager asked was the first time the baby has had hematoma or medical concerns-parents stated yes. Case manager asked again how the child received the injury-both parents stated they did not know how the child got the subdural hematomas. Case manager was informed the Grandmother did not reside at the same residence as they do.

Kayla is employed with Wal-greens on Celenese and Michael is employed at Food Lion. When Parents are at work the child usually goes to his Grandmother Charlotte Williams home in which she lives around the corner.

Michael stated the baby was normal now and has not had any concerns/problems since then. He stated he does not know how the baby received the injury they are glad that the baby is better. Michael played on the floor with the baby as case manager spoke to them. Owen was vibrant lying on his back on a blanket kicking his feet and arms laughing and smiling as his father interacted with him. Kayla sat on the couch with case manager during the interview. Case manager inquired about discipline-parents stated they do not discipline the child because the baby does not know any better and he's just a baby. Case manager inquired about sleeping arrangements for the child-case manager was given a walk thru of the home-the home was clean and organized and spacious-Owen had his own bedroom in which he had a crib and plenty of supplies. In the parents' room the child also had a crib-Parents informed case manager that the child spends most of the time in their room in his crib-sometimes the child is taken to his room however since the incident the baby is in the room with them most of the time. A safety plan was put in place with the family.

Actions:

Collateral Contact

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/17/2009 **Action Time:** 3:00 PM **Time Spent:** 0.25

Input Date: 1/19/2010 **Input Time:** 5:18 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 5:18:14 1/19/2010

Supervisor spoke with Lt Miller with YCSD. He stated that he received LE referral for Owen [redacted] on 12/16/09 after hours around 7pm. Lt. Miller stated that he needed additional information. Supervisor explained to Lt. Miller that the hospital states that they cannot determine if Owen's injuries are accidental or not and that the hospital has concerns for lack of superivision primarly. Supervisor told Lt. Miller that all scans have been negative. Supervisor read dictation to Lt. Miller from conversation with hospital SW from CAPSS. Lt. Miller asked Supervisor to fax over dictation with conversation with hospital. Supervisor faxed dictation around 4pm to Lt. Miller.

HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Face to Face with child/client

Recipients:

0001545390 - Lythgoe, Kayla [redacted]

Action Date: 12/17/2009 **Action Time:** **Time Spent:** 0.75

Input Date: 1/13/2010 **Input Time:** 12:44 PM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:44:44 1/13/2010
Face to Face with Child/Client

Arrived at the home to speak with the family regarding the allegations and access the home. There was a jeep that pulled on the side of the road and a lady got out of the car and walked inside the home. Case manager observed a man delivering new page books to the mobile home. Case manager knocked on the door and spoke with Kayla regarding the allegations. Kayla stated she did not know what happened to the baby-she stated the baby had not been himself and he would sleep longer and not eat as the child normal does. Case manager inquired about the baby-she mentioned that she was on her way to work and the baby is out with the grandmother-case manager inquired about a phone number for her-she stated she was not able to receive phone calls however she could get text messages. Case manager informed her that she needed to access the home and speak with everybody that lived in the home. Kayla informed case manager she received the home attempt letter in the mail and the day scheduled would be fine. Case manager informed Kayla about the concern and put a safety plan in place with Kayla.

Case manager inquired about Michael-Case manager was informed that Michael was at work and was not for sure he would be home. Case manager informed Kayla to tell Michael and members of the household case manager would be at the home on December 21, 2009 at 9am-Kayla informed case manager they would be home-case manager inquired about the time-she stated case manager could come to the home earlier if need be-they would be there.

Actions:

Face to Face with child/client

Recipients:

0001545390 - Lythgoe, Kayla - [redacted]

Action Date: 12/17/2009 **Action Time:** **Time Spent:** 0.25

Input Date: 1/13/2010 **Input Time:** 12:48 PM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:48:48 1/13/2010
Face to Face with Child/Client-Safety Plan

While at the home with Kayla Lythgoe-Case manager spoke with Kayla in reference to the allegations. Kayla was on her way out the door to work at the time. Case manager was able to put a safety plan in place with Kayla.

Michael and Kayla agree to supervise Owen [redacted] at ALL times and follow up with All medical appointments. Start date today, Tuesday, December 8, 2009-until investigation ends. Michael and Kayla will comple with safety plan-failure will result in court intervention/removal. Case manager Hill will follow up with records, staff case with supervisor, follow up with family.

Actions:

Referred to Law Enforcement

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/16/2009 **Action Time:** **Time Spent:** 0.25

Input Date: 2/16/2010 **Input Time:** 12:01 PM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:01:49 2/16/2010
Referral to Law Enforcement

A law enforcement Referral was made to York County Sheriff Department regarding the allegations.

HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Face to Face with child/client Attempted

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/10/2009 **Action Time:** **Time Spent:** 0.50

Input Date: 1/13/2010 **Input Time:** 8:41 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 8:41:14 1/13/2010
Face to Face with Child/Client Attempted

Arrived at residence to speak with family about allegations-Case manager observed no cars in the drive way of the home. Case manager was informed from the neighbor next door to the left the family was not at the home at the time.

Actions:

Telephone Contact

Recipients:

0001545391 - Williams, Charlotte - [redacted]

Action Date: 12/10/2009 **Action Time:** **Time Spent:** 0.25

Input Date: 1/13/2010 **Input Time:** 8:43 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 8:43:27 1/13/2010
Telephone Contact

SCDSS 0301

Charlotte Williams(grandmother) called and left message.

Actions:

Face to Face with child/client Attempted

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/8/2009 **Action Time:** **Time Spent:** 0.50

Input Date: 12/16/2009 **Input Time:** 12:02 PM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:02:58 12/16/2009
Face to Face with Child/Client Attempted

Arrived at the residence to follow up with the family-case manager observed no vehicle in the yard-there was no answer at the home when case manager knocked several times and sat in the car to call the family on the phone number listed on the intake form-left message for family to call case manager back.

HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen - [redacted]

Action Date: 12/7/2009 **Action Time:** 3:34 PM **Time Spent:** 0.25

Input Date: 12/7/2009 **Input Time:** 3:41 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:41:05 12/7/2009

Supervisor received message from Laura McDowell, SW at Levine's. She stated that Owen will be discharged today and is going home with the parents.

Actions:

Collateral Contact

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/7/2009 **Action Time:** 3:00 PM **Time Spent:** 0.25

Input Date: 12/7/2009 **Input Time:** 3:10 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:10:16 12/7/2009

Supervisor contacted Laura Newmark, SW with Levine's. Supervisor advised Laura that the case had been staffed with the legal department and that Owen should be discharged to his parents and that DSS will follow up with a home assessment. Laura stated that Owen's second CT Scan was stable. Laura stated that

she would call and let Supervisor know when Owen is discharged.

Actions:

Collateral Contact

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/7/2009 **Action Time:** 11:50 AM **Time Spent:** 0.50

Input Date: 12/7/2009 **Input Time:** 3:08 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:08:21 12/7/2009

Supervisor received call from Laura Newmark who is another SW with Levine's Childrens Hospital in Charlotte, NC. Laura's contact number is 704-355-3189. Laura stated that she is the SW that has been working with Owen [redacted] family. She stated that she has talked with the pediatric staff and at this time the hospital cannot determine whether the injuries are accidental or nonaccidental. She stated that Owen's Eye Exam and Skeletal Survey were negative. She stated that they are going to repeat the CT scan today because Owen's head still appears swollen. She stated that the family has no clear history of trauma, however, the hospital still cannot rule out any trauma. She stated that they parents are too young parents and the hospital mostly has concerns for lack of supervision. She stated that it is unknown if Owen will be discharged today or tomorrow and that will be determined by the results of Owen's CT Scan. Laura stated at this point there are no obvious findings of abuse/neglect. Laura stated that the family will need to follow up with another skeletal survey in 2 weeks. She stated that the parents will be able to do that back home and will not need to come back to Charlotte. Supervisor inquired about the doctor that is working with Owen. Laura statd that Dr. Cheryl Courtlandt is working with Owen. Dr. Courtlandt stated that she cannot determine if the injuries are an accident or not at this point. Supervisor advised Laura that she would staff the case with the legal department and get back with her asap with a discharge plan for the baby.

HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Collateral Contact

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/7/2009 **Action Time:** **Time Spent:** 1.00

Input Date: 12/7/2009 **Input Time:** 3:01 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:01:11 12/7/2009

Supervisor contacted Laura McDowell, who is a SW with Levine's Childrens Hospital. Laura stated that she was familiar with Owen [redacted] Supervisor advised Laura that DSS would need to speak with a doctor or the SW could speak with the doctor to determine of Owen's hematomas were accidental or not. Laura stated that she would follow up with the doctor and get back with Supervisor.

PM 3:12:44 12/7/2009

Action Time was 10:01am

Actions:

Staffing With Supervisor

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/7/2009 **Action Time:** **Time Spent:** 1.00

Input Date: 12/9/2009 **Input Time:** 9:13 AM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:

SCDSS 0305

Support Service ID:

Dictation:

AM 9:13:14 12/9/2009

Case staffed with CM. See DSS Form 3062 in file.

HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

PM 4:44:31 1/12/2010

Current Situation:

Owen has two subdural hematomas. One would indicate non accidental trauma. Parents appropriate. Owen went to Sunshine Peds on 12/2/09 bc baby not acting himself. Saw Dr. Paxter - baby had throat infection and cold. No meds given. Dad said baby was sleeping a lot. Funky odor from child's mouth. Parents took baby to PMC. PMC sent child to Levine's. SW has concerns because CT scan shows non-accidental trauma. No Dr is staying injuries are non accidental. Hospital has a sitter and parents are having supervised contact with baby. Parents also took child to Riverview. Parents said they noted a bruise on the baby's head in November - neither of them knew what happened. Parents have witnessed no injury to baby. Nurse said it is non-accidental. GM saw bump on baby's head a few days ago. Baby was with dad and uncle. SP put in place that parents are to follow all doctor's recs. Baby is ready for discharge.

Recs:

Get Medical Recs: CMC Levine's, Piedmont Medical, Riverview Medical and Sunshine Pediatrics
Refer to Law Enforcement
LE incidents
Pull public index
Follow up and talk with doctor
Meet with Grandmother(assess)
Go to home and assess home
Talk to Grandmother separately - any concerns?
Talk to Laura McDowell - (704) 355-3189 - Does doctor think trauma is non-accidental
Get release of info signed

Actions:

Staffing With Supervisor

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/7/2009 **Action Time:** **Time Spent:** 1.00

Input Date: 12/9/2009 **Input Time:** 9:13 AM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 9:13:44 12/9/2009
Case staffed with CM. See DSS Form 3062 in file.
AM 9:14:02 12/9/2009

SCDSS 0307

Case was staffed with legal for directions/recomendations.

Actions:

Face to Face with child/client Attempted

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/7/2009 **Action Time:** **Time Spent:** 0.50

Input Date: 12/16/2009 **Input Time:** 11:59 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 11:59:53 12/16/2009
Face to Face with Child/Client Attempted

Case manager arrived at [redacted] to find a Dodge 4x4 suv in the yard-license tag number FED 997-case manager observed two men outside the home talking-they informed case manager the family was not at home. Knocked at the mobile home-observed no sound coming from the inside of the home-case manager called phone number on the intake form-(803)230-3048-Case manager received voice mail in which the phone belong to Charlotte(Grandmother)-case manager left message for the family to give case manager a call back.

HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Case Plan/Evaluation

Recipients:

0001545389 - [redacted] Michael - [redacted]

Action Date: 12/6/2009 **Action Time:** 8:30 PM **Time Spent:** 0.25

Input Date: 1/21/2010 **Input Time:** 1:35 PM **Worker:** Tyler, Chandra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 1:35:25 1/21/2010

Safe Plan also explained to parents and they received a copy and signed.
parents not to remove the child from the hosipital against medical advice and until dss determines

Actions:

Initial Face to Face With Child/Client
Initial Face to Face With Family

Recipients:

0001545389 - [redacted] Michael - [redacted]
0001545390 - Lythgoe, Kayla - [redacted]
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/6/2009 **Action Time:** 7:45 PM **Time Spent:** 4.00

Input Date: 12/9/2009 **Input Time:** 11:42 AM **Worker:** Tyler, Chandra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 11:42:35 12/9/2009

CM conducted a face to face with Michael [redacted] and Kayla Lythgoe at CMC Main (Levine Children's Hospital) in order to interview parents on cause of Owen [redacted] injuries. Present in the hospital room was parents, Owen, paternal grandmother Jennifer [redacted] and paternal uncle Brian [redacted] Ms. Lythgoe

SCDSS 0309

said Mr. [redacted] stepped out for a minute, so Cm begin interviewing her. Ms. Lythgoe said that they first noticed a change in Owen's behavior on 11/28/09. Ms. [redacted] said that Owen was sleeping a lot and screamed when awake, non stop. Ms. Lythgoe said that they took Owen to Riverview 24hr Clinic that same evening that the doctor said nothing was wrong with him. Ms. Lythgoe said Owen continued this abnormal behavior throughout the week and on 12/1/09 went all day and night without urinating. (Mr. [redacted] entered the room and sat by Ms. Lythgoe) Ms. Lythgoe said they scheduled an appt with his pediatrician for 12/2/09 at Sunshine Pediatrics with Dr. Paxtor. Ms. Lythgoe said that Dr. Paxtor said that Owen had a throat infection and a minor cold. Dr. Paxtor did not prescribe any medication. On 12/4/09 Ms. Lythgoe said she was pulling in the driveway and Michael came outside and said that Owen just went limp, but was still breathing and they rushed Owen to Piedmont Medical Center. Upon arriving at PMC, Ms. Lythgoe said Owen let out a loud scream and took a huge breath. Ms. Lythgoe said PMC transferred Owen to Levine Hospital on 12/5/09.

CM then asked Mr. [redacted] happened and he also said that Owen's behavior has been different since 11/28/09 and told CM of taking him to Riverview and Sunshine Ped. Mr. [redacted] said that he was home watching the baby on 12/4/09 by himself. Mr. [redacted] said that Owen was sleeping a lot and not eating. Mr. [redacted] said he woke Owen up to feed him and that Owen let out a loud scream and then stretched out, turning red and went limp. Mr. [redacted] said as that happened he heard Ms. Lythgoe pull up and ran outside to get her. They then rushed Owen to PMC where he was transferred to CMC Main (Levine Children's Hospital) Mr. [redacted] said that he had no knowledge of anything that could have injured the baby and doesn't know why his behavior changed.

Cm asked Ms. Lythgoe who watches the baby and she said herself, Michael when their not working and maternal grandmother Charlotte Williams. CM asked Ms. Lythgoe if anyone else watches Owen and she said no. Cm asked Ms. Lythgoe and Mr. [redacted] Owen sleeps and they said in a pack and play in their room. Cm asked if there where any toys in the pack and play and they said no only a blanket if needed. Ms. Lythgoe said they swaddle Owen when he sleeps. Cm asked Ms. Lythgoe if there is any incident that has happened where Owen had hit his head or fell and Ms. Lythgoe said no. Both parents said that the only thing that they noticed was in November Owen had a small flat brownish bruise on the left side of his head. Ms Lythgoe said she asked Mr. [redacted] at that time did he know where it came from and she said Mr. [redacted] no. Ms. Lythgoe also said that sometimes Owen head turns and jerks around during tummy time on the floor.

CM also asked parental grandmother and brother if they have ever watched Owen and GM said she and her husband have watched Owen briefly when parents ran an errand. Uncle said that he has never watched the children alone, but that he has been in the home with either parent and watched Owen while they did things around the home.

A sitter was also present in the room 24/7 and both parents stayed the night with Owen in the hospital room.

PM 5:06:46 1/21/2010

Upon completing the interview with Michael [redacted] and Kayla Lythgoe CM went to the nurse's station on the same floor to see if this CM could find a copier to make copies of the safety plan. CM asked a nurse on-duty if she could make a copy for this CM and she said sure. The nurse asked this CM if she relieved the sitter for Owen [redacted] room and CM said no, that that is not why this CM is here. The nurse said that she thought that is why this CM was called, because DSS makes the detemination of whether to relieve the sitter. CM informed the nurse that this CM was called by the Social Worker at Levine because of her concerns that reports showed fatx subdural hematoma rises possibility of non accidental trauma. The nurse seemed confused and said that they had no known concerns of non accidental trama and that the social worker was not supposed to be calling for those reason, but was to call to get DSS approval to remove the sitter for Owen's room. CM informed the nurse that the purpose of this CM 's visit was to investigate the recent report and that this CM was not here to decide whether to relieve the sitter. CM returned to Owen's room to give parents their copy of the safety plan and then CM left.

HRC690-R01 South Carolina Department of Social Services 1/5/2012 10:30 AM

Case Dictation

Case ID - 0001113743

Actions:

Brochure Given

Recipients:

0001545389 - [redacted] Michael - [redacted]

0001545390 - Lythgoe, Kayla - [redacted]

Action Date: 12/6/2009 **Action Time:** **Time Spent:** 0.25

Input Date: 12/9/2009 **Input Time:** 12:27 PM **Worker:** Tyler, Chandra

Service ID: 0001388329

Program Service Type: Child Protective Services Assessment

Authorization:

Support Service ID:

Dictation:

PM 12:27:05 12/9/2009

Brochure Given to parents and they both signed that they received it. Safe Plan also explained to parents and they received a copy and signed.

CLT

Q: Is someone going to talk to my child?
A: Yes. During the course of the assessment, DSS workers will talk to your child. A parent's permission is not necessary for DSS workers to talk to any child in the household. Law enforcement officers may talk with your child, if needed. Your child also may be seen by a doctor or other professional.

Q: What is the process of resolving complaints about a case?
A: First, talk to your caseworker, then the supervisor, and finally, if questions or problems are not resolved, speak with the county director.

Children in Foster Care

If your child has been abused or neglected and is not considered to be safe at home, law enforcement officers or the family court can remove the child from the home. DSS will place the child in foster care. Foster care is a temporary service for you and your child.

In most cases, arrangements will be made for you to visit your child. Your caseworker can discuss with you plans for your child and services for you and your child. The family court may order you to do certain things.

After a child has been in foster care for a year or less, the court will hold a "permanency planning" hearing. This hearing will review the progress toward the child's return home or any other "permanent plan" approved at an earlier hearing. If the judge decides it is safe for the child to return home, the judge might require that the family be supervised by DSS and receive services.

If your child is removed, you will be given more detailed information on the foster care system's procedures.

In accordance with Title IV, Section 601, of the Civil Rights Act of 1964 and Title V, Section 504, of the Rehabilitation Act of 1973, the South Carolina Department of Social Services will administer its programs in such a manner that no person shall solely by reason of race, color, national origin or qualified handicap, be excluded from participation in, be denied the benefit of or be subjected to discrimination under any program or activity administered by DSS.

If You are Reported for Child Abuse or Neglect

If you are reported for child abuse or neglect, you have the following rights:

- To be represented in family court by a lawyer. If you cannot pay for one, a lawyer will be appointed by the family court.
- To be notified that you are the subject of a report and that your name has been recorded by DSS as a "suspected perpetrator" of child abuse or neglect.
- To be notified if your name is entered into the Central Registry of Child Abuse or Neglect.
- To examine the report and evidence used to decide an indicated case, except for the identity of the reporter.
- To a timely handling of your case.
- To visit any children removed from your home, if appropriate.
- To help plan and take part in your family treatment.
- To be notified of, and take part in family court hearings that involve your case.
- To ask for a review of your case by the county Child Protective and Preventive Services supervisor and/or county director.
- To challenge a finding against you through a DSS hearing if the case is not brought before family court.

Your caseworker is _____.

The supervisor is _____.

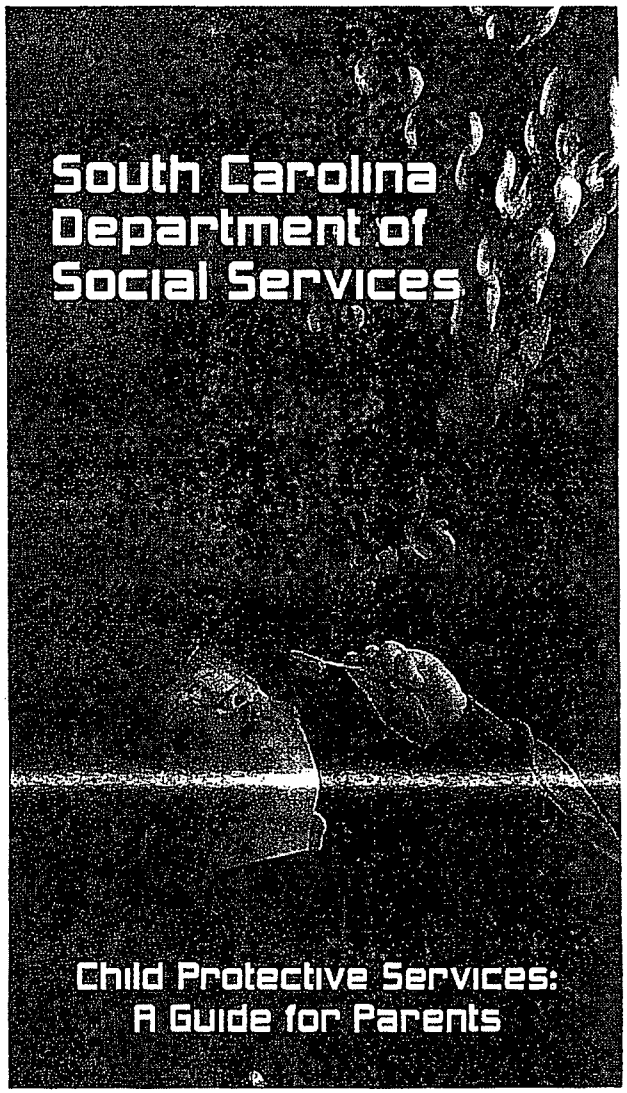
They can be reached at Select County ... _____

County DSS. Their phone number is _____.

The allegation(s) being investigated is (are):

- ☐ Sexual Abuse
- ☐ Physical Abuse
- ☐ Mental Injury
- ☐ Abandonment
- ☐ Physical Neglect
- ☐ Medical Neglect
- ☐ Educational Neglect
- ☐ Contributing to the Delinquency of a Minor
- ☐ Threat of Harm: (specify) _____

DSS Brochure 3034 (FEB 03) Edition of JAN 98 is obsolete.



APPENDIX "C"

South Carolina's law seeks to protect children and keep them safe. The Department of Social Services (DSS) must follow certain steps when it receives a report of child abuse or neglect. This brochure provides specific information about that process.

Investigating Reported Abuse or Neglect

If a report is made that a child has been harmed, DSS must begin to investigate, or assess, the situation within 24 hours. The person assigned to look into the report is called a caseworker. His/her name and phone number is on the back of this brochure. The caseworker will talk to parents and the child to find out what happened. It is likely that the caseworker will need to talk to other people who may know about the parent(s) and the family. The assessment may include an examination of the child by a doctor, and the taking of photographs.

DSS has 45 days to complete this assessment process. If there is specific information that can't be gathered in that time, 15 extra days may be approved.

As soon as possible after the assessment begins, DSS will give this brochure to the parents or guardian, or any other person named as harming the child.

Sometimes when a child is harmed, the child is placed in foster care, or with a relative. At other times, DSS will require the family to correct its problems, and the child will remain at home. If DSS and the parent(s) cannot agree on a treatment plan, DSS can ask the family court for a hearing.

When a case does not go to family court, the person named as harming the child may appeal the decision.

DSS encourages you to seek and accept services to help your family.

Some Important Questions

Q: What are the possible outcomes of the assessment?
A: The case may be "indicated" or "unfounded."

- "Indicated" means that it is more likely than not that the child was abused or neglected.
- "Unfounded" means the report is untrue or not supported by the information gathered.

Unfounded cases fall into four categories:

- *Category I:* Abuse or neglect was ruled out following assessment.
- *Category II:* There is not enough evidence to decide if the child was abused or neglected.
- *Category III:* The assessment could not be completed because DSS could not locate the child or family or for some other reason.
- *Category IV:* Information received about harm to a child did not result in an investigation.

Q: If my family is involved in a report of abuse or neglect, how will the records be kept?
A: Information about an investigation or a case is kept in a paper file and on the agency database. Paper records will be filed in the county DSS office except when foster parents, employees or volunteers of an institution, group home or child care facility are involved. When foster parents or employees or volunteers are involved in a report, the records will be kept at the state DSS office. For both paper files and database records, information on indicated reports is kept for seven years from the date the case is closed. If no abuse or neglect is found, the records will be kept for at least five years from the date of the decision to unfound. Information contained in agency records, whether on paper or in the electronic database, is kept confidential.

Q: Will my name be recorded in DSS records as a suspected perpetrator?
A: Yes. Your name will be recorded in DSS records as a suspected perpetrator until a case decision is made following the assessment.

Q: Is my name going to be entered in a central registry of child abuse or neglect?
A: A court order is required to enter your name on this Registry unless you are a foster parent or an employee or volunteer of a group home, institution or child care facility. The order may come from family court or criminal court. The Central Registry is not the same thing as the DSS case record. The Central Registry is a perpetrator registry separate from the DSS agency data system.

Q: What happens to records in an unfounded case?
A: If the case is unfounded, the records will be kept in confidence, but will be used to assess other reports or for certain purposes allowed by state law.

Q: Do I have the right to inspect DSS records about my child's case?
A: Yes. You do have a right to inspect these records if the case is indicated. You also have the right to a copy of the report but not to the name of the person making the report. If the report is unfounded and you think the report is made by someone who was only trying to hurt you, ask your caseworker what you can do about it.

Q: What if I don't cooperate with the caseworker?
A: DSS still must complete the assessment. DSS will use the family court or law enforcement to help it do that job. You have the right to consult with a lawyer at any time you wish. However, the right to a court-appointed lawyer, if you cannot pay for one, does not exist unless your case is going to court.

Q: If I give DSS information, how will that information be used?
A: It may be used to determine if a child was abused or neglected. It may be used to determine who abused or neglected the child. In an indicated case, DSS may share the information you provide with people who need it in order to serve you or your family. Your caseworker will tell you who gets any information you provide.

Q: Can the worker give the information to law enforcement?
A: Yes. Under state statute, DSS records are available to law enforcement officials investigating certain crimes.

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
ACKNOWLEDGEMENT

NAME: Michael [redacted] & Kayla Lythgoe

CASE NUMBER: _____

I acknowledge that as notice of this investigation a copy of the DSS Brochure 3034 and Child Protective Services: A Guide For Parents was provided to and discussed with me by the York County Department of Social Services Case Manager.

I acknowledge that I was provided a handbook on legal rights entitled Child Abuse/Child Neglect – What Parents Should Know If They Are Investigated.

Signature _____ Date 12/6/09

Signature _____ Date 12/6/09

Signature _____ Date _____

Signature _____ Date _____

Case Manager _____ Date 12/7/09

SCDSS 0465

South Carolina Department of Social Services

SAFETY PLAN

Michael [redacted]

Name: Kayla Lythgoe Case Number: _____

DSS has identified the following concerns about the safety of your child or children. The purpose of this plan is to prevent removal of the child to foster care or as a plan to keep your child safe during the investigation and/or until the safety threats are reduced. The parties enter into this agreement voluntarily. The parents' agreement to this plan is not an admission that they have abused or neglected the child.

If YES is checked, DSS has determined that if the safety services are not provided or are not effective, foster care will be the plan for the child. ☐ Yes ☐ No

Describe the safety threats including a description of when, how often, and under what circumstances they are present; other influences involved; and how parents' or caregivers' access to the child(ren) affect the safety threats.

Gwen [redacted] admitted to Cone Main on 12/5/09 with subdural hematoma. Reasons of non accidental trauma possible

1. Describe in detail the safety action or service selected to control the safety threat.

At this time it is to follow medical advice of the hospital and doctor recommendations. Not to Remove the child from the hospital until medical discharge.

2. Identify the start date, frequency and level of effort for the safety action or service.

12/6/09. Parents are in agreement with safety plan.

3. Identify the person(s) responsible for performing the safety action or service. Describe how the person was confirmed to be suitable to participate in the safety plan. (Protective Capacity – Can and Will Protect)

Michael [redacted]
Kayla Lythgoe

4. Describe the method for monitoring the safety action or service.

DSS involvement monitoring home, verbal communication with DSS.

By signing this Safety Plan, the parents and the protector understand and agree that the protector will be responsible for the safety of the child(ren) during the investigation or until safety threats are removed.

The parents and protector have the right to and agree to contact the caseworker if they no longer wish to carry out any part of the agreement, wish to change any part of the agreement, have questions, or want to bring something to the worker's attention. If the parent or protector withdraws from this agreement, the Department will reassess safety and do what is necessary to protect the child(ren).

If the report is unfounded, the Safety Plan will end automatically on the date of case decision.

Kayla Lythgoe	Mother	803-280-3045	
Protector's Name	Relationship to Child	Telephone No.	
Kayla Lythgoe	12/6/09		
Protector's Signature	Date	Worker's Signature	Date
Kayla Lythgoe	12/6/09	[signature]	12/6/09
Parent's Signature	Date	Parent's Signature	Date

☐ Parent(s)/Caretaker Refused to Sign

Note: Failure to comply with the Safety Plan may result in court intervention to assure the child's safety.

DSS Form 3087 (DEC 08) Edition of MAY 06 is obsolete.

SCDSS 0464

State of South Carolina)
)
County of York)

Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen [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 York County,)
Defendants.)

11-CP-46-04508

Video Deposition
of
Lola Sutherland

Video deposition of Lola Sutherland, taken before Kathleen R. Tackett, CVR, a notary public in and for the State of South Carolina, commencing at the hour of 2:08 p.m., Thursday, January 10, 2013, at the office of McGowan, Hood & Felder, LLC, 1539 Health Care Drive, Rock Hill, South Carolina.

Reported by
Kathleen R. Tackett, CVR

APPEARANCES

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

For the Defendant South Carolina Department of Social Services:
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Davis, Frawley, Anderson, McCauley, Ayer, Fisher & Smith, LLC
140 East Main Street
Lexington, South Carolina 29072

For the Defendant Bruce Bryant, as the Constitutional Office of York County:
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For the Defendant Carolinas Medical Center:
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1310 Gadsden Street
Columbia, South Carolina 29201

Also Present: Brooks Oswald, Videographer

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EXHIBITS

No exhibits were marked during this deposition.

STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Rules of Civil Procedure.

- - - -

The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Whereupon,

Lola Sutherland, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. HARRILL:

Q Good afternoon, Ms. Sutherland. How are you?

A I'm fine. Thank you.

Q I'm Lara Harrill; we met right before this deposition. Have you ever given a deposition before?

A No.

Q Okay. I'm going to give you, sort of, the ground

rules, which, I'm sure, your attorney has already done, but just in case.

We have a court reporter here taking down everything we say. And even though it's on video, it's hard for her if we talk too fast or if we talk over each other. I will try and let you answer my question if you would let me ask my question without interrupting me. If I interrupt you at any time, which I do often, stop me. You know, just let me know that you're not finished, and I will do that.

If you -- I would like for to answer yes or no instead of uh-huh or unh-unh. It would be easier for the court reporter to understand what we're talking about.

If you have any questions during the deposition, I would ask that you would direct those to me rather than to your attorney once the deposition has started. You-all can talk about the weather, but you may not talk about the -- the testimony. Okay?

A (Nods head up and down.)

Q If you need a break at any time, all you have to do is let me know. I don't think we are going to be here very long, but we'll see how it goes.

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wasn't saying anything about anybody hurting the child.
Q Who -- the grandmother wasn't?
A Right. That I recall. May I look at Chandra's dictation?
Q Please. And that one we were just looking at was on --
MR. FRAWLEY: 253 and 254, on the bottom.
A No. That was -- they're mostly talking about what's been going on for him since 11/28, and the different hospitals they were taking him to, and the -- and who supervised him if the parents went out. (Reads softly to herself.) Grandma said something to a social worker or doctor. She didn't say it to us.
Q Where do you see that?
A That -- that was -- is that not in there? That's what I was recollecting.
Q Okay.
A That's how come it came up. Or if I read ahead of the game, but -- because there was a reason why we asked.
Q Uh-huh. Would -- if -- if Chandra talked to the uncle, would that be in the dictation?
A Yes.

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Q Okay.
A It should be.
Q Okay.
A Because -- yes. It is.
Q What page are you on? Are you on 254 where we were just a minute ago?
A Yes.
Q Okay.
A "Uncle said that he never watched the children alone, but that he'd been in the home with either parent and watched them." But that doesn't have on the dictation --
Q Now --
A -- that he was there.
Q I'm sorry. Talk to me a little bit about this whole sitter issue. What do you recall about Chandra being there and somebody thinking she was a sitter? Do you have any recollection of that?
A That was at the end of the gathering of information, staffing, and closing up, allowing her to leave the scene now. We had the information that we needed, and then Chandra brought up, "By the way, the hospital is thinking we were here to relieve a sitter." So -- and that was just strange.

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Q I agree.
A Uh-huh.
Q Okay. When you say you had the information that you needed, you have the information -- did you have enough information at that time to make a case decision?
A Oh, no.
Q Okay. So is it -- and I don't want to put words in your mouth, but is it fair to say you had enough information for -- to be done for the night, at -- how -- when you say you had enough -- all the information that you needed, what does that mean?
A We had the information we needed for determining the safety of the child for the evening. We did the brochures, the handbook, interviewed the -- the family. We started our initial assessment of the case. Safety plan was done. Safety plans, in 2009, was done on every case.
Q Right. So then the next morning, I think you testified earlier, correct me if I'm wrong, that then you would staff the case with the receiving worker and supervisor?
A Yes.
Q Okay. And at that time -- and we'll -- we can look at the staffing, but do you have any -- as you sit

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here today, do you have any recollection at that time -- were they to refer to law enforcement, or were you -- the on-call supervisor and the worker that was on call to refer to law enforcement?
A No. The receiving supervisor and worker. The only thing we're responsible for was put in the dictation from the initial contact in CAPPS.
Q Okay. So all of the -- all of the information that went back and forth between you and Chandra, then she does her documentation based on her interviews; is that fair?
A Yes.
Q Okay. And, once that documentation is done, the case is effectively transferred?
A No. The case is effectively transferred the first -- at first thing in the morning when we've sat down and staffed it.
Q Okay. And so then there'd be some time frame where she's doing her dictation, possibly?
A Yes.
Q Understood.
A Because even, too, back then, reports couldn't get keyed in right away. An on-call report's not keyed in the system like it is during business hours. So you're passing a report off to another -- to intake

Page 1

State of South Carolina)
)
County of York)

Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen [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 York County, Defendants.

11-CP-46-04508

Video Deposition of Krista M. Hinnant

Video deposition of Krista M. Hinnant, taken before Kathleen R. Tackett, CVR, a notary public in and for the State of South Carolina, commencing at the hour of 9:56 a.m., Thursday, January 10, 2013, at the office of McGowan, Hood & Felder, LLC, 1539 Health Care Drive, Rock Hill, South Carolina.

Reported by
Kathleen R. Tackett, CVR

Page 2

APPEARANCES

For the Plaintiff: Lara Pettiss Harrill, Esq.
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Davis, Frawley, Anderson, McCauley, Ayer, Fisher & Smith, LLC
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For the Defendant Bruce Bryant, as the Constitutional Office of York County: Daniel R. Settana, Jr., Esq.
McKay, Cauthen, Settana & Stubley, PA
1303 Blanding Street
Columbia, South Carolina 29201

For the Defendant Carolinas Medical Center: Monteith P. Todd, Esq.
Sowell Gray Stepp & Laffitte, LLC
1310 Gadsden Street
Columbia, South Carolina 29201

Also Present: Brooks Oswald, Videographer

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EXHIBITS

Plaintiff's Exhibit Number 21, Handwritten notes.	59
Plaintiff's Exhibit Number 22, "Release of Information"; "Safety Plan"; "South Carolina Department of Social Services Acknowledgement."	81

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Rules of Civil Procedure.

- - - -

The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Whereupon,

Krista M. Hinnant, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. HARRILL:

Q Good morning, Ms. Hinnant.
A Good morning.
Q My name's Lara Harrill. We met right before this deposition. Have you ever given a deposition before?
A No, ma'am.
Q I'm going to go over the rules with you.

Page 4

A Okay.
Q Although I know someone has probably done it. First thing is, since we have a court reporter here, she's trying to take down everything we say.
A Right.
Q I have a tendency to talk over people. If you'll let me finish my question, I'll try and let you finish your answer.
A Okay.
Q If I interrupt you, please stop me.
A Uh-huh.
Q I want to make it clear for her. Even with the videographer, it's harder for her to get everything on the record.
A Okay.
Q If you will say yes and no instead of nodding your head --
A Yeah.
Q -- or saying uh-huh or unh-unh, that'll make it much easier for her as well. If you have any questions during this deposition, I'd asked that you direct those questions to me rather than to your attorney.
A Okay.
Q If you do not understand my question, please ask me

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appears to be documentation from you as well. Do you usually document?
A. Yes.
Q. If you'll look, please, down at the bottom. We talked about the Bates numbers on here.
A. Uh-huh.
Q. Defense-produced 00244?
A. Uh-huh.
Q. You have done a -- what appears to me to be your dictation for a staffing?
A. Uh-huh.
Q. And I guess -- talk to me a little bit about what this is. You have a staffing, but are these the recommendations related to the staffing just underneath there?
A. Yes. That is correct.
Q. Okay. It says there -- one of the things it says, "Get all medical records. Follow up with law enforcement." How long do you have to complete those tasks like that?
A. Well, it would depend on the case. You would get the medical records as soon as possible. If you're at the hospital and you can get them then, you would get them then. If you needed to do a formal request, you would do that. And law enforcement,

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there are a lot of records that you can obtain online. And then we would request incident reports, and typically that would just take four or five days to get those.
Q. Okay. So these would be -- have been the recommendations from your staffing on 1/4?
A. Correct.
Q. Okay.
MR. FRAWLEY: (To Ms. Harrill) Okay. Again, could you -- I'm sorry. Go ahead.
MS. HARRILL: You sure?
MR. FRAWLEY: Yeah. I -- I misread it. I'm sorry.
MS. HARRILL: Okay.
MR. SETTANA: (To Ms. Harrill) Where is the law enforcement reference?
MS. HARRILL: Okay. If you look -- there. He'll -- he can show you.
MR. FRAWLEY: Down there.
MR. SETTANA: All right. Oh, I see it. Thank you. Sorry.
Q. And it says, "Follow up with law enforcement. What is their status?" What do you mean by that, "What is their status?"
A. What is their current status of their investigation

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in regards to Michael [redacted].
Q. Okay. So on 1 -- on 1/4 they were investigating --
A. Yes.
Q. -- already?
A. Uh-huh.
Q. Okay. 12/5. I remember these go backwards.
A. Yes. Yeah.
Q. Let's start at the back. Apologize. I'm getting myself tangled up and turned around. Go to Defense-produced 002 --
A. -- 54, but it actually --
Q. -- 54.
A. -- starts on 253.
Q. I would like for you to go to 25 -- hang on. I would like for you to go to 250, please. There's a note there -- a dictation note done by you?
A. Uh-huh.
Q. And is it fair to say that it was -- you actually inputted on 12/7, but it also was for 12/7; is that fair?
A. Yes.
Q. Okay. And this appears to have been a conversation that you had with the social worker at Levine's.
A. Correct.
Q. And it says that you talked -- let's see, you were

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going to staff the case with the legal department?
A. Correct.
Q. Do you know who all you staffed this case with?
A. Me, Dirvondra, and our attorney at the time, Adrienne Woods.
Q. Is Adrienne still with DSS?
A. She's not with York County DSS.
Q. Okay.
A. I'm not sure if she's with the state office or not.
Q. And it says, "We'll get back with her ASAP and with a discharge plan for the baby."
A. Correct.
Q. Do you recall what your decision was?
A. To release the baby to the parents, based off of the information provided.
Q. Provided by whom?
A. The social worker.
Q. At --
A. At Levine's Children's Hospital.
Q. Okay. Let me ask you this: Would they have discharged the baby if you-all did not recommend it? Do you know?
A. I'm not sure.
Q. Have you ever had that come up before?
A. Not that I recall.

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Q Okay.
A We're typically on the same page.
Q Go to the next page forward, 249. There's two notes on here. I'm looking at the bottom one. "Supervisor contacted Laura Newmark, social worker with Levine's."
A Uh-huh.
Q "Supervisor advised Laura that the case had been staffed with the legal department, and that Owen should be discharged to his parents, and that DSS will follow up with a home assessment." When should -- if you're following -- if your people are following up with a home assessment, when should that be completed?
A Typically, the same day.
Q Do you know what day he was discharged?
A I believe it was on 12/7.
Q If it were after hours, would there be somebody to complete that home assessment?
A Dirvondra would've completed it, yes.
Q Okay. Do you know whether or not she saw them on the 7th?
A She did not.
Q Do you know why?
A She went to the home and attempted to make contact,

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but there was no one at the house.
Q Do you know whether or not the baby had been discharged already?
A Yes. The baby had been discharged.
Q Go to page 246 for me, please. Again, there's two entries on this page as well.
A Uh-huh.
Q You'll have to -- I was just going to tell you to do that.
A Yeah.
Q It appears that your documentation on this page is for 12/17 --
A Uh-huh.
Q -- 2009?
A Correct.
Q This is what we were talking about earlier, about the referral to law enforcement?
A Yes, ma'am.
Q Says that Lieutenant Miller stated that he needed additional information. Do you recall what additional information he needed?
A He wanted the notes from us, from my conversation with the social worker.
Q From which social -- your conversation with which social worker?

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A Laura Newmark.
Q Okay.
A Levine's.
Q What -- when you do a referral, what do you typically send to law enforcement?
A The allegations, typically, and then any notes that we would have as well.
Q Where would the allegations be written down?
A On the intake report.
Q Okay. So --
A They would receive a faxed copy of the intake report.
Q So you'd send them the intake report, whatever dictation you had done?
A Correct.
Q What else?
A And have a conversation with them as well as to any concerns that we would have.
Q Okay. And -- so is it fair to say that Lieutenant Miller had not talked to Dirvondra at this time?
A That is correct, yes.
Q Did you have a conversation with Dirvondra about when that referral was made?
A Yes. I did.
Q And was she reprimanded?

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A I don't know if it was formal, but, verbally, yes. I did speak with her regarding this.
Q Okay. Did she have any reason why it hadn't been done for ten days?
A She stated that she was working on other cases, and it's something that she overlooked.
Q Okay. Turn back one more page. 245 for me, please. This is -- I realize this is Dirvondra's note. And you see the action date is 2/21.
A You mean December 21st?
Q I'm sorry. 12/21.
A Correct.
Q I left off a "1."
A Okay.
Q Do you know, as you sit here today, if this is the first time that she met with the family?
A She had brief contact on the 17th, where she showed up at the home to try to do a home visit, and Kayla was there, but Kayla was getting ready to go to work. So then she scheduled this visit with her on the 21st.
Q Okay. And do you know if she scheduled that -- I mean, if they had a conversation about scheduling that or how she got that scheduled?
A She -- they had a conversation about it, as well as

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she had sent a letter to the home because she had been unable to make contact.
Q Uh-huh.
A So she had sent the mom a letter and made some phone calls.
Q Any idea when the letter was sent?
A I do not recall what date she sent it on.
Q Okay. Turn to 9 for me, please. Tab 9.
MS. HARRILL: Oh, goodness. Can we take a break please?
MR. FRAWLEY: Uh-huh.
(Off the record from 10:33 a.m. until 10:35 a.m.)
THE EXAMINATION BY MS. HARRILL CONTINUES
Q Okay. Let's go to Tab No. 6, please.
A Okay.
Q Talk to me about what these are -- these case reviews.
A I'm not necessarily familiar with this particular case review in a case.
Q Do you -- do you-all do case reviews? Have you seen documents like this?
A No, ma'am.
Q So you don't know who does this?
A No. I'm not sure. Unh-unh.

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Q Do you have any idea what they're for?
A I -- no. I really don't -- I don't have --
Q Never seen one before?
A No. Not like this, no.
Q Okay. Is there another document that's a case review that's similar to this?
A The staffing sheet would be --
Q Okay.
A -- what we'd refer to.
Q And I'm curious because, to me -- and you may not be able to tell, but, if you look through this, it appears to be sort of a summary of the dictation of the case; is that fair?
A Yeah. That's what it appears to be. Yes. That's correct.
MR. FRAWLEY: Lara --
MS. HARRILL: Lara.
MR. FRAWLEY: Lara, the -- the lower right-hand corner Bates number for the DSSPMW --
MS. HARRILL: Yes.
MR. FRAWLEY: -- that indicates it's from Phyllis Moore Ward's material.
MS. HARRILL: Oh.
MR. FRAWLEY: And if you look at -- I think it's Number 8. It's another case review.

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MS. HARRILL: Yes. There's three of them.
MR. FRAWLEY: Right. That's DSSYS. The "YS" would be from Yvonne Stewart's material. In other words, we asked them for the official DSS file, and we also asked if Yvonne Stewart and Phyllis Moore Ward had material, and we produced those as well, but we marked them differently.
MS. HARRILL: Okay.
MR. FRAWLEY: So if it has a "YS," it's from Yvonne Stewart's material. If it has a "PMW," it's from Phyllis Moore Ward's material.
MS. HARRILL: Okay.
Q All right. Let's then -- that will be questions for someone else. Look at 9 for me, please. And then look at page 1356.
A Okay.
Q I'm sorry. 1340 -- 1354. Go back. And then we'll go back to 1356. We talked a little bit about staffing this case with Adrienne Woods. How many times -- it appears to me this case was staffed several times on the 7th; is that --
A Twice, yes.
Q Twice.
A Uh-huh.

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Q Once with -- is it fair, once with a worker, and once with the legal staff?
A Once with Lola, Chandra, myself, and Dirvondra, and then myself, Adrienne, and Dirvondra --
Q Okay.
A -- separately.
Q All right. So, at this time, would these recommendations on this staffing be recommendations for Dirvondra?
A Yes. All of the recommendations would've been for Dirvondra.
Q Okay. We talked a little bit -- a little go -- a little bit ago about discharging the baby home.
A Uh-huh.
Q That that was a staffing that you had had with your attorney?
A Right.
Q Would this staffing sheet on 12/7 with Adrienne Woods recommend that -- or represent that staffing --
A Yes.
Q -- to your knowledge?
A Yes.
Q Okay. And there's also a referral-to-law-enforcement recommendation?

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A Correct.
Q And, if you turn to the next staffing sheet, which is dated the same day. I'm sorry, 1355. Go the other way.
A So this way? Okay.
Q This appears to have been a staffing with you, Dirvondra, and Lola?
A And Chandra. Uh-huh.
Q Okay. So that's what that is.
A This would've been the first staffing, and the legal staffing would've been second.
Q And it's Chandra Tyler, right?
A Yes. That's correct.
Q And, again, would these recommendations have been recommendations for Dirvondra?
A Yes.
Q Okay. And, again, it says -- and I -- you may not can read it. It's better on my copies. "Refer to law enforcement"?
A Yes, ma'am.
Q "Go to home and assess home"?
A Correct.
Q And is it fair to say -- you said that she went that day to see the home?
A She did. She went on the 7th.

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Q If you'll turn to the next tab for me, please. Tab 10. It's Defense Produced 00401. This is -- appears to be a letter from Dirvondra to Michael [redacted] and Kayla --
A Uh-huh.
Q -- Lythgoe? Do you have any idea when this was written?
A I have no idea. No, ma'am.
Q I'll ask her.
Turn to Tab 11 for me, please. This appears to be a staffing done on January 4th?
A Uh-huh.
Q Is that fair?
A Correct.
Q Between you and Dirvondra?
A Uh-huh.
Q Do you see there where it says "Follow up with law enforcement. What is their status?"
A Yes.
Q At this time, did you have any idea whether or not they had been notified?
A On the 4th? Yes. I knew that she had referred them, but it was late. But, yeah. She did it on the 16th.
Q And when did you find out that it was late?

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A On this -- I believe it was the staffing. It would've been the next time that I staffed the case with her.
Q Okay. Turn to Tab 12 for me, please. Do you know whose handwriting this is?
A No. I do not. Unless it -- it would have to be Phyllis or Yvonne's handwriting.
Q Yvonne, I bet.
A Yeah.
Q It has the "YS" on it. Have you ever seen this before?
A No.
Q Would you turn to Defense Produced 00200 in this section, please? The -- you see how these are sort of blocked off in lines? The second section, can you read that for me?
A Which section are you referring to?
Q This --
A This?
Q Yes, ma'am.
A "Krista had called Dirvondra and talked about her timeliness, and put her on" -- I don't know what that says. "To do timely contacts. Did written" -- I'm not sure. It's hard to read her handwriting.

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Q It is.
A Uh-huh.
Q And I -- okay. Let me see if it makes sense if I read it like this: "Did written warning in April. Numerous individual conference sheets." I don't know what that is. "-- in July. She started" --
A Started --
Q -- "doing timely contacts. Has lots of documentation of working with her until August when she started getting timely."
A Yes.
Q Does that -- is that fair?
A Yeah. I mean --
Q It's hard to read, isn't it?
A It's very hard to read.
Q All right. Let me ask you this: Talk to me a little bit about what this is about. Did you have a conversation with Yvonne Stewart about Dirvondra?
A Not to my knowledge. A conversation was had between myself and Phyllis Ward.
Q And can you tell me about that conversation?
A We did have a conversation in regards to her not making a law enforcement referral until the 16th.
Q Had you ever had that problem before that you were aware of?

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and Lieutenant Miller -- well, let me ask you this: This exchange is from a January 12, 2010 conversation, correct?

A Correct.

Q That's the day after the second injury, correct?

A Right.

Q All right. And -- and what -- what is this exchange with Lieutenant Miller? What are you talking about?

A We're just reviewing the facts of the case. This is the first time that I had spoken with him, I believe, after the incident took place. We're discussing what we had previously discussed in regards to the first allegation.

Q Okay. And -- and when you say, on Page 4 between Lines 4 through 6, "They, of course, are making all the statements that we need now, but because there was no serious injury last time," the "they" you're talking about is the hospital, correct?

A Yes. That's correct.

Q And the statements they're making now are relating to the second injury, which was a much more serious injury, correct?

A Correct. Yes.

Q So they're telling you, after the second injury,

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that it is non-accidental trauma, and we -- we got a serious issue right now, correct?

A Yes.

Q But they weren't making those statements before, with regard to the January -- I'm sorry -- the December 5th injury/December 6th intake, because at that time they were not able to determine if there was non-accidental trauma --

A Yes.

Q -- correct?

MR. TODD: Objection.

Q Now, is it -- is it your understanding that the second injury was a much more serious injury than the first injury?

A Yes.

Q Now, one of the questions that has come up is the date of the referral to law enforcement. When -- Ms. Hill faxed the referrals to law enforcement December 16th in the evening -- seven o'clock or something like --

A Yes.

Q -- that, and I think Lieutenant Miller said in his -- his conversation with you that he wouldn't have gotten those actually till the morning of the 17th. Is that your understanding?

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A Yes.

Q And I think you said that, pursuant to policy, law enforcement inquiries are supposed to be sent within 24 hours of -- of us having gotten our intake. Was that your policy?

A Yes.

Q Okay. So that would've been -- if the intake comes in December 6th, essentially they should've been sent December 6th, but they weren't sent for ten days later, correct?

A Correct.

Q All right. Now, is it your understanding that this child was injured again before December 16th?

A Can you repeat that, please?

Q Yeah. Or let --

A I'm sorry.

Q -- me ask it a different way.

A Yeah.

Q We -- we got our initial intake December 6th, correct?

A Yes.

Q For an injury that occurred on or before December 5th?

A Yes.

Q All right. By December 16th -- maybe the law

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enforcement inquiry wasn't sent in for ten days, but the child hadn't been injured again between December 6th and December 16th, had he?

A That's correct.

Q All right.

A Yes.

Q He wasn't injured between December 16th and January 10th, was he?

A No.

Q Okay. Not that we know.

A Not that we know of --

Q All right.

A -- correct.

Q Do you know the -- the law enforcement inquiry -- when -- when they did the law enforcement inquiry that was sent in, it was sent in to -- for law enforcement to inquire into whether there's any kind of criminal history for Kayla Lythgoe, the mom, correct?

A Correct.

Q And for Michael [redacted] the dad, correct?

A Correct.

Q And also Charlotte Williams, correct?

A Correct.

Q All right. How about Larry Williams, the step-

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granddad on the maternal side? Was -- was anything sent in for him?
A. I believe so, yes, sir.
Q. Okay. Whether it was or wasn't, we know for sure it's sent in for Kayla Lythgoe, for Michael [redacted] and for --
A. -- Charlotte --
Q. -- Charlotte Williams, correct?
A. Yes.
Q. Now, as to those three, do you know if the law enforcement inquiry came back with any kind of criminal history for Kayla Lythgoe?
A. It had no criminal history for her.
Q. No -- no criminal history for the mama, correct?
A. Correct.
Q. How about for Michael [redacted] the guy who eventually admitted to injuring the child for the second injury -- January 11th? Was -- was there any criminal history for Michael [redacted]
A. No. There was not.
Q. So whether this law enforcement inquiry was sent in December 6th or December 16th or at any time before he pled guilty to injuring this child, there would've been no criminal history for Michael [redacted] correct?

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A. Correct.
Q. How about Charlotte Williams? Was there any criminal history that came back for her?
A. Yes. I believe there was some criminal history for her.
Q. She had a CDV in her history, didn't she?
A. Yes.
Q. So, if the criminal history inquiry did go in in a timely manner, all we would've found out was that the maternal grandma --
A. Uh-huh.
Q. -- who still has access to the kid, had a CDV history, correct?
A. Correct.
Q. But mama and daddy had no history, correct?
A. Correct.
Q. I'm sorry. I can't read my handwriting on my notes. Okay.

There was a question that was asked about whether there was a recommendation for parenting classes, which is a relevant question because the issue had come up that there was concern about these being young, possibly immature, parents, who maybe had supervision issues.

A. Correct.

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Q. All right. And I think the question was: In one of the staffing sheets, was there a recommendation for parenting classes? And I think the response was there was not, correct?
A. Correct.
Q. Let me ask you this: As far as the way things work with DSS, there's an intake, there's an assessment originally, correct?
A. Yes.
Q. And -- and assessment is the investigation, isn't it?
A. Correct.
Q. And at some point -- I think we have 45 days with that assessment -- more time if we have to request it, but essentially 45 days to complete the assessment and determine if a case is founded or unfounded, correct?
A. Correct.
Q. All right. When does treatment kick in?
A. Treatment only kicks in if there is an -- if there is abuse or neglect that's been found during the case, and the case --
Q. Okay.
A. -- was indicated.
Q. In other words: The -- the assessment process was

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still ongoing --
A. Correct.
Q. -- when this staffing doesn't mention parental supervision classes, correct?
A. Correct.
Q. Parenting classes, is that a treatment function or an assessment function?
A. Treatment.
Q. So, in order for parenting classes to have kicked in and have been provided, would there not have had to have been a completion of the assessment and a finding?
A. Correct.
Q. Which we didn't have at the time of that staffing?
A. Correct.
Q. We didn't have at the time of the second injury?
A. Correct.
Q. If you could look at Exhibit 18, which I believe is the conversation of January 19th.
A. Uh-huh.
Q. All right. Let me make sure you've got that page in there. All right. You do not. It goes between Page 7 and Page 11. So I want to show you Page 19 on the copy of the transcript I have, from January 19th, 2010, transcript of recording labeled

State of South Carolina)
)
County of York)

Elizabeth Hope Rainey, as the appointed Guardian ad Litem to Owen [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 York County,)
Defendants.)

11-CP-46-04508

Video Deposition
of
Dirvondra Hill

Video deposition of Dirvondra Hill, taken before Kathleen R. Tackett, CVR, a notary public in and for the State of South Carolina, commencing at the hour of 9:58 a.m., Monday, January 14, 2013, at the office of McGowan, Hood & Felder, LLC, 1539 Health Care Drive, Rock Hill, South Carolina.

Reported by
Kathleen R. Tackett, CVR

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EXHIBITS

Plaintiff's Exhibit Number 23, Handwritten notes. 79

STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Rules of Civil Procedure.

- - - -

The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Whereupon,

Dirvondra Hill, being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MS. HARRILL:

Q Good morning, Ms. Hill.

A Good morning.

Q My name's Lara Harrill. We met right before this deposition. Have you ever given a deposition before?

A No, ma'am.

Q Okay. Let's talk a little bit about the ground rules. I'm going to ask you some questions today

that I'd like for you to answer to the best of your ability. We do have the court reporter here. And, even though it's on video, if you could have all your answers be verbal, yes or no instead of uh-huh or unh-unh, it will be easier for her to take that down.

I have a tendency sometimes to want to talk over your answer with my next question. If you'll let me finish my question, I'll try and let you finish your answer. If I interrupt you, please stop me, okay?

A (Nods head up and down.)

Q If you need to go back at any time to another question, you're more than welcome to do that. Once the deposition has started, if you have any questions, I'd ask that you would direct those towards me as opposed to your attorney. Once the deposition has begun, you-all cannot discuss the deposition. Y'all can talk about the weather or whatever else but not about your testimony.

A (Nods head up and down.)

Q If you need a break at any time, please let me know. If you need for me to repeat or rephrase a question, please say so. I'll be happy to do that. If you answer a question, I'm going to assume that

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family?
A Yes.
Q Do you recall how many times you met with them?
A I would have to refer to my notes.
Q Okay. Well, we're going to do that in a minute --
A Okay.
Q -- for sure. Let's go ahead and look at -- we're going to look at Tab 4. And when you said you'd have to refer to your notes, are --
A Yes.
Q -- these the kind of notes you would refer to?
A Yes.
Q And this is the dictation for the file; is that fair?
A Yes.
Q Okay. Let's talk a -- a little bit about how this is organized. It appears to me that this goes from most recent to the past, so when I -- when we talk about it, I want to talk about it from the back forward. Is that okay with you?
A That's fine.
Q Okay. Because what I want to do is talk to you about your notes.
A Okay.
Q And yours appear to be mostly closer to the back.

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So if you could start for me --
A Okay.
Q -- with Defense-produced 00254, which would be the last --
MR. TODD: (To Ms. Harrill) I'm sorry. What tab?
MS. HARRILL: We're in 4. I hope.
Q And I think probably the easiest way to do this is to look and tell me which -- where you see your notes if you go back --
A Okay.
Q -- in time.
A I see an -- a dictation entry, 00252, at the bottom.
Q Okay.
A "Face to face with child client attempted."
Q And what date was that? This was input on 12/16, right?
A Yes.
Q But it was done -- the action date is 12/7; is that fair?
A Correct.
Q Do you know what time this was done?
A There is not an action time for this dictation entry. I can recall that it was sometime in the

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afternoon/evening with the face-to-face. At times there are no times that's entered. For initial a time has to be entered.
Q For -- what do you mean "for initial, a time has to be entered"?
A Initial contact. That's the time -- the time has to be entered because, if not, then it -- the dictation would not be accepted.
Q Would she -- what would be considered an initial contact?
A Initial contact is the first time having contact with the family, whenever a DSS case is brought into our office.
Q Okay. So, in this particular case, would the initial contact have been done by you, or would it have been done by Chandra Tyler?
A Ms. Tyler.
Q Okay. So the first time you see the family would not be considered an initial contact; is that --
A Correct.
Q Okay. Do you have any sense of what time Owen [redacted] was discharged from the hospital on the 7th?
MR. TODD: Objection.
Q You can answer the question.

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A I do not know what time he was discharged from the hospital.
Q Okay. All right. So this dictation indicates that you went out on the 7th, but the family was not home.
A Correct.
Q Is that fair?
A Yes.
Q And when you-all bring a case in such as this one -- I understand you received this case on a Monday; is that correct? And you staff the case with the -- the on-call worker and supervisor?
A On-call worker, supervisor on call, my supervisor, and myself.
Q Okay. And then the case is officially transferred to you; is that fair?
A Yes.
Q Okay. And what then is your responsibility from that point on?
A My responsibility is to -- after the staffing, we were to staff this case with our legal department, find out additional information as to when the child will be discharged, and any plans that we will put in place or any recommendations, and follow up with the family.

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Q Okay. What would you need to look at to know whether or not you had requested them?
A Look and see if there are records in the file.
Q Okay. Would those records say when they came in?
A If a fax was sent.
Q Okay.
A If not, then -- at times, we do call and pick up the records, so there would not be a fax that's sent.
Q Do you recall whether or not you picked up records from Levine's or Piedmont or the pediatric --
A I cannot recall --
Q Okay.
A -- that information.
Q Because we can go and look at that. I just don't have it in here. So we'll talk about that a little bit later.
A Okay.
Q If you sent a request for medical records, would -- would a copy of your request be in the file?
A I don't know how to answer that because at times, if I have already received the records, then -- are you asking regarding a faxed confirmation?
Q No. I'm asking if you sent out a medical request --

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A Uh-huh.
Q -- whether you faxed it, or mailed it, or however --
A Uh-huh.
Q I don't -- I don't know what your standard practice is. I'm going to ask you that next.
A Uh-huh.
Q If you sent out a request for records, would a copy of that request be in the file? Like, if I send a letter to you, I will have a copy of it in my file. Would you have a copy of that request in the client's file?
A If it was sent off faxed, yes.
Q Okay.
A If it was picked up, no.
Q If it was mailed, would you have --
A Well, we typically -- we don't mail.
Q Okay. How do you normally request records from medical?
A We request -- we fax medical records. And at times, we pick up medical records.
Q Okay.
A So we can make a phone call and inform them that we, you know, need medical records.
Q How long does it normally take for you-all to get medical records when you request them?

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A It varies. At times, we receive medical records that week. And at times, it might not be until almost the end of the case that we receive medical records.
Q Uh-huh. Turn to the next tab for me, please, which is 10. And Defense-produced 00401. Tell me what this is.
A This is a home-attempt letter.
Q Do you have any idea when it was sent?
A I do not. Know that it was sent before December the 21st, and I do know that it was received before December the 17, because she was aware of the home-attempt letter in which we discussed the appointment for the 21st.
Q When you saw her on the 17th, is that what you're saying?
A Yes.
Q Okay. If you had scheduled this meeting for the 21st, were you still going out to the house to try and meet with them prior?
A Yes.
Q Okay.
A I was going out to the home to try to follow up with them.

Page 36

Q And this meeting was going to be in their house or at your office?
A At their home.
Q Okay. And -- okay. So we don't know what date this was sent?
A I do not see a date.
Q Okay. And would you document, in your records anywhere, when you sent this letter?
A It should have been documented.
Q In the dictation?
A At times, home-attempt letters are -- are documented. This one slipped.
Q Let me ask you this: What -- as a case manager for York County DSS, what are you supposed to document, related to your case files?
A Initial face-to-face --
Q Okay.
A -- brochure given --
Q Okay.
A -- safety plan face-to-face, if there are any attempts, face-to-face with child client, collateral contacts, or collateral statements, telephone contact --
Q Uh-huh.
A -- and the case decision.

on-call DH

South Carolina Department of Social Services
CASE TRANSFER AND/OR CASE STAFFING

Case Name: Michael [redacted] Date of Case Staffing: 12/7/09
Case Number: Date of Transfer:

Type of Staffing: __Transfer __Placement __Supervisory __ Closure
__Multi-or-Inter-Disciplinary __Case Decision
__Other:_____

Court Involvement: __Yes ___No
If yes, date and type of most recent hearing:
Date of next hearing:

Intake Date: 12/6/09 Typology TOHPN

Child	Age/DOB	Mother	Father
Owen	2 months	Kayla Lythgoe	Michael [redacted]

Charlotte Williams MGM

Prior Hx

Ø

Current Situation:

Owen has two subdural hematomas. one would indicate non accidental trauma. parents appropriate.

Owen went to Sunshine Peds on 12/2/09 b/c baby not acting himself. Saw PA baby had throat infection + cold. NO meds given. 12/4/09 - bad rash baby was sleeping a lot. Funky odor from mouth. parents took baby to PMC. PMC sent child to Levines. SW has concerns b/c CT scan shows non-accidental trauma. NP is saying it non accidental.

GM saw baby a few days ago - baby was sad & uncle sp → Fellow doctors with PCA. Baby is ready for discharge

Follow up on previous Recommendations:

~~Recommendations from Staffing:~~

- Parents are having supervised contact w/ baby. Hospital has a sitter.
- took child to Riverview. Parents also said they noticed a bruise on baby's head in November - neither of them knew what happened. Parents have witnessed no injury - nurse said it is non accidental
- Get medical - Levines, pmc, Riverview & Sunshine Peds
- ~~Refer to LE~~ ★
- LE incidents (requested)
- Full public index
- Follow up and talk w/ doctor.
- Meet w/ GM (assess)
- Go to home and assess home.
- Talk w/ GM separately - any concerns?
- Talk to Laura McDowell - peer doctor (704) 355-3189 - minic trauma is non accidental - Release of info.

For Child Welfare Cases: Date of Diligent Search for Absent Parent or Other Relative and Outcome Search: _____

Case Manager 12/7/09 Date | Supervisor Kristin M. Date 12/17/09

Transfer case to _____ from _____

Sending Worker's Signature 12/7/09 Date | Sending Supervisor's Signature and Date 12.17.09

Receiving Worker's Signature Date | Receiving Supervisor's Signature Date

DSS Form 3062 (Oct 04) Edition of APR 91 is obsolete.

BH

LEGAL STAFF...S

South Carolina Department of Social Services
CASE TRANSFER AND/OR CASE STAFFING

Case Name: Michael [redacted] Date of Case Staffing: 12/7/09
Case Number:

Court Involvement: ___Yes __No
If Yes, date/type of most recent hearing:_____
Date of Next Hearing:_____

Child	Age/DOB	Mother	Father
Owen	2 months	Kayla	Michael

Date of Intake: 12/6/09 Typology: TU HHA
Date Indicated:_____ Typology:_____

Victim(s): Perpetrator:

Current Situation:

Baby in hospital. Two subdural hematomas. Unknown how baby received. Hospital cannot determine if accidental or non-accidental..

Recommendation from Staffing:

~~Does~~ child go to day care?
~~DSS~~ - Baby supervised at all times..
~~Discharge~~ to parents
- refer to LE

INVOLVED STAFF:
A Woods
K. Finnant
D. Hill

WITNESSES:

Primary Testimony by:

Court Supervisor:

Signature Date 12/7/09

Signature Date 12/7/09

Signature Date

Signature Date

Signature Date

DSS Form 3062 (9/18/08)

SCDSS 0994a

DSS

Serving Children and Families

KATHLEEN M. HAYES, P.H.D.
STATE DIRECTOR

Dear Michael [redacted] Kayla Lythgoe,

The York County Department of Social Services received a report on December 6, 2009 alleging your child has been abused or neglected. Attempts to contact you have not been successful. In order to complete a thorough assessment in the allotted time, it is important that I interview all household members and assess all children. Therefore, I have scheduled a home visit appointment for Monday, December 21, 2009 at 9:00am. If you are unable to keep this appointment, contact me as soon as possible so that we may schedule a mutually convenient time. Our office hours are Monday through Friday 8:30 am to 5:00 pm. I may be reached at (803) 684-2315 ext. 148. Your cooperation will be greatly appreciated.

Sincerely,

Dirvondra Hill
York County DSS
Human Service Specialist II

APPENDIX "K"

DSS

Serving Children and Families

KATHLEEN M. HAYES, PH.D.
STATE DIRECTOR

MARK SANFORD
GOVERNOR

FAX COVER SHEET

Date: December 16, 2009 Number of Pages: (including cover sheet) 5

To: Organization: York County Sheriff Department-Detective Division
Attention: Lt. WJ Miller
Fax Number: (803)628-3158

From: Division or County: York County Department of Social Service
Address: 18 West Liberty Street/P.O. Box 261 York, SC 29745
Name: Dirvondra Hill
Fax Number: (803)684-8155
Telephone Number: (803)684-8148
Comments: Attached is a referral- please call when receive referral-Thanks in advance. My cell phone number is (803)230-3981

Transmitted by: Dirvondra Hill

This transmission may contain information that is protected from disclosure by federal and/or state law, or is otherwise privileged or confidential. This communication is intended only for the use of the individual or entity to whom it is addressed. If you are not the intended recipient or the employee or agent responsible for delivering this message to the recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited and violations of applicable federal and/or state law may subject you to civil and/or criminal penalties. If you have received this communication in error, please notify the sender immediately by telephone and return this communication by mail to the address shown above.

DSS

Serving Children and Families

KATHLEEN M. HAYES, PH.D.
STATE DIRECTOR

MARK SANFORD
GOVERNOR

FAX COVER SHEET

Date: December 16, 2009 Number of Pages: (including cover sheet) 4

To: Organization: York County Sheriff Department
Attention: Incident Reports
Fax Number: (803)628-3217

From: Division or County: York County Department of Social Service
Address: 18 West Liberty Street/P.O. Box 261 York, SC 29745
Name: Dirvondra Hill
Fax Number: (803)684-8155
Telephone Number: (803)684-8148

Comments: Please fax incident reports. Thanks for all you do!

Transmitted by: Dirvondra Hill

This transmission may contain information that is protected from disclosure by federal and/or state law, or is otherwise privileged or confidential. This communication is intended only for the use of the individual or entity to whom it is addressed. If you are not the intended recipient or the employee or agent responsible for delivering this message to the recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited and violations of applicable federal and/or state law may subject you to civil and/or criminal penalties. If you have received this communication in error, please notify the sender immediately by telephone and return this communication by mail to the address shown above.

YORK COUNTY DSS REQUEST FOR CRIMINAL HISTORY/INCIDENT REPORTS

Law Enforcement Agency (circle one)	RHPD Ft. Mill PD Clover PD York PD York County Sheriff
Date of Request	December 16, 2009
Client Name	Charlotte Williams
Client DOB	
Client Social Security Number	
Client Address	[redacted]
Client Race / Sex (circle one)	Black White Other / Male Female
Incident Dates	ALL
Caseworker Name/Room door #	Dirvondra Hill
Caseworker Phone Number	(803) 684-8148
Caseworker Fax Number	— (803) 684-8155
Additional Information	Criminal Records Check

SCDSS 0459

YORK COUNTY DSS REQUEST FOR CRIMINAL HISTORY/INCIDENT REPORTS

Law Enforcement Agency (circle one)	RHPD Ft. Mill PD Clover PD York PD York County Sheriff
Date of Request	December 16, 2009
Client Name	Michael [redacted]
Client DOB	[redacted]
Client Social Security Number	
Client Address	[redacted]
Client Race / Sex (circle one)	Black White Other / Male Female
Incident Dates	ALL
Caseworker Name/Room door #	Dirvondra Hill
Caseworker Phone Number	(803) 684-8148
Caseworker Fax Number	(803) 684-8155
Additional Information	Criminal Records Check

YORK COUNTY DSS REQUEST FOR CRIMINAL HISTORY/INCIDENT REPORTS

Law Enforcement Agency (circle one)	RHPD Ft. Mill PD Clover PD York PD York County Sheriff
Date of Request	December 16, 2009
Client Name	Kayla Lythgoe
Client DOB	[redacted]
Client Social Security Number	
Client Address	[redacted]
Client Race / Sex (circle one)	Black White Other / Male Female
Incident Dates	ALL
Caseworker Name/Room door #	Dirvondra Hill
Caseworker Phone Number	(803) 684-8148
Caseworker Fax Number	(803) 684-8155
Additional Information	Criminal Records Check

APPENDIX "L"

DH

South Carolina Department of Social Services
CASE TRANSFER AND/OR CASE STAFFING

Case Name: Michael [redacted] Date of Case Staffing: 1/4/10
Case Number: Date of Transfer:

Type of Staffing: __Transfer __Placement __Supervisory __Closure
__Multi-or-Inter-Disciplinary __Case Decision

__Other:_____

Court Involvement: __Yes ___No
If yes, date and type of most recent hearing:
Date of next hearing:

Intake Date: 12/6/09 Typology TOH PR

Child	Age/DOB	Mother	Father
Owen	[redacted] 2months	Kayla	Michael

Charlotte Williams - Grm

Prior Hx

Current Situation:

Hospital cannot determine if hematmas are accidental or non-accidental. Concerns for lack of supervsn. Charlotte - babysits Owen. Baby is doing well. Crib + all baby supplies in home.

Follow up on previous Recommendations:

Recommendations from Staffing:

- Get all medical records
- Follow up w/ LEO - what is their status?
- assess GMS home - get incident reports

For Child Welfare Cases: Date of Diligent Search for Absent Parent or Other Relative and Outcome Search: _____

Case Manager 1/4/10 Date

Supervisor 1/4/10 Date

Transfer case to _____ from _____

Sending Worker's Signature Date

Sending Supervisor's Signature and Date

Receiving Worker's Signature Date

Receiving Supervisor's Signature Date

DSS Form 3062 (Oct 04) Edition of APR 91 is obsolete.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF YORK	)	SIXTEENTH JUDICIAL CIRCUIT
Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to Owen C., a minor	)	Civil Action No.: 2011-CP-46-4508
Plaintiff,	)	
v.	)	**PLAINTIFF'S MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES' MOTION FOR SUMMARY JUDGMENT**
South Carolina Department of Social Services	)	
Defendant,	)	

FILED-RECEIVED
2017 MAR 10 AM 11:29
DANA HAMILTON
C.C.P. & GS
YORK COUNTY, SC

Plaintiff Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to Owen C. a minor, through her attorneys, respectfully submits this Memorandum of Law in Opposition to South Carolina Department of Social Services' ("DSS") Motion for Summary Judgment. DSS argues the evidence demonstrates it acted with slight care and for that reason summary judgment should be granted. This position is misplaced for four reasons. First, DSS's position that the only reasonable inference from the record is that DSS acted with slight care over simplifies its duty and is in direction contradiction to *Bass v. South Carolina Department of Social Services*, 414 S.C. 558, 571, 780 S.E.2d 252, 258–59 (2015). Second, whether DSS's action and/or inaction constitutes gross negligence is best determined by the jury because it is a mixed question of law and fact. Third, Plaintiff has put forth more than a mere scintilla of evidence that DSS breached its statutory duty to thoroughly investigate allegations of abuse/neglect and failed to exercise slight care in its investigation. Fourth, to the extent DSS is arguing immunity applies or is asserting

another affirmative defense, it has failed to carry its burden. For these reasons, DSS's motion for summary judgment should be denied.

FACTS

Michael [redacted] and Kayla Lythgoe, a young couple, were dating and living together in December 2009. Kayla had recently given birth to the couple's child, Owen C. At the time of these events, Owen C. was a three-month-old being cared for by parents, who were still children themselves—one being eighteen-years-old and the other nineteen-years-old.

On December 4, 2009, Owen C. "got real stiff," turned red, and appeared to be "straining." His parents took him to the emergency room at Piedmont Medical Center ("PMC"). When he arrived staff noted he was "lethargic, not responsive and we thought he was dead." Exhibit 1, York County DSS 00143. After triage and an examination, Owen C. was transferred to Carolinas Medical Center's Levine Children's Hospital ("Levine") in Charlotte, North Carolina because of an "apparent life threatening event." Exhibit 2, Levine History & Physical, CMC0059-0062. Owen C. was admitted to Levine during the morning hours of December 5th and medical tests were performed to determine the cause of his physiological symptoms. A CT scan on December 6th revealed a subdural hematoma, i.e. bleeding on his brain. This raised concerns that Owen C.'s injuries were non-accidental. As a result of these concerns, Levine notified the York County office of DSS. Exhibit 3, Deposition of Kristen Hinnant, p. 109 (agreeing DSS was called because Levine's staff had concerns that Owen C.'s injury was non-accidental).

After the subdural hematoma was diagnosed, neither parent could explain how the injury happened. Levine's social workers took very brief notes of their conversations with Michael, Kayla, and a couple other family members.

That evening, the York County office of DSS received a call from Levine explaining an infant with two subdural hematomas had been admitted. Exhibit 4, Dictation Notes, p. 253-255. The call was received around 5:01 p.m. The on-call case worker Chandra Tyler responded to the hospital. *Id.* Ms. Tyler arrived at Levine at approximately 7:45 p.m. *Id.* She spoke with Michael and Kayla, along with the maternal grandparents. *Id.* Ms. Tyler had Michael and Kayla enter into a safety agreement, and she provided the parents with a DSS brochure outlining their rights. *Id.* Ms. Tyler documented that she spoke with a nurse about using a copier, but there was no indication she discussed Owen C.'s medical status. *Id.*

The next day, December 7th, Ms. Tyler and her supervisor Lola Sutherland, both on call from the weekend, had a staff assessment with the caseworker being assigned the case, Dirvondra Hill, and her supervisor Krista Hinnant. Around 9:00 a.m., Ms. Hinnant went to Levine for a face-to-face with Owen C.'s family and any collateral sources (i.e. nurses and Levine's social workers). She noted in her dictation that the "nurse said it is non-accidental" injury. *Id.* at p. 251. In direct contradiction to the nurse's assessment, Ms. Hinnant stated Owen C. was "ready for discharge." Significantly, Ms. Hinnant dictated that she was going to refer this matter to law enforcement and speak with the doctor handling Owen C.'s case. *Id.*

Two hours later, at approximately 11:50 a.m., Ms. Hinnant dictated that she received a call from a Levine social worker who told her that "the hospital cannot determine whether the injuries are accidental or nonaccidental" and "the hospital still cannot rule out any trauma." *Id.* at p. 250. The social worker also shared that the treating physician "stated that she cannot determine if the injuries are an accident or not at this point." *Id.* Moreover, the social worker explained an overarching concern has been that the "parents are t[w]o young parents and the hospital mostly has concerns for lack of supervision." *Id.* By around 3:00 p.m., Ms. Hinnant advised Levine's

social worker that DSS determined Owen C. would go home with his parents, and DSS would follow up with a home assessment that day. *Id.* at p. 249. As described by multiple DSS workers, a DSS investigation continues well past the initial twenty-fours when they are called in.

Later on December 7th , a Levine social worker informed Ms. Hinnant that Owen C. would be medically discharged that afternoon. Ms. Hinnant instructed Ms. Sutherland to go out to Owen C.'s home that day for a home visit. No contact was made that day, December 8th, or December 10th. Exhibit 4, Dictation, at p. 248, 252-253. On December 17th, ten days after Owen's medical discharge and release by DSS, DSS had the first contact with a member of Owen C.'s family, Kayla. At that point, DSS had still not seen Owen C. outside of the hospital. *Id.* at p. 247. During this brief encounter, Ms. Sutherland confirmed that the family would meet on December 21st. At the first home visit, on December 21st, Ms. Hill learned for the *first* time who lived in Owen C's home. Exhibit 5, Deposition of Dirvondra Hill, p. 19.

Also on December 17th, law enforcement was contacted for the *first* time by DSS. Contact was made pursuant to DSS's statutory requirement to report to law enforcement any alleged "facts indicating abuse or neglect" that also appear to indicate a criminal violation within twenty-four hours. S.C. Code § 63-7-980(B)(1); *see* Exhibit 4, at p. 246; Exhibit 6, DSS Letter Requesting Law Enforcement Involvement. Lieutenant Miller of the York County Sheriff's Office informed Ms. Hinnant that he needed additional information regarding the allegations. Exhibit 7, Transcript of Telephone Call between Lt. Miller and Ms. Hinnant, p. 5-13. She informed Lieutenant Miller that the hospital did not know the nature of Owen C.'s injuries, and the hospital would not give her an opinion on the cause of the injury. *Id.*

In a matter of weeks, Owen C. was left alone with Michael. In early January 2010, 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 to get him 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."

When he arrived at Levine for a second time, he was diagnosed with a new subdural hematoma, retinal hemorrhaging, and persistent seizures. It was determined that Owen C. suffered an anoxic brain injury, causing permanent blindness and deafness. Owen received morphine for his pain and was eventually placed in hospice care. After a period of hospice care, Owen C.'s medical outlook began to improve. He was released from hospice but has suffered serious, permanent injuries. He is blind, deaf, and will never be able to walk. Michael plead guilty to child abuse and is currently in prison. *See* Exhibit 8, News Articles.

PROCEDURAL HISTORY

On December 1, 2011, Plaintiff filed the current suit as Owen C.'s Guardian ad Litem. The suit alleges negligence and gross negligence against Levine, DSS, York County Sheriff Bruce Bryant, and the York County Sheriff's Office.[1] DSS answered the Complaint with a qualified general denial in addition to affirmative defenses of lack of foreseeability of a third party, South Carolina Tort Claims Act ("TCA") defenses under S.C. Code Ann. § 15-78-60(1), (2), (3), (4), (5), (12),(20), (23) and (25), and a bar to punitive damages pursuant to S.C. Code §15-78-120(b). DSS now seeks summary judgment on the issue of gross negligence.

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

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 trial court 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 (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); *Moriarty v. Garden Sanctuary Church of God*, 341 S.C. 320, 534 S.E.2d 672 (2000). "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).

ARGUMENTS

I. DSS's Motion Should Be Denied Because There is Evidence That DSS Was Grossly Negligent in Failing to Protect Owen C. from Harm.

Plaintiff has sufficiently presented evidence, far exceeding a mere scintilla, that DSS and its employees failed to exercise even slight care under the circumstances. Further, the evidence presents genuine issues of material fact as to whether DSS thoroughly investigated the allegations

of abuse and neglect for the purpose of proving gross negligence. These inquiries must be resolved by a jury.

"In a negligence action, a plaintiff must show the (1) defendant owes a duty of care to the plaintiff, (2) defendant breached the duty by a negligent act or omission, (3) defendant's breach was the actual and proximate cause of the plaintiff's injury, and (4) plaintiff suffered an injury or damages." *Steinke v. S.C. Dep't of Labor, Licensing & Regulation*, 336 S.C. 373, 387, 520 S.E.2d 142, 149 (1999).

Under the TCA, a "governmental entity is not liable for a loss resulting from . . . responsibility or duty including but not limited to supervision, protection, control, confinement, or custody of any student, patient, prisoner, inmate, or client of any governmental entity, *except when the responsibility or duty is exercised in a grossly negligent manner*." S.C. Code Ann. § 15–78–60(25) (emphasis added). Gross negligence "means the absence of care that is necessary under the circumstances." *Bass*, 414 S.C. at 571, 780 S.E.2d at 258–59. It is also described as "the failure to exercise slight care." *Etheredge v. Richland Sch. Dist. One,* 341 S.C. 307, 310, 534 S.E.2d 275, 277 (2000). "Gross negligence has also been defined as a relative term, and means *the absence of care that is necessary under the circumstances*." *Id.* (emphasis added). Because gross negligence claims implicate mixed questions of law and fact, their determination typically rests with the jury. *Faile v. S.C. Dep't of Juvenile Justice,* 350 S.C. 315, 332, 566 S.E.2d 536, 545 (2002).

The Legislature enacted child protection statutes for the essential and expressed purpose of protecting individual children like Owen C. from the risk of parental abuse and/or neglect. S.C. Code Ann. § 63-7-10 (A)(3) ("State and community agencies have a responsibility to implement prevention programs aimed at identifying high risk families and to provide supportive intervention

to reduce occurrence of maltreatment."); S.C. Code Ann. § 63-7-10(B) ("It is the purpose of this chapter to establish an effective system of services throughout the State to safeguard the well-being and development of endangered children" and to "establish an effective system of protection of children from injury and harm while living in public and private residential agencies and institutions meant to serve them."). These protections are reiterated by Legislature's enactment of the children's code, which specifically relates to DSS. *See, e.g.*, S.C. Code Ann. § 63-1-20(B).

By statute DSS is the state agency responsible for investigating and intervening in cases of suspected child abuse and neglect. As such, DSS had a statutory duty to protect Owen C. from harm and to safeguard his well-being—a duty that encompassed protecting him from his own parents, if necessary. *See, e.g.*, S.C. Code Ann. § 63-7-20(4), (6), (10), (13)[2] (discussing DSS obligations to children); S.C. Code Ann. § 63-7-960 (same); *see also Jensen v. S.C. Dep't of Soc. Servs.*, 297 S.C. 323, 331–32, 377 S.E.2d 102, 106–07 (Ct.App.1988) (holding the sections mandating DSS investigate and intervene to remove an endangered child from the home create a special duty); *Jensen*, 304 S.C. at 202-03, 403 S.E.2d at 619 (DSS has a duty to intervene with parents in cases of reported abuse).

DSS's statutory and common law duties owed to Owen C. are further supported by the Court of Appeals' review of Owen C.'s appeal, in which the Court held that the responsibility for thoroughly investigating suspected abuse or neglect belongs with DSS, and not the hospital. The Court held:

> [O]ur legislature has designated DSS as the entity responsible for investigating a case of suspected child abuse or neglect within twenty-four hours of receiving a

[2] Section 63-7-20(4) of the South Carolina Code states, "'indicated report' means a report of child abuse or neglect supported by facts which warrant a finding by a preponderance of evidence that abuse or neglect is more likely than not to have occurred." *See Nelson v. Piggly Wiggly Central, Inc.*, 390 S.C. 382, 389, 701 S.E.2d 776, 779 (Ct. App. 2010) (explaining a preponderance of the evidence simply means the greater weight of the evidence).

> report. *See* § 63–7–310 (requiring certain persons to report suspected abuse or neglect to DSS or law enforcement); S.C. Code Ann. § 63–7–920(A)(1) (2010) ("Within twenty-four hours of the receipt of a report of suspected child abuse or neglect or within twenty-four hours after the department has assumed legal custody of a child pursuant to Section 63–7–660 or 63–7–670 or within twenty-four hours after being notified that a child has been taken into emergency protective custody, the department *must* begin an appropriate and *thorough* investigation to determine whether a report of suspected child abuse or neglect is 'indicated' or 'unfounded.' " (emphases added)).

Rainey, 2015 WL 1880212, at *3.

Further, DSS has promulgated its own policies and procedures, which outline the standard of care that must be followed by DSS "[i]n all instances." S.C. Code Ann. § 63-7-900 (emphasis added); *accord* S.C. Code Ann. § 63-7-960. *See also* Exhibit 9, Portions of DSS Human Services Policy and Procedure Manual, Chapter 7: Child Protective and Preventive Services (outlining the responsibilities of DSS personnel with respect to investigation and assessment); *accord Madison ex. rel. Bryant v. Babcock Ctr., Inc.*, 371 S.C. 123, 140, 638 S.E.2d 650, 659 (2006) (stating a defendant's standard of care in a negligence action "may be established and defined by . . . a defendant's own policies and guidelines); *Id.* (explaining in a negligence claim, a party breaches its duty by deviating from the applicable standard of care which "may be established and defined by the common law, statutes, administrative regulations, industry standards, or a defendant's own policies and guidelines."); *see also* Exhibit 10, NASW Code of Ethics 2008 & NASW Clinical Social Work in Social Work Practice 2005. DSS's overarching policy states, "The safety of children is the paramount concern that must guide child protection efforts." Exhibit 9, at p. 3–4; *see also Id.* ("The child is our primary client in child protection cases . . . .").[3]

[3] *Id.* at p. 4 ("When parents do not protect their children from harm and meet their basic needs—as with cases of child abuse and neglect—society has a responsibility to intervene to protect the health and welfare of these children.").

DSS contends there exists no genuine issue of material fact because the only reasonable inference from the evidence is that DSS met the requisite standard of slight care. DSS relies on the fact that its employees went to Levine in less than three hours following the initial call, along with Ms. Hill's attempt to see Owen C. after his release to Michael and Kayla. This position overly simplifies the duty to *thoroughly* investigate beyond the initial twenty-four hours. DSS's duty required the agency to explore all available sources to determine whether Owen C.'s parents were fit and to continue its investigation until receiving reasonable assurances that Owen C.'s home environment was safe.

The South Carolina Supreme Court in *Bass*, rejected DSS's argument that any evidence in the record of DSS acting demonstrates slight care during investigation sufficiently demonstrates slight care throughout the entirety of the investigation when evidence contracts such care; thereby making it a jury question. 414 S.C. at 571, 780 S.E.2d at 258. Specifically, the Court was reviewing whether there was evidence in the record to support the denial of DSS's JNOV motion as to gross negligence. *Id.* DSS asserted that it properly investigated and acted to remove children in emergency circumstances, analogous to the twenty-four-hour requirement in this matter, and as such demonstrated slight care. *Id.* The Court agreed that DSS demonstrated slight care as to the initial decision. *Id.* However, it found that whether DSS acted with slight care in thoroughly investigating following the initial action was a question for the jury. *Id.* This distinction is significant because the Supreme Court acknowledged that the duty to demonstrate slight care exist for each decision/action by DSS. As *Bass* makes clear, DSS may not rely on its purportedly reasonable conduct during one portion of its investigation to justify failings in the overall investigation.

In determining whether there was evidence in the record to uphold the verdict of gross negligence, the Court focused on key facts that led to DSS's decision making. Briefly, in *Bass*, the parents were accused of overdosing their two children, which led to the emergency removal and restricted visitation. In finding there was evidence to support the jury's verdict of gross negligence, the Supreme Court gave an example that "DSS failed to conduct *any* investigation into the medication during its post-EPC investigation, even though they claimed they based their decision to remove the children on the medicine." Further, the Court noted DSS's own expert testified that DSS's action at one point was unlawful. *Id.* at 574, 780 S.E.2d at 260.

Turning to this matter, evidence in the record creates genuine issues of material fact and supports Plaintiff's position that DSS failed to exercise slight care in its investigation, assessment, communication with law enforcement, and efforts to intervene on behalf of Owen C.

i. Failure to Exercise Slight Care to Thoroughly Investigate at the Hospital Prior to Owen C.'s Release to his Parents.

There are at least three genuine issues of material fact related to whether DSS thoroughly investigated with slight care prior to Owen C.'s release to his parents on December 7th. These include (1) whether DSS had the requisite facts to make a determination regarding maltreatment, i.e. risk of harm to Owen C. at the time of his release; (2) whether DSS allowed a medical discharge to abrogate its own duty to protect Owen C. and rely solely on Levine; and (3) whether Ms. Hinnant fundamentally appreciated the information shared by Levine and exercised slight care in forming her assessment/opinion/recommendation.

DSS has recognized in its policies and procedures that "child maltreatment results from a combination of factors: psychological, social, situational, and societal." Exhibit 9, at p. 3–4. Further it acknowledges that "[f]actors that may contributed to an *increased risk for child abuse and neglect include*, for example *family structure*, *poverty*, substance abuse, *poor housing*

conditions, *teenage pregnancy*, *domestic* and *community violence*, mental illness, and *lack of support from extended families* and community members."[4] Exhibit 9, at p. 3–4 (emphasis added). Evidence in the record demonstrates that at the time of discharge DSS knew Owen C.'s parents were teenagers and had substantial reason to suspect Owen C. was being released to a questionable family structure. In fact, the questionable family structure was a primary concern of Levine's staff. *See* Exhibit 3, Dictation, at p. 250 ("parents are t[w]o young parents and the hospital mostly has concerns for lack of supervision."); Exhibit 3, Hinnant, at p. 63 (explaining that DSS had concerns about Owen C.'s "young," "immature" parents and "lack of supervision"). Significantly, evidence suggests at the time of Owen C.'s release DSS was unaware of Owen C.'s housing conditions, family structure, community violence, and level of support of extended family. DSS had not been to the home and was unaware of the conditions. Ms. Hill stated at her deposition that she did not know the family structure, admitting she was unware that grandmother did not reside with Owen C. until December 21st. Exhibit 5, Hill, at p. 19. Further, law enforcement was not contacted prior to Owen C's release, and therefore DSS was unaware if there was any domestic or community violence. Exhibit 5, DSS Letter Requesting Law Enforcement Involvement; Exhibit 11, Deposition of Charlotte Williams, p. 12-13 & Sherriff Records, p. 59 (discussing grandmother's prior criminal record and domestic violence charge); *Id.* p. 27-28 (Michael telling police he was charged with possession of stolen goods sixteen). This lack of information is significant because each of these factors suggested an increased susceptibility to abuse, which coupled with a significant injury raises heightened concerns.

[4] Significantly, the factors identified by DSS's own policies and procedures are mirrored by national standards. *see also* Exhibit 9, NASW Code of Ethics 2008 & NASW Clinical Social Work in Social Work Practice 2005.

DSS's information-gathering failures are further exemplified by DSS's policy and procedure related to child removal, which states DSS should pursue removal of children from a home where a person's abusive behavior endangers the child's safety and there is no other protective caregiver in the home. *See* Exhibit 9, at p. 7-8. At the time of Owen C.'s release from Levine, DSS had not addressed this critical issue. *See* Exhibit 12, Affidavit of George Savarese, Ph.D., LCSW, p.2 (explaining DSS failed "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.]).[5] Thus, there is a genuine issue of material fact as to whether DSS had the requisite facts to make a determination regarding maltreatment, i.e. risk of harm to Owen C. at the time of his release; and thus whether it exercised slight care.

Furthermore, a review of the evidence suggests that DSS's decision to release Owen C. to his parents was premised on Levine's decision not to give an opinion on the cause of the "apparent life threatening event" that brought Owen C. to the hospital. Exhibit 2, at CMC0059-0062. It is undisputed that Levine and its employees informed DSS numerous times[6] that it was uncertain of the cause of Owen C.'s injuries.[7] These sentiments were echoed by Owen C.'s treating physician at her deposition, in which she explained that Owen C.'s medical tests did not eliminate the possibility that Owen was abused. The physician testified that some elements presented concern for non-accidental trauma. Overall, "it could not be determined whether . . . he had been the victim of child abuse." Exhibit 13, Deposition of Dr. Cheryl Courtlandt, at p. 45. Despite these repeated

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[5] *See also* Exhibit 10, NASW Code of Ethics 2008 & NASW Clinical Social Work in Social Work Practice 2005.

[6] Notably, no multidisciplinary meeting took place with law enforcement, hospital, and DSS prior to Owen C.'s medical discharge or release to his parents.

[7] This reliance on Levine is especially troubling given the "minimal information" gathered by the hospital's social workers, which independently violated the national standard of care and the hospital's own policies and procedures. Exhibit 12, Savarese Aff. Exhibit 2, at CMC 0092-0098.

assertions, as documented in DSS's file, Ms. Hinnant summarized Levine's findings and lack of opinion as the basis for DSS's release of Owen C. Practically, this creates a genuine issue of material fact of whether DSS allowed a medical discharge to abrogate its own duty to protect Owen C. and rely solely on Levine; thereby failing to exercise slight care.

Moreover, Ms. Hinnant's characterization of the facts, as provided to Lieutenant Miller raises a genuine issue of material fact on whether Ms. Hinnant fundamentally appreciated the information shared by Levine and exercised slight care in forming her assessment/ opinion/recommendation. Exhibit 8, Transcript of Telephone Call between Lt. Miller and Ms. Hinnant at p. 11–12. For example, she told Lieutenant Miller the Levine didn't have "any suspicions." *Id.* at p. 12. Not only is this statement factually inaccurate and a misrepresentation, it improperly influenced Lieutenant Miller's independent assessment and investigation of the case specific circumstances.[8]

ii. Failure to Exercise Slight Care in the Investigation and Assessment of Allegations of Abuse and Neglect Following Owen C.'s Release from Levine.

At a minimum, there are at least three genuine issues of material fact related to whether DSS thoroughly investigated with slight care following Owen C.'s release from Levine. These include: (1) whether Ms. Hill exercised slight care when she had no contact with the family for ten days and no contact with Owen C. for fourteen days; (2) whether Ms. Hill exercised slight care when there is no evidence to suggest she attempted to request medical records or contact collateral sources to further the investigation with no contact with Owen C. or his family; (3) whether Ms. Hinnant exercised slight care as a supervisor of this case when she knew Ms. Hill had no contact with Owen C.

[8] This misrepresentation of the facts, also raises a genuine issue of material fact as to whether Ms. Hinnant used slight care in communicating the known facts and potential harm to law enforcement.

DSS has established policies and procedures for the investigation and assessment of a suspected child abuse victim. *See* Exhibit 9, at p. 52–75. DSS states the purpose of these policies and procedures is to (1) identify safety concerns and ensure immediate safety, along with safety throughout the investigation/assessment; (2) make a determination of whether or not the child was abused or neglected; (3) make a decision regarding future risk of maltreatment; and (4) plan for agency intervention. *Id.* at p. 52; *see also* S.C. Code Ann. § 63-7-20; § 63-7-620; § 63-7-920. To achieve this purpose, a DSS social worker is instructed to gather "information necessary to analyze the current functioning of the [child] and family and determining if [child is] safe using the six fundamental assessment questions that inform the safety assessment decision." *Id.* at p.58; *see also Id.* at p. 58–59 (listing the six questions: (1) what is the extent of the maltreatment; (2) what are the circumstances surrounding the child maltreatment; (3) how does the child function on a daily basis; (4) what are the disciplinary approaches and typical context used by the caregiver; (5) what are the overall pervasive practices used by caregivers; (6) how does the caregiver function with respect to daily life management and general adaption including substance use and mental health functioning).

Following Owen C's release from Levine, DSS effectively had no assessment or investigation into Owen C.'s case for fourteen days. It is undisputed that DSS had no contact with Owen C.'s family for ten days. Exhibit 4, Dictation at p. 248, 252-253. Despite the encounter on the December 17th, Ms. Hill did not learn any substantive information to address *any* of the six pertinent questions nor had she seen Owen C. until December 21st. Exhibit 5, Hill Deposition, p. 19. Ms. Hill stated as an assigned social worker it is her responsibility to follow up with the family after discharge from a hospital. *Id.* at p. 12. While she stated it is the best practice to follow up with a family after a child is discharged, Ms. Hill would not provide a timeframe in

which this should occur and she stated that she could not recall what the timeframe should be. *Id.* at 26. During her deposition, Ms. Hill agreed that the purpose of an ongoing investigation, as set forth in Section 719 of DSS's policies and procedures, is to (1) identify safety concerns and insure the immediate safety of a child; (2) make a determination on whether the child was abused or neglected; (3) a decision regarding the future risk of maltreatment, and (4) plan for agency service intervention. *Id.* at p. 38. In order to achieve this purpose, Ms. Hill explained that it requires speaking with the family as a means of assessing the family. However, for more than ten days DSS had no contact with the family and for more than fourteen days she had no contact with Owen C. As a result, there was not a single act done to ensure Owen C.'s immediate safety or address any of the necessary inquires.

Additionally, there is no evidence in the record that Ms. Hill made any other efforts to further the investigation and assessment of the alleged abuse when she had no contact with the family. There is no evidence that Ms. Hill requested medical records or contacted collateral sources like doctors, neighbors, family friends, etc. to investigate the alleged abuse. *Id.* at p. 39 (testifying that she could not recall ordering medical records). This is significant because DSS suggests that the failed attempts for a face-to-face in the days following Owen C.'s release are enough to demonstrate slight care. The evidence suggests Ms. Hill knew she had not gathered any information about Owen C. and did not make any effort to garner information from any other source. For these reasons, there is a genuine issue of material fact whether Ms. Hill exercised slight care in assessing and investigating Owen C.'s case.

There is also a genuine issue of material fact whether Ms. Hinnant exercised slight care in her role as a supervisor of Ms. Hill and Owen C.'s case. It is undisputed that Ms. Hinnant knew that there was no contact. *See* Exhibit 7, Transcript of Telephone Call between Lt. Miller and Ms.

Hinnant, at p. 13 (informing Lieutenant Miller that Ms. Hill had no contact with Owen C.). There is no evidence to suggest that Ms. Hinnant was taking any action to address this lack of communication, assessment, and investigation despite her acknowledgement of the role of DSS in protecting clients like Owen C. Exhibit 3, Hinnant Deposition, at p. 22 (agreeing the primary client of DSS is the child); *Id.* at p. 22–23 (agreeing the safety of the child is the primary concern that guides child protection efforts); *Id.* at p. 68 (agreeing she had the most contact with Ms. Hill).

iii. Failure to Exercise Slight Care in Contacting and Communicating with Law Enforcement in Direct Violation of South Carolina Law.

At a minimum, there are at least two genuine issues of material fact related to whether DSS exercised slight care in fulfilling its duty to thoroughly investigate Owen C.'s case when law enforcement was not contacted within twenty-four hours as required by law. These include (1) whether Ms. Hill exercised slight care as a social worker when she took ten days to contact law enforcement; and (2) whether Ms. Hinnant exercised slight care as a supervisor when she instructed Ms. Hill to contact law enforcement and later became aware that law enforcement had not been contacted.

Section 63-7-980(B)(1) of the South Carolina Code of Laws mandates that DSS contact law enforcement within twenty-four hours when there are accusations of abuse or neglect that "also appear to indicate a violation of criminal law." S.C. Code Ann. §63-7-980(B)(1); *see also* Exhibit 9, DSS Policy and Procedure 710(15) at p. 17. Thus, DSS was required to report Owen C.'s injuries by December 7th. However, contact did not occur until late in the evening on December 16th, effectively December 17th.

Evidence in the record demonstrates that DSS failed to exercise slight care in reporting to law enforcement. Ms. Hill stated at her deposition that DSS automatically refers cases with injuries or abuse to law enforcement, and that her responsibilities included reaching out to law

enforcement when those issues arose. Exhibit 5, Hill Deposition, at p. 27-28; *see also* Exhibit 3, Hinnant Deposition, at p. 24 (stating "its absolutely our responsibility" to contact law enforcement). This position was supported by the deposition of Ms. Southerland, who stated that a child with a subdural hematoma would require a law enforcement referral within twenty-four hours. Exhibit 14, Deposition of Lola Southerland, p. 33. She further explained that in those types of injuries "we're not the ones to decide." *Id.* at p. 35. However, Ms. Hill did not notify law enforcement as required within the first twenty-four hours of the allegations. Instead, she waited ten days before contacting law enforcement. *See also*, Exhibit 5, Hill Deposition, at p. 29. (acknowledging referral was ten days late).

This failure to act with slight care is further supported by the transcript of the call between Lieutenant Miller and Ms. Hinnant. *See* Exhibit 6. In response to receiving a DSS notification of abuse, Lieutenant Miller called Ms. Hinnant. He first explained the information that was provided was inadequate and he needed more to go by to understand the circumstances of this case. During this call, Lieutenant Miller expressed his frustration with the lack of notice by DSS stating, "I guess the thing that bugs me the most is getting it ten days after." *Id.* at p. 7; *see also Id.* at p. 9, (explaining his immediate reaction to receiving DSS's paper worked included "What the hell?" regarding the delay, and an automatic concern that "*we've got some body that's done hurt this child*") (emphasis added); *see also* Exhibit 15, Transcript of Telephone Call between Lt. Miller and Lola Southerland (reacting to the ten delay Lieutenant Miller states "just infuriates the living hell out of me, because in the statement that says that the child has a none of the—the parents don't know anything about the falls."); *Id.* ("Now, if anything's going to stroke me out, this –this will."). In response, Hinnant explained that she had asked Ms. Sutherland to make contact and "fussed at her" about the delay. *Id.* at 7. Moreover, she stated, "[Ms. Sutherland] should've made it as soon

as she got the report when we staffed it from on-call," on December 7th. *Id.* Hinnant admitted to Lieutenant Miller that she knew the call had not been made within the twenty-four hour period, as required by their policy (as well as statute), but had not realized there was such a significant delay. *Id.* In fact, Hinnant stated this inaction was "unacceptable" because an injury like Owen C.'s requires reporting per DSS's policy, and characterized this failure as a "big problem." *Id.* at p. 8, 10, 14.

In sum, there are multiple issues of material fact for a jury to determine whether DSS acted with slight care. Moreover, Plaintiff contends that as a result of DSS's numerous breaches in the standard of care and failure to exercise slight care, DSS contributed to the injuries and damages sustained by Owen C. *See* Exhibit 12, Savarese p. 2 ("it is my opinion to a reasonable degree of professional certainty that the actions or inactions of the employees and/or agents of [DSS] . . . contributed to the injuries and damages of Owen [C.]."). A determination on proximate cause is also a matter that should be left to the jury. *McKnight v. S.C. Dep't of Corr.*, 385 S.C. 380, 387, 684 S.E.2d 566, 569 (Ct. App. 2009) (recognizing that ordinarily, proximate cause is a question for the jury). For these reasons, summary judgment should be denied.

II. DSS's Immunity is inapplicable

To the extent DSS is seeking summary judgment based on its immunity such an argument must fail because DSS fails to carry its burden of explaining why any of the immunities are applicable in this matter. *See Faile,* 350 S.C. at 324, 566 S.E.2d at 540 (discussing burden of defendant to establish entitlement to immunities). DSS's claims of immunity fail because acts of gross negligence are exceptions to the immunities claimed by DSS under S.C. Code Ann. § 15-78-60. *See Steinke,* 336 S.C. at 398, 520 S.E.2d at 155 (holding that acts of gross negligence are an exception to immunities set forth in the Tort Claims Act);[6] *Jensen*, 304 S.C. at 198, 403 S.E.2d at

616 (negligence may give rise to a private cause of action against DSS); *see also Bass,* 414 S.C. at 571, 780 S.E.2d at 258 (upholding jury verdict finding DSS grossly negligent in its investigation of parents).

CONCLUSION

Based on the arguments stated above, Plaintiff respectfully requests this Court deny DSS's Motion for Summary Judgment. Plaintiff has presented sufficient evidence that DSS, through one ore more of its employees, failed to act with slight care. Additionally, DSS failed to carry its burden in asserting any claim for immunity or affirmative defense.

Signature Page to Follow

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March 9, 2017
Rock Hill, South Carolina

CERTIFICATE OF SERVICE

I, Jessica L. Cooksey, an employee of the law firm McGowan, Hood & Felder, LLC do hereby certify that I served copies of the above ***Plaintiff's Memorandum of Law in Opposition to Defendant South Carolina Department of Social Services' Motion for Summary Judgment*** on the Defendants in the above-captioned matter by email and by depositing the same in the United States Postal Service, with proper postage affixed thereto, on this 10th day of March, 2017, addressed to the attorney(s) listed below:

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

Jessica L. Cooksey
Paralegal

Exhibit 1

Piedmont Medical Center - Rock Hill, SC 29732

Patient:	[redacted], OWEN M	DOB:	9/9/2009
MR #:	000345331	Age/Gender:	12w M
DOS:	12/4/2009 17:12	Acct #:	020022224
Private Phys:	Sunshine Pediatrics	ED Phys:	Christopher DiOrio, DO

Past Medical/Surgical History
Amendments to history obtained earlier:
FT/SVD at no pre, peri or post natal complications
"throat infection" diagnosed by Pediatrician Dr paxtor

Daycare none, no smokers in housem first child <CD3 12/04/09 19:34 >
No significant medical history. <RS 12/04/09 18:54 >
No significant surgical history. <RS 12/04/09 18:54 >

Past Social History
Patient does not use drugs. <RS 12/04/09 18:54 >
Patient does not use alcohol. <RS 12/04/09 18:54 >
Patient does not use tobacco. <RS 12/04/09 18:54 >

HISTORY OF PRESENT ILLNESS

Note
Medical Screening examination has been initiated.

Notes: seen with mother and father and gmother <CD3 12/04/09 19:32 >
Medical and surgical history obtained. <CD3 12/04/09 18:57 >
Social history obtained. <CD3 12/04/09 18:57 >
Past family history obtained. <CD3 12/04/09 18:57 >
HPI: A12 week old white male presents with "lethargic, not responsive and we thought he was dead."
Per mother and more specifically father who is with the child at the time of the incident, the patient was nonresponsive but still breathing and had good pulses and no cyanosis for a period of 5 to 10 minutes. Father states that the child got tense and quite possibly had a tonic episode with no clonic activity and subsequently was not arousable to gentle shakes or further stimuli.
They state the child has been having a poor appetite, and mildly "lethargic" which they describe as less crying more irritable over the past 24 hours.

ROS: As documented in HPI. All other symptoms are negative.

PE:
GENERAL: well appearing; well nourished; in no apparent distress; non-toxic, this is a "great" looking child very healthy with a strong suckle on my gloved finger
HEAD: normocephalic; atraumatic
EYES: PERRL; EOM intact
ENT: normal nose; no rhinorrhea; mucous membranes moist; pharynx clear
NECK: supple; trachea midline; non-tender
CARDIAC: RRR; S1, S2; no appreciable murmurs, rubs or gallops
LUNGS: breath sounds clear and equal bilaterally; no appreciable wheezes, rales or rhonchi
ABDOMEN: soft; non-tender; non-distended; no appreciable organomegaly
bilateral descended testes with a circumcised penis

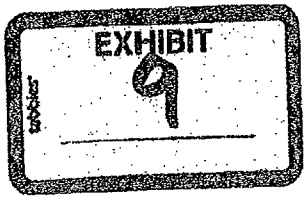

Exhibit 2

CAROLINAS HEALTHCARE SYSTEM
HISTORY AND PHYSICAL

PATIENT: [redacted] **Owen Michael**		**HISTORY NO:**	**000-545-02-19**
DOB: [redacted]			
ATT. MD: DEPT OF PEDIATRICS CMC		**ADMIT DATE:**	**12/05/2009**
ACC. NO: 0933900393		**LOCATION:**	**8PC 802301**

[redacted] Owen Michael 000-545-02-19

TEAM: LCH CHIPS Team A.

ATTENDING PHYSICIAN: Dr. Sarah Gall.

CHIEF COMPLAINT: Apparent life threatening event.

HISTORY OF PRESENT ILLNESS: This patient is a 2-month-old previously healthy Caucasian male who presents to the emergency department at Levine Children's Hospital from Piedmont with ALTE. The patient's parents report that around 1630 on Friday evening, the patient had an episode shortly after a feed, where he cried out and then arch his back. He went limp for approximately 10 minutes afterwards. There is no color change, no cyanosis, no loss of consciousness. The patient did not have any shaking or seizure-like movements at the time. Parents report that he was whimpering around with the 10 minutes mark and when he was removed from his car seat at the emergency department, he then cried and began acting more normally. They also reported that he has been more sleepy since that time and has been fussy but somewhat consolable. He was noted to have a minor cold about one week ago and what the parents describe as a throat infection. The patient in addition, today has had nonbloody, nonbilious vomiting that has been nonprojectile in nature after all feeds last evening. There is marked decrease in urine output and the patient has only had one wet diaper so far today as well as the urine that was obtained when he was catheterized. The patient received one dose of Rocephin at the outside hospital before being transferred here, after labs were obtained for a full sepsis workup.

PAST MEDICAL HISTORY: Birth history is remarkable for a full-term standard vaginal delivery. The patient did spend two days in the NICU. According to the parents report maternal labs were normal with the exception of GBS which was treated adequately per mom's report.

HOSPITALIZATIONS AND SURGERIES: NICU stay as noted above.

IMMUNIZATIONS: Up-to-date per family.

HOME MEDICATIONS:
1. Tylenol q.6 hours p.r.n. fever since Wednesday.

DIET: Good Start 4 ounces q.2h.

ALLERGIES: No known drug allergies.

PATIENT: [redacted], Owen Michael		HISTORY NO:	000-545-02-19
DOB: [redacted]			
ATT. MD: DEPT OF PEDIATRICS CMC		ADMIT DATE:	12/05/2009
ACC. NO: 0933900393		LOCATION:	8PC 802301

will continue to follow the patient's blood, urine and CSF cultures as obtained prior to receiving any antibiotics at Piedmont.
3. Neuro: This patient is alert and interactive with no focal neurological deficits. He is somewhat fussy but seems to be consolable. Because of his full fontanel and previously mentioned anemia that is normocytic in nature, a bleed must be considered. We will obtain a stat head CT to rule out any possible bleed. Any time ALTE is being considered the differential must include seizures, however, this event does not sound seizure-like in nature but we would consider an EEG if the patient continues to have episodes here.
4. FEN/GI: This patient is currently mildly dehydrated on exam, although his CO2 at the outside hospital was 22, he does appear to have dry mucous membranes and delayed capillary refill. We will give him a bolus of normal saline before starting him on maintenance IV fluids. He can take p.o. formula on demand as tolerated.

Preliminary-Unreviewed by Physician

D: 12/05/2009 6:22 A STEPHEN FORD RENFROW, MD/R
T: 12/05/2009 2:13 P bh4
002287345
cc: STEPHEN FORD RENFROW, MD/R

* Paxtor Sunshine Pediatrics, . .

Carolinas Patient Care Brochure Printing Processor
Run Dec 06, 2009 05:30 pm

Unit No	Name	Unit Number	Birthdate
559-00795	[redacted] OWEN MICHAEL	090545 03 19	[redacted]

1) Date : 12-06/09
2) Init : KAH
3) Planning Code : CEST FPSI-CHILD PROT SVC INITIAL REFER
4) Referred From : DSS

```
          1         2         3         4         5         6         7
1234567890123456789012345678901234567890123456789012345678901234567890123456789012345
1206/2009 -1500 MSW received page re r/o NAT. Work-up is negative for NAT
but pt does have a small subdural hematoma. Gaia, RN reports that parents
have been appropriate, grandparents have been visiting. MSW met c parents.
Mom is Kayla Lythgoe, dad is Michael [redacted]. baby lives c both parents.
Baby lives at [redacted], Rock Hill, SC 29732. parents do not
have a home phone, only a cell phone c texting, [redacted], phone #
listed on demographic sheet belongs to MSW Charlotte Williams 803 280-3048.
pt's parents report that on Weds. 12/02/2009, parents noticed that baby
"not seeming like himself, sleepy more than usual" "screaming non-stop"
"funky smell out of his mouth" took the baby to Sunshine Pediatrics, so
saw Dr. Paxton, who told the parents that it was a viral infection and to
give the baby Tylenol every 6 hours.  On Friday night 12/04/2009 (note con
dit Notes (Y/N)?
```

Carolinas Medical Center Discharge Planning Processor

Mon Dec 07, 2009 12:07 pm

Account No	Name	Unit Number	Birthdate
99339 00393	[redacted] OWEN MICHAEL	000545 02-19	09/09/09 2M

(1)Date : 12/07/09
(2)Init : LMN
(3)Planning Code : CPSU-CPSU-CHILD PROT SVC UPDATE
(4)Referred From : U/H

```
     1         2         3         4         5         6         7
1234567890123456789012345678901234567890123456789012345678901234567890123
01|MSW spoke c worker Christa Hinnant 803 684-8154 re. patient condition. NAT
02|workup.  Optho (-). NAT series (-). no other obvious signs of abuse,
03|neglect.  MSW spoke c attending Dr. Courtlandt re. likely inability to
04|confirm NAT d/t limited findings. would like to have ongoing DSS
05|involvement c investigation, home visit, parenting education. f/u NAT
06|series in two weeks as outpt.  Owen to have repeat CT scan today. no clear
07|d/c date.  DSS to staff c attorney, but likely will allow d/c home c
08|parents.  Child Maltreatment Coordinator has seen child as well. Nsg
09|following.  Updated RN Tracey.  Will follow.
10|
11|Laura Newmark, MSW 58728                                        MSW
12|12/7/09  1300
```

F1 Delete Line | F2 Insert Line | F3 Center | F4 Exit | F5 Store Line | F6 Restore Line | F7 Pack | F10 Help

Carolinas Patient Care Discharge Planning Processor

Sun Dec 06, 2009 06:44 pm

Account No	Name	Unit Number	Birthdate
09339-00393	[redacted],OWEN MICHAEL	000545 02-19	09/09/09 2M

(1)Date : 12/06/09
(2)Init : KAH
(3)Planning Code : CPSA CPSA-CHILD PECT SVC ACCEPTANCE
(4)Referred From : LCH

```
          1         2         3         4         5         6         7
01234567890123456789012345678901234567890123456789012345678901234567890123
01 12/06/2009 ~1830 MSW received phone call from Shandra Tyler, DSS York Cty,
02 Ms. Tyler will be coming to the hospital to do an assessment. MSW will
03 notify Sherry Deedrick, MSW ED SW. MSW d/w Sara, RN who has the pt. Sara
04 does not feel parents are a flight risk and will let parents know that the
05 DSS worker is coming out to meet c the parents. MSW will follow as needed.
06 For any questions this evening, please contact Sherry Deedrick, ED MSW at
07 [illegible]6.
08
09 Katie Harrison, MSW p 6703
10
11
12
Edit Notes (Y/N)?
```

Carolinas Pediatric Care Discharge Planning Progression

Sun Dec 06, 2009 05:41 pm

Account No	Name	Unit Number	Birthdate
19339-00393	[redacted],OWEN MICHAEL	000545-02-19	09-09/09 2M

(1)Date : 12/06/09
(2)Init : KAH
(3)Planning Code : CPSI-CMS: CHILD PROT SVC INITIAL REPOR
(4)Referred From : ED4

```
        1         2         3         4         5         6         7
123456789012345678901234567890123456789012345678901234567890123456789012345
01|12/06/2009 MSW note continued...after she briefs the case w her supervisor|
02|Baby is not for d/c today, possibly will be d/ced tomorrow. Baby does have|
03|SC Medicaid, WIC, mom has foodstamps. Both parents work, MGM watches baby |
04|when parents are working. Pt's bedside RN Sara did report that MGM did    |
05|tell her privately that when she had picked baby up from dad and uncle    |
06|that she noticed baby had a bump on his head, she asked dad and uncle     |
07|about this and dad and uncle stated that they had no idea why this        |
08|happened.  MSW will leave note for weekday MSW.                           |
09|                                                                          |
10|Katie Harrison, MSW p 2544                                                |
11|                                                                          |
12|                                                                          |
Edit Notes (Y/N)/--
```

Carolinas HealthCare System Pediatrics Progress

Page: 2 Sun Dec 06, 2009 03:16 pm

Account No	Name	Unit Number	Birthdate
39339-00393	[redacted] GWEN MICHAEL	0F0549-01 19	09/09/99 2Y

(1) Date : 12/06/09
(2) Init : KAH
(3) Planning Code : CFST-CFSL-CHILD PROT SVC INITIAL REFER
(4) Referred From : LCH

```
          1         2         3         4         5         6         7
01234567890123456789012345678901234567890123456789012345678901234567890123
01|12/06/2009 NSW note continued...dad noted that pt was sleeping more than
02|usual, woke up crying, then "stretched out, went limp but was still
03|breathing." Dad took baby to Piedmont Hospital, baby was limp during the
04|ride there, wimpered a little, did not open his eyes and when he handed
05|the baby to the nurse at Piedmont, baby screamed. Baby was evaluated at
06|Piedmont and was transferred to LCH early Saturday morning. Parents are
07|aware that a full body x-ray was done and that pt has "blood on the right
08|side of his brain." Parents deny any trauma, that anyone dropped the baby,
09|pt's birth was normal, full-term. Baby is only watched by parents and
10|maternal grandmother, no daycare. Baby is bottle fed. NSW contacted York
11|DSS after hours 803-628-3056 and received a call from on-call DSS worker
12|Shandra Taylor who took the report and will call NSW back. (NSW note conti
Edit Notes (Y/N)?--
```

Carolinas Medical Center-Behavioral Health Services

Mon Dec 06, 2009 04:40 pm

Account No	Name	Unit Number	Birthdate
37139-00393	[redacted].GAGE MICHAEL	0000545-02-19	09/09/09 2N

: 1)Date : 12/06/09
: 2)Unit : KAE
: 3)Planning Code : CPST CPST-CHILD PROT SVC INITIAL, EXPER
: 4)Referral From : LCH

```
          1         2         3         4         5         6         7
01234567890123456789012345678901234567890123456789012345678901234567890123
01 1206/2009 -1500 MSW received page re r/o NAT, work up is negative for NAT
02 but pt does have a small subdural hematoma. Sara, RN reports that parents
03 have been appropriate, grandparents have been visiting. MSW met c parents,
04 mom is Kayla Lythgoe, dad is Michael [redacted], baby lives c both parents.
05 Baby lives at [redacted], Rock Hill, SC 29732, parents do not
06 have a home phone, only a cell phone c texting. [redacted], phone #
07 listed on demographic sheet belongs to MGM Charlotte Williams 803-280-1048
08 Pt's parents report that on Weds, 12/03/2009, parents noticed that baby
09 "not seeming like himself, sleepy more than usual" "screaming non-stop"
10 "funky smell out of his mouth" took the baby to Sunshine Pediatrics, to
11 see Dr. Paxton, who told the parents that it was a viral infection and to
12 give the baby Tylenol every 6 hours. On Friday night 12/04/2009 (note con
Edit Notes (Y/N):-
```

Exhibit 3

Page 9

have been?
A Staffing the case with a worker and, kind of, giving them guidance as to what they should do in terms of putting in safety plans and investigating the case.
Q Did you carry any cases of your own?
A Yes. Initially, when I was an assessment worker, I did.
Q As a supervisor, did you carry any cases?
A No.
Q Okay. And are you a licensed social worker?
A No.
Q When you went to work for DSS, did they give you any specific social work training?
A Yes.
Q And about how long did that take?
A Initially, we went to Columbia. I believe, it was for a two-week training, and then we had a lot of of courses and other training that we had to -- had to attend, as well.
Q Did you have, like, continuing training?
A Yes. Uh-huh.
Q Okay. Have you discussed this case with anyone other than your lawyer?
A No, ma'am.

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Q Did you review anything in preparation for your deposition today?
A Yes.
Q Can you tell me what that was?
A I reviewed the, primarily, the case dictation, the intake, and the staffing sheets for the case.
Q And did you bring any of those documents with you?
A Yes, ma'am. I did.
Q Do you mind if I look at them real quick?
A Sure.
MS. HARRILL: Deborah, do you mind looking over just to see if you see anything that we don't already have? That way we can keep going.
MS. CASEY: Sure.
MS. HARRILL: Okay.
MR. FRAWLEY: Excuse me, Lara. Could I look at that first to make sure that there's no e-mails or anything from me?
MS. HARRILL: Certainly.
MR. FRAWLEY: Don't know that there are. But we'll -- I'll look through this quickly and give it back to Deborah. You can go ahead while I'm --
MS. HARRILL: Go ahead. Okay.

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THE DEPONENT: There's not.
MR. FRAWLEY: Okay. Well, that's good enough for me.
THE DEPONENT: There's nothing in there besides the case dictation and the staffing sheets.
Q Okay. So you had -- at any time you had four caseworkers with 15 to 20 cases per worker?
A That's correct. Yes, ma'am.
Q And you said your -- your job, sort of, was to staff the cases with the caseworkers and to guide them?
A As to what they should do in each individual case.
Q And how do you follow up to see what they are doing?
A We had staffings four and five times throughout the duration of the case.
Q And how long would your duration -- would the duration of a case typically be in York?
A Forty-five days.
Q Forty-five days?
A Yes, ma'am.
Q So is it fair to say you have 45 days to make the case decision?
A You can have longer if you need it, but typically

Page 12

it's 45 days.
Q Okay. Do you recall Owen [redacted] or his family?
A Yes, ma'am. I do.
Q What do you recall about him, specifically?
A That it was a case that we had in 2009, that came in with a child who had subdural hematomas.
Q Did you ever meet Owen?
A No. I did not.
Q Did you meet anybody in his family?
A No. I did not.
Q Do you know if you had any contact with them?
A Yes. I did. Telephone.
Q Do you remember who you talked to?
A I spoke with Charlotte Williams on the telephone, and I think that's the only party that I spoke with directly myself.
Q So you don't think you ever spoke to Kayla?
A No, ma'am. I don't recall.
Q Okay. If you had, would that be documented somewhere?
A Yes. It would.
Q In the dictation?
A Yes.
Q Okay. Who -- when you were a supervisor, who was your supervisor?

Page 13

A Phyllis Moore Ward.
Q And what is her title?
A Program coordinator.
Q Program coordinator of?
A York County Department of Social Services.
Q So for the county?
A For treatment. Yeah, for -- for treatment and for assessment.
Q Is there a difference in your offices between treatment, assessment, and intake?
A No. Treatment, assessment, and intake were all caballed into one.
Q Okay.
A Foster care was the only thing that was separate.
Q So when a case comes in, is it fair to say -- not if it comes in in the middle of the night -- but if a case comes in, does it come in to your workers?
A In comes into intake and then a decision is made whether or not to accept it for an investigation or to not accept it. And, if it's accepted, then it's assigned to a worker.
Q Okay. So it's fair to say that your workers aren't manning the phones?
A Correct.
Q And that those -- the people that are manning the

Page 14

phones are considered intake?
A Intake workers, yes, ma'am.
Q So they make a decision about whether or not the allegations are credible?
A They don't make the decision. The supervisor makes the decision after they review the report.
Q Awesome. Okay. And then, once they've made that decision, it comes to your unit; is that fair?
A It's dispersed throughout the workers. So, yes, it would either have come to me or one of the other two supervisors.
Q Okay. So are there three intake -- or assessment supervisors?
A Supervisors. That's correct, yes.
Q How --
A When I was there.
Q Sorry. How are the cases then -- how are the cases divided out?
A They are dispersed. There's a list of workers. It's primarily by supervisor. So that a supervisor wouldn't be getting two cases back to back, it would rotate through the supervisors; so that's, typically, how we try to do it.
Q Let me just make sure I understand. There's three supervisors.

Page 15

A Yes.
Q In this treatment and assessment.
A Assessment only. Treatment's separate.
Q Okay. That's where I was getting confused. So three assessment supervisors.
A Correct. And then there's treatment supervisors.
Q And then is it fair to say that each one of the assessment supervisors has about four caseworkers?
A Yes. That's correct.
Q Okay.
A Uh-huh.
Q All right. And, when the cases come in, it just goes by list as to who?
A There's a list of individuals, yes.
Q Okay. As to who gets what?
A Yes. So no one would get one back to back.
Q No one supervisor or no one case manager?
A No one case manager and no one supervisor is how we tried to do it.
Q Either one.
A Yes.
Q So, when the Gwen [redacted] case came in, it was just y'alls turn to take it?
A That's correct.
Q Okay. Got it. Now, we -- I got a little off

Page 16

track. Phyllis Moore Ward?
A Uh-huh.
Q She's the supervisor for York County DSS treatment and assessment?
A She's the program coordinator for intake, assessment and treatment for York County DSS.
Q Okay.
A There's a separate program coordinator for foster care and APS.
Q So foster care is entirely separate?
A Yes. Correct.
Q So we don't need to talk about foster care.
All right. Who is Phyllis Moore Ward's supervisor?
A Yvonne Stewart, the county director.
Q Okay. Phyllis Moore Ward still work there?
A Yes. To my knowledge, yes.
Q Who are the other two supervisors for treatment and assessment below -- you know, equal to you?
A Assessment. It would assessment only. It's Lola Sutherland and --
Q I'm sorry.
A It's okay. -- Lola Sutherland and Diane Stevenson.
Q Okay. And I understand that you-all have caseworkers that are on call. How do you decide

Page 17

who's on call?
A Everyone is on call, whether you be a foster care worker, an assessment worker, or a treatment worker. It's placed on a calendar, and I think they did alphabetically, but -- so that most workers would only be on call maybe one time in a month.
Q Okay. So out of all three of the groups --
A Yes.
Q -- any one person would be on call?
A Foster care, treatment, or assessment, and the supervisor on call could be in -- anyone from assessment, treatment, or foster care as well.
Q So much like how you-all got your cases, when this -- when Owen [redacted] case came in, that was just Chandra Taylor's . . .
A It was just her turn. She was a foster care worker. Uh-huh.
Q Okay. How do you-all -- and, of course, this is all for that time frame: December 2009/January 2010.
A Right.
Q How would you communicate between workers? Would you talk to each other? Would you e-mail each other?

Page 18

A Talk and staff.
Q And staff.
A Yeah.
Q So the staffing sheets too?
A Yes. Sometimes over the phone if they were out in the field, but, primarily, it would be face to face contact with them.
Q Okay. We talked a little bit -- a little bit about your responsibilities related to your caseworkers. What are the responsibilities of your caseworkers?
A Their responsibility is to go out and make contact on their individual cases and to staff it with a supervisor.
Q And you said how often do you staff these cases?
A Typically, we would staff it four and five times throughout the duration of the case.
Q Are you always staffing with the same people?
A Yes. Unless we're making case decision and then we staff in a group. So I, as supervisor, would not make a case decision on my own.
Q Okay. So, if you're doing case staffings, those could be between just you and the caseworker, correct?
A That's correct.
Q And then there are times when you would have a

Page 19

staffing with the county attorney, as well?
A Yes.
Q And who else would be involved in a staffing for a case decision?
A Typically, it would be me, Lola, and Diane. All three of us would be there. If it were something -- well, sometimes Phyllis Ward would sit in, but that would not be every single case. The high-risk cases she would sit in for case decision.
Q Okay. And did you have your DSS attorneys for the case decision? Would they be on staffings?
A Not all of them, but yes, some.
Q Okay. Do you or does -- did anyone one in your office ever have to conduct audits of charts or -- I guess files is the better phrase?
A Well, I would in terms of reviewing a file before it was transferred to the next department.
Q Okay.
A And then Phyllis would sometimes do audits as well.
Q And how often would Phyllis audit files?
A It just -- it would just depend.
Q Did you know --
A She stayed pretty involved. I mean, it wasn't always -- typically, it was in those high-risk cases that she would review the case files.

Page 20

Q And, if she reviewed case files, did she give you any report on what needed to be fixed and files or --
A Absolutely. Yes, ma'am.
Q Was it a written report?
A Typically, there was a staffing, and it would've been a staffing sheet. Sometimes there would have just been conversations that she and I had.
Q Okay. Do you recall -- during this time frame or really during your employment there, do you recall the state office ever coming in and doing any audits?
A Yeah. We had an audit before. They had a group of individuals that would come in and audit case files.
Q About how often?
A The time that I was there, was only one time, that I can recall.
Q Okay. Do you have any idea when that was?
A No, ma'am. I do not.
Q And did you get any written feedback regarding their audit?
A Not specifically that I remember.
Q Okay. Is it fair to say that the case files -- your client case files -- that, like, the dictation

Page 21

and stuff, is that all on the computer?
A. Yes. It is in the computer.
Q. And are there ever any case notes that are not in the computer?
A. Well, I guess when the caseworker's out there, and they're taking notes on a notepad, when they're interviewing individuals. Then they're placed into dictation.
Q. And I'm assuming they don't keep those handwritten notes?
A. No. Unh-unh.
Q. And how often do you -- or if there -- is there a rule as to how often the dictation needs to be updated?
A. No. Not typically. The initial contact would have to be in as soon as possible.
Q. And how do you define "as soon as possible"?
A. Typically, by the five-day staffing.
Q. And is there any information that goes into the computer file that doesn't end up in the paper file?
A. Typically, no. I mean, besides health records and stuff. Those would be in the file and not necessarily summarized and documented into CAPPS dictation.

Page 22

Q. Okay. So like medical records?
A. Yeah. Medical records, law enforcement reports. If there were anything that was of concern, it would be in there, but not completely documented, no.
Q. But that would be in the paper file? So if I --
A. You would have -- yeah. It would be available --
Q. Right.
A. -- to you.
Q. You would have access to it if you needed it?
A. Correct.
Q. Okay. Is it fair to say that DSS, and specifically Child Protective Services, is mandated to protect children from abuse and neglect?
A. Correct.
Q. And, if you have an open case, who is the primary client?
A. The child.
Q. Okay. And is it fair to say that the position of DSS is that all children have the right to live in an environment free of -- free from abuse and neglect?
A. Yes.
Q. And is it fair, also, to say that the safety of children is the primary concern that guides child protection efforts?

Page 23

A. Yes.
Q. Do you routinely involve law enforcement in your cases?
A. It -- typically, we do not. It just depends on if it's an allegation of physical abuse or sexual abuse, typically.
Q. So, if it's a neglect case, you wouldn't call -- call law enforcement?
A. It would depend on the situation. Everything's dealt with on a case-by-case basis.
Q. Okay. What sort of -- well, strike that.
So if you have a -- an allegation of physical abuse, would you typically involve law enforcement?
A. Yes.
Q. Would you always involve law enforcement?
A. No.
Q. When would you not?
A. If it were -- let's say it were an instance of a child being spanked on the bottom. Usually, when it's just -- they're using punishment -- using corporal punishment. That's not always involved. Unless they use -- leave marks and bruises. Then it would be of concern.
Q. Do you know, related to Owen [redacted] if there was

Page 24

a recommendation to contact law enforcement?
A. Yes.
Q. And do you know if that was done?
A. It was done. Yes.
Q. Do you know when it was done?
A. I believe it was December the 16th.
Q. And is it DSS's responsibility -- in a case like Owen [redacted] is it a -- is it DSS's responsibility to contact law enforcement, or does the hospital have that responsibility as well?
A. I'm not sure if it's their responsibility, but it's absolutely our responsibility.
Q. When you have a case where the hospital is involved, how do you-all communicate with the hospital? Who do you typically talk to?
A. The social worker.
Q. And do you e-mail with that person? Do you call that person on the phone? How does that work?
A. Talk to them on the phone.
Q. Do you ever interview doctors?
A. Typically, no. Usually, that's nurses that we would interview. If the doctors are available, we would most certainly interview them.
Q. Do you get their -- do you get medical records of your clients?

Page 61

A Uh-huh.
Q Yes. -- to your deposition. On the second page of those notes, it says, "Nurse thought DSS was called to release sitter."
A Yeah. That's in --
Q Would you tell me what that's about?
A I'm sorry. That's in Chandra Tyler's dictation.
Q Okay.
A A nurse told her that they were not supposed -- she was under the assumption that there weren't any concerns of abuse or neglect and that they were primarily contacting DSS in order to release the sitter that was in the room. And I guess that's something that North Carolina does; that's not something that South Carolina DSS does.
Q That was my next question.
A Yeah.
Q Your DSS wouldn't typically go and --
A We wouldn't have --
Q -- be a sitter?
A -- done that anyhow, no.
Q Okay. But that was Chandra Tyler?
A Yes. That would've been in her dictation.
Q And these notes are just notes that you took as --
A Yeah. As I read through the dictation, and things

Page 62

that I remembered, yes.
Q Okay. I want to look at them. Turn to page -- Tab 17, for me, please. And this conversation is actually -- appears to be January the 12th, also transcribed conversation between you and Lieutenant Miller --
A Correct.
Q -- is that fair?
A Uh-huh.
Q If you look at -- this one is a little harder to read because you-all were doing what I do and you were talking over each other. But -- so feel free to read this as I'm on Page 3. I'm looking specifically at Line 17, where you said, "They -- they wouldn't make a -- they wouldn't make a statement whether or not it was accidental or non-accidental." If you want to read that whole page to put that in context, I'm fine with that.
A I'm familiar with it.
Q Okay.
A Uh-huh.
Q Who -- and I may have asked you this before, who decides whether or not you indicate your cases at DSS?
A We do it as a group. This particular case would've

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been an attorney staffing case decision.
Q Why this particular case?
A Because we -- based off of the second incident.
Q Okay. But, with the first incident, would it have been an attorney decision?
A Probably -- maybe not. Phyllis could've been present for that. It would've depended on who was available: either Phyllis or Adrian or the other attorney that we had.
Q As a supervisor at DSS, how much difference does it make to you whether the hospital decides it was accidental or non-accidental in indicating your case?
A Can you rephrase that for me, please?
Q Rephrase it or repeat it?
A Repeat it. That'll be fine. Let's see if I can. . .
Q As a -- as a social worker --
A Uh-huh.
Q -- as a supervisor --
A Right.
Q -- how much difference does it make to you what the hospital's decision is in whether or not you indicate your case?
A Oh. We would -- if they had concerns that it was

Page 64

non-accidental, we would've indicated our case.
Q And if they have -- if they don't have concerns that it's non-accidental, does that mean you would not indicate your case?
A Not necessarily. If there had been something else that was of concern, we may have still indicated our case.
Q Do you -- excuse me. Do you know whether or not there was anything else that was of concern?
A Well, there were concerns that the parents were young and that they were immature and, maybe, concerns of lack -- lack of supervision.
Q What all can you indicate your cases for?
A Neglect, physical abuse, and sexual abuse.
Q What about threat of harm?
A You can do that, too. Threat of harm of each.
Q Okay. But, in this particular case, the second incident happened before your original case was determined, correct?
A Yes.
Q Turn to Page 4 for me, please, on your -- in Tab 17, Line 24. And if you'll read over to the next page --
A Uh-huh.
Q -- to Line 3. And you say, "We've got some

Page 65

problems with that worker." What does that mean?
A In regards to making the law enforcement referral timely. That's, specifically, what I was referring to.
Q So is it fair to say that that was something --
A I had concerns of; I must've had previous concerns on, maybe, another case.
Q Okay. And, again, you don't recall whether or not there was a written warning or a reprimand?
A No. I don't recall.
Q Do you recall when you say, "We've got some problems with that worker," if it's related to anything else besides referring to law enforcement?
A That would be the only concern that I had at that time.
Q Did you ever have any concerns about her seeing her clients in a timely manner?
A No. Not that I recall.
Q Turn to the next page for me, please, which is -- is, in fact, Page 6. Okay. If you look at Lines 12 through 16 for me, please.
"That wasn't the first" -- this is Lieutenant Miller, "That wasn't the first -- you know, that hasn't been the first problem there, too."
And then you say, "I know. And I've already

Page 66

addressed that with her, so I just wanted to make sure."
And then, "All right. Well, keep -- "
A Yeah.
Q I'm -- I'm wondering if we're still talking about this law enforcement referral, or if there's some other issue that you-all are discussing.
A As far as I know, only the law enforcement referral.
Q And I think I just asked you this, but I'm going to ask you again. Is this the only time that you recall that she had not referred to law enforcement?
A That I recall. That's the -- this is the only time that I can recall. Yes. That's correct.
Q Would you turn to Page 8 for me, please. If you'll read what you said from Line 7 to 12.
A "And we appreciate it that you help us so much. And it's typical if we could get everybody here on board with making those referrals and calling you and letting you know when we get -- when we got an issue. I think we're just -- the issue here is I'm telling her and she's not doing it."
Q And is that just related to this case or any other cases?

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A No. That was related, in general, to the workers just faxing over information and not necessarily calling before faxing.
Q So that's sort of what we talked about earlier, where you said y'all would contact law enforcement with a physical referral --
A Right.
Q -- the fax cover sheet.
A Uh-huh.
Q And then call them and talk to them about it, as well --
A Yes.
Q -- is that fair?
A That is correct. That's what we -- that's what should be done.
Q And is there a time -- is there a deadline by which they're supposed to do that?
A To do which? To make the law enforcement referral?
Q Yes.
A Typically, it's within 24 hours.
Q Typically or is that the rule?
A At that the time that was the rule; that's policy, yes.
Q Okay.
MS. HARRILL: All right. We're going to take

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about a five-minute break again.
(Off the record from 11:45 am to 11:58 a.m.)
THE EXAMINATION BY MS. HARRILL CONTINUES.
Q Okay. During the time that -- between the first injury and the second injury, when Dirvondra was investigating what had happened related to the first injury --
A Uh-huh.
Q -- would you have been the person who had the most contact with Dirvondra, related to the case?
A Yes.
Q And when y'all staff cases -- I recognize that you put recommendations on a staffing sheet, but do you also talk about what her impressions are related to the family?
A Yes.
Q And do you recall any of those conversations with her about what she thought about the family?
A Not to my knowledge, other than what I've read in her dictation --
Q Okay.
A -- from her contact.
Q And did you-all, at that time, first injury, consider this a serious case?

Page 105

A No.
Q And if not, then why do you continue to investigate?
A Because we didn't have all the information. We needed to have all the -- we had the statements, but we didn't have all the medical records to make a case decision.
Q Do you have any idea when you got the medical records?
A I don't recall that.
Q Do you --
A We had to do a formal request for them. I'm sorry.
Q That's okay. Do you know how I would know -- who could I ask to tell me when you-all received the medical records?
A It may be on the records that are in the file. Maybe if they were faxed copies or if there was an envelope that we received them in.
Q Well, let me ask you this: If you don't have all the information you need to make a case determination, how can you determine, as you sit here today, that the child was not at risk?
A Because based off the information that we had at the time, the verbal information that the hospital was giving us, they were negative surveys, and they

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-- they couldn't determine whether it was accidental or non-accidental.
Q Okay.

MS. HARRILL: No further questions.
MR. TODD: Just -- just a follow-up.

REEXAMINATION

BY MR. TODD:

Q I want to -- if you would turn to -- it's Tab 9.
A Yes.
Q And on -- on -- and it looks like it's Defendants' -- the bottom Bates stamp's 1353.
A Uh-huh.

MR. FRAWLEY: I think Tab 9 was the one that was --
MS. HARRILL: Yeah. But only for me.
MR. FRAWLEY: Okay. Okay. You're good. You're good.

Q Does -- does your Tab 9 say 1353 at the --
A Yes. It does.
Q -- bottom?
A Yes, sir.
Q Whose handwriting is that?
A That's my handwriting.
Q Okay. And what would -- when -- what's the date that you would've created that document? Would it

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be 12/7/09?
A Yes. Correct.
Q And -- and -- and "Baby in hospital. Two subdural hematomas. Unknown how baby received." Do you know where that information would've come from?
A That would've been the allegations on the report.
Q But it was -- it was reported to you that there were two subdural hematomas and nobody could say how they occurred?
A Yes.
Q And that either came from the hospital or the parents or both?
A Yes. Correct.
Q And it says, "Hospital cannot determine if accidental or non-accidental."
A Correct.
Q But were you aware at that time the -- the hospital had a sitter in the room?
A Yes.
Q And do you know why they had a sitter?
A I do not know.
Q If you turn on -- it's the same tab, 1355, is that your handwriting as well?
A Yes, sir. It is.
Q And that's -- this document, again, created

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12/7/09?
A Yes. This document was prior to the previous document.
Q Okay. It says, "Owen has two subdural hematomas. One would indicate non-accidental trauma."
A Yes.
Q Did that information come from the social worker?
A That was just the allegations of the report. I mean, that was the concern.
Q Did you ever talk to the social worker yourself?
A Yes. I did.
Q Okay. Do you know which one you talked to?
A Laura Newmark.
Q All right. Is this -- did you have notes regarding that conversation --
A Yeah. It's in --
Q -- or did you --
A -- the -- it would be in the dictation.
Q Uh-huh. It says, "Social worker has concerns because CT scan shows non-accidental trauma." Do you see at the bottom of the -- of 1355?
A Yes. And then it's cut off.
Q Okay. No doctor is saying it is non-accidental. Is that what -- is that -- is it --
A I --

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Q You can't say whether --
A I don't --
Q -- it's caused --
A -- and I can't -- yeah. I can't say that, as well as the other page that's --
Q Yeah.
A -- a lot of the information is cut off on it.
Q But -- but, you know, it's fair to say the hospital had concerns about it being accidental trauma?
A They stated that they had -- they couldn't determine whether it was accidental or non-accidental.
Q I -- I know, but because they had concerns that it was non-accidental, they reported it to DSS? You'd agree with that, wouldn't you?
A Yes.
Q And -- but it -- they couldn't make a definitive statement that it was either accidental or non-accidental?
A Correct.
Q Now, there's -- I'm -- I'm going now to Tab 6. And -- and it's like a case review.
A I -- yeah. It's just the same thing.
Q How is that -- how is that created? Is --
A I have -- this Tab 7 information --

Page 110

Q Well, actually it was Tab 6, but Tab 7 --
A Six and --
Q -- Tab 7's a case review, so my question --
A These --
Q -- would apply to either one of them.
A These two documents I am not familiar with. This is the first time I've seen either one of them.
Q All right. So you don't know who prepared them or when or --
A I mean, I know who prepared them based off of the initials on the bottom, but when they were prepared and -- I don't know.
Q Who prepared them, based on the initials on the bottom?
A Well, based on -- Tab 6, that would've been Phyllis Moore Ward, and -- let's see. Tab 7 it still shows her as well. And then --
MR. FRAWLEY: (To the deponent) Tab 8's the next one.
A -- Tab 8 would be for Yvonne Stewart. So 6 and 7, Phyllis, and then 8 would be Yvonne.
Q Okay.
MR. FRAWLEY: Monty, if you look at the lower right-hand corner, those are our Bates numbers, and the initials --

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THE DEPONENT: Yeah.
MR. FRAWLEY: -- indicate that's -- those are the files we got them from.
MR. TODD: I gotcha.
Q All right. So I see --
A Yeah.
Q -- DSS PMW would be --
A -- Phyllis Moore Ward. And YS, Yvonne Stewart.
Q Who was Phyllis Moore -- Warren?
A Ward.
Q Ward.
A The program coordinator at York County DSS.
MR. TODD: All right. Thank you.
THE DEPONENT: Okay.
MR. SETTANA: I've got some follow-up questions.

REEXAMINATION

BY MR. SETTANA:
Q Let me go back to this transcript of 1/19/2010. Okay.
A What tab is that?
Q I'm not sure if everything was in the tab or was in --
MR. FRAWLEY: I'll give her my copy.
THE DEPONENT: Okay.

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A All right.
Q Okay. And there is an Exhibit in Tab 18. I don't know if it's all there, but on Page 5 -- well, excuse me -- Page 9, okay, you read from the bottom of Page 9 onto Page 10 --
A Yes.
Q -- with your attorney and also with counsel for the plaintiff, okay.
A Uh-huh.
Q And then later you read some parts about the polygraph --
A Right.
Q -- okay. And you recall that you said that -- that -- that the polygraph -- that -- you made a reference that Lieutenant Miller made some inconsistent statements.
A Yes. He did.
Q Okay. Let me go back and actually go through that with you, and maybe --
A Okay.
Q -- clear that up --
A Okay. Sure.
Q -- see if they are inconsistent.
A Sure.
Q Starting in chronological order -- and -- and you

Exhibit 4

HRC690-R01 South Carolina Department of Social Services 1/21/2010 7:58 PM

Case Dictation

Case ID - 0001113743

Case ID: 0001113743

Actions:

Medical Contact

Recipients:

0001545398 - [redacted] Owen [redacted] B)

Action Date:	1/20/2010	**Action Time:**	2:15 PM	**Time Spent:**	0.25
Input Date:	1/20/2010	**Input Time:**	3:34 PM	**Worker:**	Moore-Ward, Phyllis

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:34:47 1/20/2010

Made a phone call to Dr. Rachel Rose after getting a message from Dr. Otwell (704) 381-6301 wanting to know DSS plans because he needed a decision by this afternoon. Dr. Rose informed me that the name was Dr. Otwell Timmons and he is her boss and the Attending Physician for Owen. Dr. Rose was asked if the hospital recommended or was in agreement to Kayla's decision to transfer Owen to the Hospice house. Dr. Rose stated that the hospital had contacted the Hospital Ethics Committee and they agreed this was the best medical decision. I informed Dr. Rose that I would call Dr Timmons and let him know that DSS was aware of the plans to transfer Owen to Hospice. Present: Yvonne Stewart, County Director; David Simpson, DSS Attorney, Adrienne Woods, DSS Attorney and Krista Hinnant, Assigned Assessment Supervisor.

Actions:

Medical Contact

Recipients:

0001545398 - [redacted] Owen - [redacted]

Action Date:	1/20/2010	**Action Time:**	11:00 AM	**Time Spent:**	0.25
Input Date:	1/20/2010	**Input Time:**	11:06 AM	**Worker:**	Moore-Ward, Phyllis

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 11:06:27 1/20/2010

Called the Wayne T Patrick House and talked with Kathy Patterson, Nurse regarding the plans for Owen. After telling Kathy about my conversation with Dr. Rogers at Levine Children's Hospital she stated they were not expecting Owen until tomorrow. After being asked Kathy stated she would contact me upon Owen's arrival. Kathy stated that this is their first time they have accepted an infant. I also explained that this matter is still under investigation and the DSS caseworker would need to make contact with Owen, family and the House staff and Kathy stated that would not be a problem.

Actions:

Medical Contact

Recipients:

0001545398 - Carduff, Owen - [redacted]E)

Action Date:	1/20/2010	**Action Time:**	10:35 AM	**Time Spent:**	0.25
Input Date:	1/20/2010	**Input Time:**	10:47 AM	**Worker:**	Moore-Ward, Phyllis

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 10:47:06 1/20/2010

Returned a phone call to Dr. Rachel Rose, (704) 381-6313 after we were informed yesterday in a telephone conversation that Kayla, Owen's mother had opted no further medical treatment for Owen including feeds and hydration, Owen will be discharged today. The Hospital had contacted Wayne T. Patrick House (Hospice) and they are willing to take Owen. Dr. Rose stated the discharge and transport paperwork could be completed by noon and arrival at Wayne T Patrick will depend on transportation schedules. Dr. Rose was informed that we will continue to monitor Owen at the Wayne T Patrick House.

Actions:

Medical Contact

Recipients:

0001545398 - Carduff, Owen [redacted])

Action Date:	1/20/2010	**Action Time:**	2:40 AM	**Time Spent:**	0.25
Input Date:	1/20/2010	**Input Time:**	3:25 PM	**Worker:**	Moore-Ward, Phyllis

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:25:29 1/20/2010

Returned a phone call from Dr. Otwell Timmons (704) 381-6301, Owen's Attending Physician at Levine

Children's Hospital. He had left a message with the assigned CW wanting to know DSS plans because he needed a decision by this afternoon regarding Owen's discharge. I informed Dr Timmons that I had talked to Dr Rachel Rose and had been informed that Kayla's decision to transfer Owen to a Hospice House had been presented by the hospital to their Hospital Ethic Committee and it was stated that ethically if was the best medical decision. I stated that DSS's position was to acknowledge that we are aware of that decision and our responsibility would be to continue our investigation and to monitor Owen. Dr. Timmons thanked me for the return phone call and stated that Owen would arrive at the Hospice House later today for tomorrow. Attorney Adrienne Woods was present for my conversation.

Actions:

Medical Contact

Recipients:

0001545398 - [redacted] Owen [redacted])

Action Date:	1/19/2010	**Action Time:**	4:28 PM	**Time Spent:**	0.25
Input Date:	1/19/2010	**Input Time:**	5:01 PM	**Worker:**	Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 5:01:51 1/19/2010

Supervisor spoke with Dr. Rachel Rose at Levine Childrens Hospital (contact # 704-381-6313) . Dr. Rose informed that the hospital staff has met with the family in reference to Owen and his current condition. Dr. Rose stated that the family has opted no further medical care for Owen including feeds and hydration. Dr. Rose stated that the hospital will stop providing care on 1/20/10. She stated that they have contacted Wayne T. Patrick Hospice House in York County (contact # 803-329-1500) and that they are willing to take Owen. Owen will be transported via ambulance. She stated that the hospital is looking to discharge Owen as early as tomorrow. Dr. Rose stated that Owen will probably only make it for 1 week to 10 days once medical care has stopped. Supervisor informed Dr. Rose that she would staff this information with the agency and get back with her first thing tomorrow.

Actions:

Medical Contact

Recipients:

0001545398 - Corduff, Owen - [redacted]E)

Action Date:	1/19/2010	**Action Time:**	11:15 AM	**Time Spent:**	0.25
Input Date:	1/19/2010	**Input Time:**	5:05 PM	**Worker:**	Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 5:05:26 1/19/2010

Supervisor spoke with Dr. Rachel Rose with Levine Children's Hospital. Dr. Rose informed Supervisor that the hospital staff is having a meeting with the Carduff family because the family is opting no further medical care for Owen. Dr. Rose stated that the hospital hopes to get hospice involved with the child. She stated that the child has little brain stem function and is basically only able to breathe on his own at this point. Dr. Rose stated that the hospital will discharge the baby if the family opts no further medical care.

Actions:

Collateral Contact

Recipients:

0001545389 - [redacted] Michael [redacted])
0001545390 - Lythgoe, Kayla - [redacted]E)
0001545398 - [redacted] Owen - [redacted]E)

Action Date: 1/19/2010 **Action Time:** 10:40 AM **Time Spent:** 0.50

Input Date: 1/19/2010 **Input Time:** 5:14 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 5:14:09 1/19/2010

Supervisor spoke with Lt. Miller with York County Sheriff's Department (contact # 628-3110). Lt. Miller stated that he received LE referral from DSS after hours on 12/16/09 around 7pm. He stated that he did not contact hospital to verify information provided by DSS and did not send an officer out to do any further investigation. Lt Miller stated that based on the information provided to DSS by hospital SW that he did not feel that there was any evidence to support any abuse. He stated that he did not feel that there was any need for any further law enforcement investigation. He stated that the hospital did not state that anyone had harmed the baby. He stated his impression was that the hospital wanted the parents to supervise and monitor the child closely upon discharge. Lt. Miller informed Supervisor that LE is still investigating Kayla, however, they have "stepped" back to allow Kayla to be with Owen at this time. Lt. Miller stated that Michael did not admit to shaking the baby in December. He stated that Michael was given a polygraph. Supervisor and Lt Miller sheduled a staffing between DSS and YCSD to take place at YCSD on 1/20/10 at 2pm.

Actions:

Staffing With Supervisor

Recipients:

0001545389 - [redacted] Michael - [redacted] (E)
0001545390 - Lythgoe, Kayla - [redacted]E)
0001545391 - Williams, Charlotte - [redacted] (E)
0001545398 - [redacted] Owen - [redacted] (E)

Action Date: 1/19/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/20/2010 **Input Time:** 5:44 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 5:44:19 1/20/2010

Current Situation: Owen in breathing on his own per Levine Children's Hospital. Owen was taken offf the ventilator on 1/18/10. Owen's condition is still critical. On-call spoke with Levine's. Per hospital Mom has been acting strangely. Recs: Add all contact attempts between 12/8 and 12/21 Add telephone attempts Letter to Kayla Add LE referral to CAPSS CMC - get x-rays and all records (any records that weren't already faxed) Add TC contacts to Charlotte to CAPSS Follow up with Parents

Actions:

Telephone Contact

Recipients:

0001545398 - [redacted] Owen [redacted] (E)

Action Date: 1/18/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/19/2010 **Input Time:** 8:57 AM **Worker:** Love, Kimberly

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 8:57:42 1/19/2010

Supervisor Love received phone call from Levin Childrens Hospital. Love spoke with Laura the social worker at the hospital. Laura states that the mother has decided that she does not want Owen to be on the ventilator any longer. They are planning to unhook him about 3:30 this afternoon. She states that Owen will probably breath on his own due to he has some brain activity still. States that they will not do anything if he starts to die due to the mother does not want medical help for him if he starts to pass away. She states if he does live through this he will have major problems and will never be mentally over the age of an infant. She states that she will let Love know how he is doing this afternoon.

Actions:

Telephone Contact

Recipients:

0001545398 - [redacted] Owen [redacted] (E)

Action Date: 1/18/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/19/2010 **Input Time:** 9:05 AM **Worker:** Love, Kimberly

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:

Support Service ID:

Dictation:

AM 9:05:48 1/19/2010

Love contacted the Levin Hospital and spoke with Laura about 4:30 pm. Laura states that Owen is breathing on his own and that there has been no change since they unhooked him around 3:30 pm today. Laura states that when they unhooked him that he started gasping which is normal and the grandparents started crying and the mother just sat there with not emotions and stared at Owen. Laura states that the mother is acting "fishy" and does not show any emotion. Laura states that the grandparents are feeling guilty because they have stated that they noticed bumps on Owens head and did not do anything about it. Laura states that if Owen continues to breath then they will have to make decisions as to if he is going to need feeding tubes and other medical devices to help him continue to live. Laura states that if the mother does not want him to have the devices then Hospice will need to get involved to make him comfortable until he passes away.Laura will keep DSS up to date on Owen's condition.

Actions:

Medical Contact

Recipients:

0001545398 - [redacted], Owen - [redacted])

Action Date:	1/14/2010	**Action Time:**	10:00 AM	**Time Spent:**	0.25
Input Date:	1/14/2010	**Input Time:**	10:21 AM	**Worker:**	Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 10:21:55 1/14/2010

Supervisor spoke with Lora McDowell to get an update on Owen's conditions. She stated that the hospital had to put a 2nd drain in Owen's back because the 1st drain was not successful. Lora stated that the hospital hopes that the 2nd drain will hopefully relieve some of the pressure. Lora stated that Owen's condition got worse yesterday. Lora stated that Owen is doing the same today as yesterday and he is still continuing to have seizures.

Actions:

Collateral Contact
Telephone Contact

Recipients:

0001545398 - [redacted], Owen - [redacted])

Action Date:	1/13/2010	**Action Time:**	12:45 PM	**Time Spent:**	0.50
Input Date:	1/13/2010	**Input Time:**	1:00 PM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:

Support Service ID:

Dictation:

PM 1:00:24 1/13/2010

Telephone Contact/Collateral Contact-Laura Neomark (704)355-3189 Received a call from Laura Neomark from Levine's Children's Hospital she stated they been monitoring the EET(it measures the brain waves) in which they are very concerned now because it is low-they are continuing to drain from the child's brain in which it is very bloody. Child is not doing well still in critical condition. The Grandfather has contacted the media and wish for the media to be at the hospital so he can talk to them about his grandson.

Actions:

Collateral Contact

Telephone Contact

Recipients:

0001545398 - [redacted] Owen - [redacted]

Action Date:	1/13/2010	**Action Time:**	9:10 AM	**Time Spent:**	0.50
Input Date:	1/13/2010	**Input Time:**	12:55 PM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:55:23 1/13/2010

Telephone Contact/Collateral Contact Received call from Laura McDow-she stated there was a sitter for the hospital for 12 hrs a day and then the family have to go home-nobody is allowed to stay at the hospital in the waiting area then. She has not checked on the child this morning but the last time she checked on the child he was having mild seizures and they were giving the child medication to fix that-he's not going home for a couple days-once stable they would have to access needed for maintenance. She stated she would have to check on the child again and call case manager back with the additional information.

Actions:

Medical Contact

Recipients:

0001545398 - [redacted] Owen [redacted]

Action Date:	1/12/2010	**Action Time:**	12:20 PM	**Time Spent:**	0.25
Input Date:	1/12/2010	**Input Time:**	3:28 PM	**Worker:**	Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:28:30 1/12/2010

Supervisor contacted Laura McDowell SW at Levine Children's Hospital (704) 446-5345. Laura stated that Owen has a lot of swelling and that they are doing surgery to put a stint in. She stated that they are trying to monitor the pressure on Owen's brain. Laura stated that the NAT Series test came back and that it was negative, meaning tha tthe child has no fractures. She stated that when completing the retinal exam they discovereed hemorrhages behind both of Owen's eyes. She stated that the doctor believes that Owen has been shaken more than one time and possibly by more than one person. Supervisor asked Laura which doctor is working with Owen. She stated that Dr. Bailey is working with Owen today. Laura stateed that she will fax Supervisor hospital records. Laura also stated that the cihld may have had a stroke from the previous injury, however, the hospital does not know what caused the stroke or exactly when it occurred. Laura stated that she would follow up and get back with Supervisor in regards to the stroke. Laura stated that she would keep DSS informed of any changes/new information.

Actions:

Medical Contact

Recipients:

0001545398 - [redacted] Owen - [redacted])

Action Date: 1/12/2010 **Action Time:** 11:54 AM **Time Spent:** 0.25

Input Date: 1/12/2010 **Input Time:** 3:01 PM **Worker:** Hinnant, Krista

Service ID: 0001388329

Program Service Type: Child Protective Services Assessment

Authorization:

Support Service ID:

Dictation:

PM 3:01:31 1/12/2010

Supervisor contacted Lynn Myers, Child Maltreatment Coordinator at Levine Children's Hospital (704-355-4088 pager # 7814). Lynn expressed concerns that Charlotte Williams (matemal grandmother) may have known about Owen and him being shaken. Lynn stated that the Grandmother has told hospital staff that she has seen bruises on the child. Supervisor asked Lynn about the Grandmother having contact with the child while the child is at the hospital. Lynn stated that everyone who visits Owen is having supervised contact. Lynn stated that nursing staff is supervising the contact and that they have had to ask visitors to leave when nurses are unavailable to supervise. Lynn stated that Owen's conditions is deteriorating. She stated that it is possible that he will not make it. Lynn stated that Owen was seizing this morning and that the child is going to have surgery to put a stint in to drain the blood/fluid off of his brain. Lynn stated that the mother is currently at the hospital. Supervisor provided Lynn with contact information to update Supervisor with any new information.

Actions:

Collateral Contact

Telephone Contact

Recipients:

0001545398 - Carduff, Owen [redacted])

Action Date: 1/12/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 10:03 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 10:03:07 1/12/2010

Collateral Contact Called Levine's Hospital to speak with Laura McDowell regarding any updates-case manager was informed that Laura was not at the desk and she would give Laura the message to call case manager back when she get off the phone-case manager inquired about the condition of the child-case manager was informed they were doing a plug on the child-case manager inquired what a plug was-she stated a plug is when they take fluid out to release the pressure in the brain.

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen - [redacted]

Action Date: 1/12/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 3:04 PM **Worker:** Himnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:04:48 1/12/2010

Supervisor returned telephone call to Charlotte Williams, Maternal Grandmother (# 803-280-3048). Charlotte expressed concerns of not being able to see Owen at the hospital. Supervisor informed Charlotte that the hospital is supervising all contact with all visitor who come to see Owen. Charlotte appeared to be upset. Supervisor explained to Charlotte that the hospital does not always have nurses who are available to supervise. Charlotte stated that she understands. Supervisor provided Charlotte with contact information in case she has any additional concerns.

PM 3:05:34 1/12/2010

Action Code should be Telephone Contact not Collateral Contact

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Actions:

Collateral Contact

Recipients:

0001545389 - Carduff, Michael [redacted]E)
0001545390 - Lythgoe, Kayla [redacted]E)
0001545398 - [redacted] Owen [redacted]E)

Action Date: 1/12/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 3:32 PM **Worker:** Himnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:32:10 1/12/2010

Supervisor spoke with Lt Miller with York County Sheriff's Department. Lt. Miller stated that Michael is incarcerated and charged with unlawful neglect of a child. Lt. Miller stated that Michael admitted to shaking Owen. He stated that he shook Owen because Owen "would not cooperate." Lt. Miller stated that he has lots of concerns for the mother. He stated that Kayla showed no emotions over the whole situation. He stated that he does not recommend that the child be discharged to Mom. Lt. Miller stated that he would be reinterviewing Michael in regards to Kayla to determine if Kayla knew that the baby was being shaken or if she has ever shaken the baby herself. Lt.Miller stated that he would follow up with Supervisor if anything new arises.

Actions:

Staffing With Supervisor

Recipients:

0001545389 - [redacted] Michael [redacted] (E)
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte [redacted] (E)
0001545398 - [redacted] Owen - [redacted]

Action Date: 1/12/2010 **Action Time:** **Time Spent:** 0.75

Input Date: 1/12/2010 **Input Time:** 3:34 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:34:12 1/12/2010

Supervisor and CM Hill staffed case with legal, county director and program coordinator. See DSS Form 3062 in file.

IRC690-R01 South Carolina Department of Social Services 1/21/2010 7:58 PM

Case Dictation

Case ID - 0001113743

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen [redacted])

Action Date:	1/11/2010	**Action Time:**	7:20 PM	**Time Spent:**	1.00
Input Date:	1/12/2010	**Input Time:**	7:28 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:28:06 1/12/2010

Collateral Contact-Wesley Clement-optimist Arrived at the hospital after 7pm to examine the child's eyes. He reported there was hemorrhaging and bleeding in the back of the eye.

AM 7:29:13 1/12/2010

Correction-Wesley Clement-Opthlalmologist

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen [redacted])

Action Date:	1/11/2010	**Action Time:**	6:15 PM	**Time Spent:**	0.75
Input Date:	1/12/2010	**Input Time:**	7:23 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:23:51 1/12/2010

Collateral Contact-Otwell Timmons(Doctor) Child had CT Scan on December 5th and December 7th. Doctor showed case manager all three CT scans for Owen. He pointed out on December 7th the brain tissue looked healthy-however on today there was more fluid, acute blood-brain cells have died(infraction)-there were no broken bones, there were multiple bruising in which babies don't get bruised there. Doctor was

Dwight Bailey during the day-his phone number is (704)381-6100 page him if cant get in contact. Owen was taken to Piedmont Medical Center earlier this morning in which the baby was actively seizing and was airlift to Levine's. Don't know how long and when the incident occurred however the incident did happen within 24 hours-will not be able to detect until 72 hours. Doctor Timmons reported there was brain tissue dead and caused a stroke. Doctor informed case manager there was a history of head bleeds.

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen - [redacted]

Action Date:	1/11/2010	**Action Time:**	6:00 PM	**Time Spent:**	0.50
Input Date:	1/12/2010	**Input Time:**	7:22 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:22:30 1/12/2010

Collateral Contact-Heather Maykowski(Nurse) CT Scan was performed at PMC and Levine's. Almost five areas (new ones) have formed-they are not the same hematomas as the last time the child was at Levine's about a month ago. Child was admitted today around 1pm or 1:30pm. Father went with Detective back to York County with Amanda Carter to get a polygraph test. There was no explanations from either parent-baby could have been dropped. An opthlalmologist will be here at 7pm to look at the baby's eyes to determine if there is bleeding behind the eye-he will be able to detect. The bone examinations were in-the test was negative as the test was negative in December 2009 when the child was there the second time. Nurse informed the CT scan are different from last time the child was there.

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen - [redacted])

Action Date:	1/11/2010	**Action Time:**	5:45 PM	**Time Spent:**	0.50
Input Date:	1/12/2010	**Input Time:**	7:16 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:16:42 1/12/2010

Collateral Contact-Elizabeth Super(Nurse) Nurse stated the family came in today and she observed multiple bruises to the body-left leg, left hand, chest, face-she stated the statements about the baby scratching

himself-she was not buying it. Case manager inquired about the parents' statements-she stated the parents could not explain the injury-they stated they did not know how the child received the hematomas. She stated the mother said the child was normal on yesterday (Sunday). Mother checked on the child Monday morning around 5-6am and again at 10am and noticed the baby was having a seizure-child was making noises and having uncontrollable seizures-she took the child to Piedmont Medical Center in Rock Hill, SC.

Actions:

Face to Face with child/client

Recipients:

0001545391 - Williams, Charlotte [redacted](E)
0001545398 - [redacted] Owen - [redacted]E)

Action Date:	1/11/2010	**Action Time:**	5:15 PM	**Time Spent:**	2.00
Input Date:	1/12/2010	**Input Time:**	7:15 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:15:23 1/12/2010

Face to Face with child/Client FYI: Owen has acute bleed in the head actively seizing more than one bleed; multiple bruises chest, arm, cheek, and legs, actively seizing not a good sign, 2nd injury much more serious this time. Incubated ICU on a ventilator, critical condition, actively seizing. Child may not make it. Child was shaking uncontrollable and was taken to PMC before Levine's Children's Hospital(Charlotte, NC). York County Detective Amanda Carter at the hospital was at the hospital earlier however was already gone when case manager arrived. Arrived at Levine's Children's Hospital on January 11, 2010 at 5:15pm to speak with parents, doctor, social worker, and access Owen [redacted] Owen is on the Pediatric Intensive Care Unit 6th floor room 13. Outside the room was a nurse and doctor-informed case manager they were still getting information regarding the child. Case manager observed Owen [redacted] in the Pediatric Intensive Care Unit hooked up to a ventilator in critical condition with wires stuck to his head. There were multiple marks/bruises on the child's body-a red scratch on the child's leg, mark on his face, a scratch on his hand, a bruise on the chest. While case manager was at the hospital Owen did not have any active seizing. Case manager spoke with doctor and nurses regarding the child. Case manager was informed they did a CT scan however would not be able to tell until 72 hours to determine the swelling of the child's brain. At the time there was nobody in the hospital room with the child except a nurse. Kayla had left to get clothing, Michael left with York County Detective to get a polygraph, and the Grandparents went to get something to eat and will be back. Approximately thirty minutes later the Grandparents arrived back at the side of the bed of Owen-Case manager spoke to both of the Grandparents regarding the allegations. Case manager asked about Kayla's whereabouts-Mrs. Williams(Grandmother) stated they been left the hospital and Michael was suppose to have been at Moss Justice Center at 5:30pm-She called Kayla-Kayla stated they have not gotten to the Moss Justice Center because they got lost at the time it was around 7pm. Kayla spoke about making sure Michael's parents knew where they were going and they were on their way to the Moss Justice Center. Mrs. Williams did not know why Kayla was going to the Moss Justice Center and everybody at the hospital thought Michael was being transported by the detective. Kayla informed her mother she would be back at the hospital later-she did not mention a time she would be back. She knew Case manager needed to speak with her in regards to the incident that occurred with the child.

Actions:

Medical Contact

Recipients:

0001545389 - [redacted] Michael [redacted] E)

Action Date:	1/11/2010	**Action Time:**	2:00 PM	**Time Spent:**	0.50
Input Date:	1/11/2010	**Input Time:**	4:05 PM	**Worker:**	Sutherland, Lola

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 4:05:15 1/11/2010

ycso lt miller and lora newwark from levines, owen is in the hospital, sezing, has an acute bleed in head, more that one bleed, mutliple brusies chest, arm cheek, leg, detective carter at hospital, owen is actively seizing not a good sign, he is incubated icu on a ventilator, critical condition, parents and grandparents there, parents report no knowledge of injuries and bruises, much more serious this time the injuries, supervisor sutherland informed lora dss will not allow parents to take child, supervisor sutherland asked lora for clarification actively sezing not a good sign does this mean the child could die she stated yes, ycso contacted supervisor of case, supervisor checked capps and stated case is open, cw will be notified cw hill informed of phone call, cw hemphill sp parents cannot remove the child from the hospital, child to go to relative, call from lt miller 404pm, super stated injuries to lt miller per lora's call, child may die, child not to go to parents if child recovers,

Actions:

Collateral Contact

Recipients:

0001545391 - Williams, Charlotte [redacted] R)

Action Date:	1/11/2010	**Action Time:**		**Time Spent:**	0.75
Input Date:	1/12/2010	**Input Time:**	7:25 AM	**Worker:**	Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:25:13 1/12/2010

Collateral Contact- Charlotte Williams-Mat. Grandmother Mrs. Williams reported in November she observed the child to have a bruise on his head-she stated she took a picture of the bruise-Michael and Brian had the child and could not tell her how the child got the bruise on the child's head. The week prior to December 4, 2009 the child was crying a lot and the parents took the child to Sunshine Pediatrics and they informed the parents the child had a throat infection and it had gotten worse-child was taken to Riverview Medical Center and later taken to Piedmont Medical Center in which they performed test-Michael was watching the child when the baby went limb-Kayla had gotten off from work and Michael meet her at the door with the baby limb scratched out. Child was taken to Piedmont Medical Center then Levine's. It was determined the baby had bruising to the brain. Mrs. Williams stated there were no other incidents she could recall after wards until this weekend. Owen was at her home on Saturday and she observed looked like to be a scratch on the child's head-she placed the child in the light and observed a bruise about the size of a

dime on the child's forehead. She stated she felt it and it was soft and full-she stated she observed the nurses and doctors last time checking the child like that. Michael was asked about the child's forehead in which he stated he did not know. He later stated the child sleeps in the crib by himself and he maybe hit his head on something. On Sunday, during child the child was sitting on Michael's lap and later placed in his carrier. When asked to hold the child-Michael would not allow her-When asked to have the child come to her home-Michael stated the baby was going home with them. Usually the baby would visit the home of the grandparents and the parents be happy about the grandparents caring for the child-however not this Sunday. Kayla arrived at the home later-in which she usually brings the baby with her-the baby was not with her-Asked where the baby was-the baby was left at the home with Michael-When asked why she didn't bring the baby-Kayla begin to get defensive against her and stated the baby can be with his father and does not always have to come with her. She stated Kayla was at the home to eat some chili because she loves her mother's chili. Received a phone call this morning as she and her husband were on their way to Columbia for a funeral in which her husband was going to do the eulogy. Charlotte Williams information-dob [redacted] Address [redacted] phone number(803)280-3048. Has a son by the name of Aaron that lives in the home he is 12 years old. Family does not have any DSS history and no Criminal History. Have everything for the child that he will need. Has a playpen for the child however will need to get a crib for the baby-child has Medicaid.

Actions:

Collateral Contact

Recipients:

0001545389 - [redacted] Michael [redacted] (E)
0001545390 - Lythgoe, Kayla [redacted]
0001545398 - [redacted] Owen [redacted]

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 7:26 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:26:11 1/12/2010

Collateral Contact-Larry Williams-Grandfather [redacted] Mr. Williams reported child was at church on Sunday with parents. Michael held the child the entire time and then placed the child in car seat. Michael usually don't want anything to do with the child. Would not allow allow Charlotte to hold the baby. Charlotte asked to keep the baby-Michael said No-Child going with him-They usually give the child to them and allow the child to go to their house. This was the first time-Michael has done this. Mr. Williams later reported Kayla should not be ruled out-She made a phone call to the house one night to get the baby because she was about to lose it.

Actions:

Collateral Contact

Recipients:

0001545398 - [redacted] Owen [redacted]

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 7:27 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:27:15 1/12/2010

Collateral Contact-Social Worker-Yvette Case manager inquired about Medical Records for the minor child Owen [redacted] Case manager was informed she would need a release of information from the parents and they would not be able to give medical records to her tonight-they stop giving medical records at a certain thing-Case manager would need to get in contact with the hospital in the morning regarding receiving medical records.

Actions:

Face to Face with child/client

Recipients:

0001545389 - [redacted], Michael [redacted]
0001545390 - Lythgoe, Kayla - [redacted] (E)

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.50

Input Date: 1/12/2010 **Input Time:** 7:31 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 7:31:12 1/12/2010

Safety plan- Owen has acute bleed in the head, actively seizing, multiple bruises chest, arm, thighs, and legs, actively seizing not a good sign-2nd injury much more serious this time. Kayla and Michael will have No unsupervised contact with Owen [redacted] Owen [redacted] not go home with Kayla and Michael. Levine's Children's Hospital will contact York County Department of Social Services when minor child to be released/discharged. Both parents will comply with safety plan-failure will result in court intervention. Case manager Hill will follow up with ALL parties and request records, etc. Parents never arrived back at the hospital-Case manager spoke with Charlotte Williams regarding the safety plan and hospital staff-A copy of the safety plan was placed in Owen's file.

Actions:

Telephone Contact

Recipients:

0001545389 - [redacted] Michael [redacted] (E)
0001545398 - [redacted] Owen - [redacted] (E)

Action Date: 1/11/2010 **Action Time:** **Time Spent:** 0.25

Input Date: 1/12/2010 **Input Time:** 8:05 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 8:05:15 1/12/2010

Telephone contact Received telephone call stating Owen [redacted] was still actively seizing and Michael [redacted] found guilty-He admitted to shaking the baby.

Actions:

Staffing With Supervisor

Recipients:

0001545389 - [redacted] Michael - [redacted] (E)
0001545390 - Lythgoe, Kayla - [redacted] (E)
0001545391 - Williams, Charlotte - [redacted] (E)
0001545398 - [redacted] Owen - [redacted] (E)

Action Date: 1/4/2010 **Action Time:** **Time Spent:** 1.00

Input Date: 1/7/2010 **Input Time:** 4:30 PM **Worker:** Himant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 4:30:23 1/7/2010

Supervisor staffed case with Cm. See DSS Form 3062 in file.

PM 4:49:46 1/12/2010

Current Situation: Hospital cannot determine if hematomas are accidental or non-accidental. Concerns for lack of supervision. Charlotte babysits Owen. Baby is doing well. Crib and all baby supplies in home. Recs: Get all medical records Follow up with Law Enforcement - What is their status? Assess Grandmother's Home- Get incident Reports

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Actions:

Face to Face with child/client

Recipients:

0001545389 - [redacted] Michael - [redacted] (E)
0001545390 - Lythgoe, Kayla - [redacted] (E)
0001545398 - [redacted] Owen - [redacted] (E)

Action Date: 12/21/2009 **Action Time:** **Time Spent:** 1.25

Input Date: 1/12/2010 **Input Time:** 9:56 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 9:56:00 1/12/2010

Face to Face with Child/Client Present at the home were Kayla, Michael, and Owen. Owen was on a blanket on the floor in which Michael was playing with the baby when case manager arrived. The family was expecting case manager at the home-in which case manager spoke with Kayla several days ago and sent a home attempt letter to the home. The home was warm and organized in the living room. Case manager read the allegations out to the family. Allegation-R/S 2 month old male baby has two subdural hematoma(sizes: 3mm and 2 mm). R/S there is a Fatx Subdural Hematoma which raises the possibly of no accidental trauma. R/S parents behavior has been appropriate with the child. Baby is 2 months -baby initiated admitted to PMC on December 4, 2009 and was transferred to CMC Main(Levine Hospital) R/S CT Scan shows two subdural hematoma-Case manager was informed of no prior physical/mental delinquency. Parents were observed to be appropriate and concerned. Parents took the baby for medial treatment on November 28, December 2 and December 4. Kayla informed case manager the baby receive medical service at Sunshine Pediatrics in Rock Hill-child was taken there in which she was informed the child had a minor cold/throat infection in which the parents transported the child on Wednesday. Friday-the week before the child was sick-sleeping more eating less, crying more-pink(color of skin) and passed out there was not a response out of the baby-drove the baby to the ER-the baby grasped and screamed everything appeared normal. There was a concern with the baby's red blood count in which it was low. The baby was taken to Levine's Children's Hospital the same day. Afterwards, the baby was fine and normal-eating normal, sleeping and a head scan was done-they could not find out what was going on with the baby. Case manager asked the parents have the baby been dropped-both parents stated no the baby have not been dropped. Case manager inquired about caregivers-parents Michael(father), Kayla(mother), and Grandparents. Child does not attend daycare. Case manager inquired about any other members that care for the baby-parents stated no. Case manager asked was the first time the baby has had hematoma or medical concerns-parents stated yes. Case manager asked again how the child received the injury-both parents stated they did not know how the child got the subdural hematomas. Case manager was informed the Grandmother did not reside at the same residence as they do. Kayla is employed with Wal-greens on Celenese and Michael is employed at Food Lion. When Parents are at work the child usually goes to his Grandmother Charlotte Williams home in which she lives around the corner. Michael stated the baby was normal now and has not had any concerns/problems since then. He stated he does not know how the baby received the injury they are glad that the baby is better. Michael played on the floor with the baby as case manager spoke to them. Owen was vibrant lying on his back on a blanket kicking his feet and arms laughing and smiling as his father interacted with him. Kayla sat on the couch with case manager during the interview. Case manager inquired about discipline-parents stated they do not discipline the child because the baby does not know any better and he's just a baby. Case manager inquired about sleeping arrangements for the child-case manager was given a walk thru of the home-the home was clean and organized and spacious-Owen had his own bedroom in which he had a crib and plenty of supplies. In the parents' room the child also had a crib-Parents informed case manager that the child spends most of the time in their room in his crib-sometimes the child is taken to his room however since the incident the baby is in the room with them most of the time. A safety plan was put in place with the family.

Actions:

Collateral Contact

Recipients:

0001545389 - [redacted], Michael [redacted] (E)
0001545390 - Lythgoe, Kayla [redacted])
0001545398 - [redacted] Owen - [redacted]E)

Action Date:	12/17/2009	**Action Time:**	3:00 PM	**Time Spent:**	0.25
Input Date:	1/19/2010	**Input Time:**	5:18 PM	**Worker:**	Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 5:18:14 1/19/2010

Supervisor spoke with Lt Miller with YCSD. He stated that he received LE referral for Owen [redacted] on 12/16/09 after hours around 7pm. Lt. Miller stated that he needed additional information. Supervisor explained to Lt. Miller that the hospital states that they cannot determine if Owen's injuries are accidental or not and that the hospital has concerns for lack of superivision primarly, Supervisor told Lt. Miller that all scans have been negative. Supervisor read dictation to Lt. Miller from conversation with hospital SW from CAPSS. Lt. Miller asked Supervisor to fax over dictation with conversation with hospital. Supervisor faxed dictation around 4pm to Lt. Miller.

Actions:

Face to Face with child/client

Recipients:

0001545390 - Lythgoe, Kayla [redacted])

Action Date: 12/17/2009 **Action Time:** **Time Spent:** 0.75

Input Date: 1/13/2010 **Input Time:** 12:44 PM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:44:44 1/13/2010

Face to Face with Child/Client Arrived at the home to speak with the family regarding the allegations and access the home. There was a jeep that pulled on the side of the road and a lady got out of the car and walked inside the home. Case manager observed a man delivering new page books to the mobile home. Case manager knocked on the door and spoke with Kayla regarding the allegations. Kayla stated she did not know what happened to the baby-she stated the baby had not been himself and he would sleep longer and not eat as the child normal does. Case manager inquired about the baby-she mentioned that she was on her way to work and the baby is out with the grandmother-case manager inquired about a phone number for her-she stated she was not able to receive phone calls however she could get text messages. Case manager informed her that she needed to access the home and speak with everybody that lived in the home. Kayla informed case manager she received the home attempt letter in the mail and the day scheduled would be fine. Case manager informed Kayla about the concern and put a safety plan in place with Kayla. Case manager inquired about Michael-Case manager was informed that Michael was at work and was not for sure he would be home. Case manager informed Kayla to tell Michael and members of the household case manager would be at the home on December 21, 2009 at 9am-Kayla informed case manager they would be home-case manager inquired about the time-she stated case manager could come to the home earlier if need be-they would be there.

Actions:

Face to Face with child/client

Recipients:

0001545390 - Lythgoe, Kayla [redacted]E)

Action Date: 12/17/2009 **Action Time:** **Time Spent:** 0.25

Input Date: 1/13/2010 **Input Time:** 12:48 PM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:48:48 1/13/2010

Face to Face with Child/Client-Safety Plan While at the home with Kayla Lythgoe-Case manager spoke with Kayla in reference to the allegations. Kayla was on her way out the door to work at the time. Case manager was able to put a safety plan in place with Kayla. Michael and Kayla agree to supervise Owen [redacted] at ALL times and follow up with All medical appointments. Start date today, Tuesday, December 8, 2009-until investigation ends. Michael and Kayla will comple with safety plan-failure will result in court intervention/removal. Case manager Hill will follow up with records, staff case with supervisor, follow up with family.

Actions:

Face to Face with child/client Attempted

Recipients:

0001545389 - Carduff, Michael - [redacted] (E)
0001545390 - Lythgoe, Kayla - [redacted] (E)
0001545398 - [redacted] Owen - [redacted] (E)

Action Date: 12/10/2009 **Action Time:** **Time Spent:** 0.50

Input Date: 1/13/2010 **Input Time:** 8:41 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 8:41:14 1/13/2010

Face to Face with Child/Client Attempted Arrived at residence to speak with family about allegations-Case manager observed no cars in the drive way of the home. Case manager was informed from the neighbor next door to the left the family was not at the home at the time.

Actions:

Telephone Contact

Recipients:

0001545391 - Williams, Charlotte - [redacted] (E)

Action Date: 12/10/2009 **Action Time:** **Time Spent:** 0.25

Input Date: 1/13/2010 **Input Time:** 8:43 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 8:43:27 1/13/2010
Telephone Contact Charlotte Williams(grandmother) called and left message.

Actions:

Face to Face with child/client Attempted

Recipients:

0001545389 - Carduff, Michael - [redacted](E)
0001545390 - Lythgoe, Kayla [redacted]
0001545391 - Williams, Charlotte [redacted](E)
0001545398 - [redacted] Owen [redacted]

Action Date: 12/8/2009 **Action Time:** **Time Spent:** 0.50

Input Date: 12/16/2009 **Input Time:** 12:02 PM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 12:02:58 12/16/2009
Face to Face with Child/Client Attempted Arrived at the residence to follow up with the family-case manager observed no vehicle in the yard-there was no answer at the home when case manager knocked several times and sat in the car to call the family on the phone number listed on the intake form-left message for family to call case manager back.

Actions:

Collateral Contact

Recipients:

0001545398 - Carduff, Owen - [redacted]

Action Date: 12/7/2009 **Action Time:** 3:34 PM **Time Spent:** 0.25

Input Date: 12/7/2009 **Input Time:** 3:41 PM **Worker:** Himnant, Krista

Service ID: 0001388329

DSS-YS 0099

Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:41:05 12/7/2009

Supervisor received message from Laura McDowell, SW at Levine's. She stated that Owen will be discharged today and is going home with the parents.

Actions:

Collateral Contact

Recipients:

0001545389 - [redacted] Michael - [redacted])
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted](E)
0001545398 - [redacted] Owen - [redacted])

Action Date:	12/7/2009	**Action Time:**	3:00 PM	**Time Spent:**	0.25
Input Date:	12/7/2009	**Input Time:**	3:10 PM	**Worker:**	Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:10:16 12/7/2009

Supervisor contacted Laura Newmark, SW with Levine's. Supervisor advised Laura that the case had been staffed with the legal department and that Owen should be discharged to his parents and that DSS will follow up with a home assessment. Laura stated that Owen's second CT Scan was stable. Laura stated that she would call and let Supervisor know when Owen is discharged.

HRC690-R01 South Carolina Department of Social Services 1/21/2010 7:58 PM

Case Dictation

Case ID - 0001113743

Actions:

Collateral Contact

Recipients:

0001545389 - [redacted] Michael [redacted] (E)
0001545390 - Lythgoe, Kayla [redacted]
0001545391 - Williams, Charlotte [redacted] (E)
0001545398 - [redacted] Owen [redacted]

Action Date: 12/7/2009 **Action Time:** 11:50 AM **Time Spent:** 0.50

Input Date: 12/7/2009 **Input Time:** 3:08 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:08:21 12/7/2009

Supervisor received call from Laura Newmark who is another SW with Levine's Childrens Hospital in Charlotte, NC. Laura's contact number is 704-355-3189. Laura stated that she is the SW that has been working with Owen [redacted] family. She stated that she has talked with the pediatric staff and at this time the hospital cannot determine whether the injuries are accidental or nonaccidental. She stated that Owen's Eye Exam and Skeletal Survey were negative. She stated that they are going to repeat the CT scan today because Owen's head still appears swollen. She stated that the family has no clear history of trauma, however, the hospital still cannot rule out any trauma. She stated that they parents are too young parents and the hospital mostly has concerns for lack of supervision. She stated that it is unknown if Owen will be discharged today or tomorrow and that will be determined by the results of Owen's CT Scan. Laura stated at this point there are no obvious findings of abuse/neglect. Laura stated that the family will need to follow up with another skeletal survey in 2 weeks. She stated that the parents will be able to do that back home and will not need to come back to Charlotte. Supervisor inquired about the doctor that is working with Owen. Laura stated that Dr. Cheryl Courtlandt is working with Owen. Dr. Courtlandt stated that she cannot determine if the injuries are an accident or not at this point. Supervisor advised Laura that she would staff the case with the legal department and get back with her asap with a discharge plan for the baby.

Actions:

Collateral Contact

Recipients:

0001545389 - [redacted] Michael [redacted] (E)
0001545390 - Lythgoe, Kayla [redacted]
0001545391 - Williams, Charlotte [redacted] (E)
0001545398 - [redacted] Owen [redacted]

Action Date: 12/7/2009 **Action** **Time** 1.00

DSS-YS 0101

Time: **Spent:**

Input Date: 12/7/2009 **Input Time:** 3:01 PM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 3:01:11 12/7/2009

Supervisor contacted Laura McDowell, who is a SW with Levine's Childrens Hospital. Laura stated that she was familiar with Owen [redacted]. Supervisor advised Laura that DSS would need to speak with a doctor or the SW could speak with the doctor to determine of Owen's hematomas were accidental or not. Laura stated that she would follow up with the doctor and get back with Supervisor.

PM 3:12:44 12/7/2009

Action Time was 10:01am

Actions:

Staffing With Supervisor

Recipients:

0001545389 - [redacted] Michael [redacted] (E)
0001545390 - Lythgoe, Kayln [redacted]
0001545391 - Williams, Charlotte [redacted] (E)
0001545398 - [redacted] Owen [redacted] (E)

Action Date: 12/7/2009 **Action Time:** **Time Spent:** 1.00

Input Date: 12/9/2009 **Input Time:** 9:13 AM **Worker:** Hinnant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 9:13:14 12/9/2009

Case staffed with CM. See DSS Form 3062 in file.

PM 4:44:31 1/12/2010

Current Situation: Owen has two subdural hematomas. One would indicate non accidental trauma. Parents appropriate. Owen went to Sunshine Peds on 12/2/09 be baby not acting himself. Saw Dr. Paxter - baby had throat infection and cold. No meds given. Dad said baby was sleeping a lot. Funky odor from child's mouth. Parents took baby to PMC. PMC sent child to Levine's. SW has concerns because CT scan shows non-accidental trauma. No Dr is staying injuries are non accidental. Hospital has a sitter and parents are having supervised contact with baby. Parents also took child to Riverview. Parents said they noted a bruise on the baby's head in November - neither of them know what happened. Parents have witnessed no injury to baby. Nurse said it is non-accidental. GM saw bump on baby's head a few days ago. Baby was with dad and uncle. SP put in place that parents are to follow all doctor's recs. Baby is ready for discharge. Recs: Get Medical Recs: CMC Levine's, Piedmont Medical, Riverview Medical and Sunshine Pediatrics *Refer to Law Enforcement* LE incidents Pull public index Follow up and talk with doctor Meet with Grandmother

(assess) Go to home and assess home Talk to Grandmother separately - any concerns? Talk to Laura McDowell - (704) 355-3189 - Does doctor think trauma is non-accidental Get release of info signed

Actions:

Staffing With Supervisor

Recipients:

0001545389 - [redacted] Michael - [redacted])
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted](E)
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/7/2009 **Action Time:** **Time Spent:** 1.00

Input Date: 12/9/2009 **Input Time:** 9:13 AM **Worker:** Himant, Krista

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 9:13:44 12/9/2009
Case staffed with CM. See DSS Form 3062 in file.
AM 9:14:02 12/9/2009
Case was staffed with legal for directions/recomendations.

Actions:

Face to Face with child/client Attempted

Recipients:

0001545389 - [redacted] Michael - [redacted]E)
0001545390 - Lythgoe, Kayla - [redacted]
0001545391 - Williams, Charlotte - [redacted]3)
0001545398 - [redacted] Owen - [redacted]

Action Date: 12/7/2009 **Action Time:** **Time Spent:** 0.50

Input Date: 12/16/2009 **Input Time:** 11:59 AM **Worker:** Hill, Dirvondra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 11:59:53 12/16/2009
Face to Face with Child/Client Attempted Case manager arrived at [redacted] to find a Dodge

4x4 suv in the yard-license tag number FED 997-case manager observed two men outside the home talking-they informed case manager the family was not at home. Knocked at the mobile home-observed no sound coming from the inside of the home-case manager called phone number on the intake form-[redacted]-Case manager received voice mail in which the phone belong to Charlotte(Grandmother)-case manager left message for the family to give case manager a call back.

Actions:

Case Plan/Evaluation

Recipients:

0001545389 - [redacted] Michael - [redacted]

Action Date:	12/6/2009	**Action Time:**	8:30 PM	**Time Spent:**	0.25
Input Date:	1/21/2010	**Input Time:**	1:35 PM	**Worker:**	Tyler, Chandra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

PM 1:35:25 1/21/2010

Safe Plan also explained to parents and they received a copy and signed. parents not to remove the child from the hospital against medical advice and until dss determines

Actions:

Initial Face to Face With Child/Client
Initial Face to Face With Family

Recipients:

0001545389 - [redacted] Michael - [redacted] (E)
0001545390 - Lythgoe, Kayla - [redacted] (E)
0001545398 - [redacted] Owen - [redacted] (E)

Action Date:	12/6/2009	**Action Time:**	7:45 PM	**Time Spent:**	4.00
Input Date:	12/9/2009	**Input Time:**	11:42 AM	**Worker:**	Tyler, Chandra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment
Authorization:
Support Service ID:

Dictation:

AM 11:42:35 12/9/2009

CM conducted a face to face with Michael [redacted] and Kayla Lythgoe at CMC Main (Levine Children's Hospital) in order to interview parents on cause of Owen [redacted] injuries. Present in the hospital room was parents, Owen, paternal grandmother Jennifer [redacted] and paternal uncle Brian [redacted] Ms. Lythgoe said Mr. [redacted] stepped out for a minute, so Cm begin interviewing her. Ms. Lythgoe said that they

first noticed a change in Owen's behavior on 11/28/09. Ms. [redacted] said that Owen was sleeping a lot and screamed when awake, non stop. Ms. Lythgoe said that they took Owen to Riverview 24hr Clinic that same evening that the doctor said nothing was wrong with him. Ms. Lythgoe said Owen continued this abnormal behavior throughout the week and on 12/1/09 went all day and night without urinating. (Mr. [redacted] entered the room and sat by Ms. Lythgoe) Ms. Lythgoe said they scheduled an appt with his pediatrician for 12/2/09 at Sunshine Pediatrics with Dr. Paxtor. Ms. Lythgoe said that Dr. Paxtor said that Owen had a throat infection and a minor cold. Dr. Paxtor did not prescribe any medication. On 12/4/09 Ms. Lythgoe said she was pulling in the driveway and Michael came outside and said that Owen just went limp, but was still breathing and they rushed Owen to Piedmont Medical Center. Upon arriving at PMC, Ms. Lythgoe said Owen let out a loud scream and took a huge breath. Ms. Lythgoe said PMC transferred Owen to Levine Hospital on 12/5/09. CM then asked Mr. [redacted] what happened and he also said that Owen's behavior has been different since 11/28/09 and told CM of taking him to Riverview and Sunshine Ped. Mr. [redacted] that he was home watching the baby on 12/4/09 by himself. Mr. [redacted] said that Owen was sleeping a lot and not eating. Mr. [redacted] said he woke Owen up to feed him and that Owen let out a loud scream and then stretched out, turning red and went limp. Mr. [redacted] said as that happened he heard Ms. Lythgoe pull up and ran outside to get her. They then rushed Owen to PMC where he was transferred to CMC Main (Levine Children's Hospital) Mr. [redacted] said that he had no knowledge of anything that could have injured the baby and doesn't know why his behavior changed. Cm asked Ms. Lythgoe who watches the baby and she said herself, Michael when their not working and maternal grandmother Charlotte Williams. CM asked Ms. Lythgoe if anyone else watches Owen and she said no. Cm asked Ms. Lythgoe and Mr. [redacted] where Owen sleeps and they said in a pack and play in their room. Cm asked if there where any toys in the pack and play and they said no only a blanket if needed. Ms. Lythgoe said they swaddle Owen when he sleeps. Cm asked Ms. Lythgoe if there is any incident that has happened where Owen had hit his head or fell and Ms. Lythgoe said no. Both parents said that the only thing that they noticed was in November Owen had a small flat brownish bruise on the left side of his head. Ms Lythgoe said she asked Mr. [redacted] at that time did he know where it came from and she said Mr. [redacted] said no. Ms. Lythgoe also said that sometimes Owen head turns and jerks around during tummy time on the floor. CM also asked parental grandmother and brother if they have ever watched Owen and GM said she and her husband have watched Owen briefly when parents ran an errand. Uncle said that he has never watched the children alone, but that he has been in the home with either parent and watched Owen while they did things around the home. A sitter was also present in the room 24/7 and both parents stayed the night with Owen in the hospital room.

PM 5:06:46 1/21/2010

Upon completing the interview with Michael [redacted] and Kayla Lythgoe CM went to the nurse's station on the same floor to see if this CM could find a copier to make copies of the safety plan. CM asked a nurse on-duty if she could make a copy for this CM and she said sure. The nurse asked this CM if she relieved the sitter for Owen [redacted] room and CM said no, that that is not why this CM is here. The nurse said that she thought that is why this CM was called, because DSS makes the detemination of whether to relieve the sitter. CM informed the nurse that this CM was called by the Social Worker at Levine because of her concerns that reports showed fatx subdural hematoma rises possibility of non accidental trauma. The nurse seemed confused and said that they had no known concerns of non accidental trama and that the social worker was not supposed to be calling for those reason, but was to call to get DSS approval to remove the sitter for Owen's room. CM informed the nurse that the purpose of this CM 's visit was to investigate the recent report and that this CM was not here to decide whether to relieve the sitter. CM returned to Owen's room to give parents their copy of the safety plan and then CM left.

Actions:

Brochure Given

Recipients:

0001545389 - [redacted] Michael [redacted]E)
0001545390 - Lythgoe, Kayla - [redacted]E)

Action Date:	12/6/2009	**Action Time:**		**Time Spent:**	0.25
Input Date:	12/9/2009	**Input Time:**	12:27 PM	**Worker:**	Tyler, Chandra

Service ID: 0001388329
Program Service Type: Child Protective Services Assessment

Authorization:

Support Service ID:

Dictation:

PM 12:27:05 12/9/2009

Brochure Given to parents and they both signed that they received it. Safe Plan also explained to parents and they received a copy and signed. CLT

Exhibit 5

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Q Okay. Okay. If you look at 24 -- 00248 for me, please. In the middle there's a note from you; it appears to be another attempt to meet with the family; is that fair?
A Yes.
Q And did you have a phone number for the family?
A I did have a phone number.
Q And it says you left a number? Do -- do you have -- whose -- do you know whose phone that was that you were calling?
A It was the number on the intake and -- which from dictation December the 10th, 2009, it was the grandmother's phone number.
Q Okay. Do you know whether or not you had a number for the -- for the mother?
A At the time I did not. That was the only phone number on the intake.
Q Okay. So, if you turn to the next page, 24 -- were we on 248? Yeah. 247. There's an entry, 12/10, which was actually input on 1/13, correct?
A Yes.
Q Again, you tried -- you said you tried to speak with the family, but no one was home.
A Yes.
Q Okay. And let me ask you this: How long do you

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have to update your dictation? because it -- I see this one was input on 1/13, but it was done on 12/10?
A Yes. For initial, we have seven days to enter the dictation. Policy has changed from 2009 up until this year. A lot of my entries were written -- a lot of my notes were written in which it was in my file.
Q Oh, handwritten?
A Handwritten.
Q Okay.
A And which those entries were not in the case until that time that they were entered on the input date.
Q Okay. And what do you do with those handwritten notes after you put them into the computer?
A Usually, I type the entry, and, once I type the entry in dictation, I put a "C" on the notes and get rid of the notes.
Q You throw them away?
A Yes.
Q Okay. Okay. The next entry above that is also yours entered on the 13th but apparently done on the 17th. Do you have any independent recollection of this at the time as you sit here today?
A The action date, December the 17th?

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Q Yes, ma'am.
A The safety plan?
Q Well, it says -- let's see. Yes. It appears to be a safety plan.
A What was the question? I'm sorry.
Q Do you have any independent recollection of this meeting with Kayla on the 17th?
A Yes.
Q And can you tell me, was this at her house?
A It was at her home.
Q And who else was there?
A She was the only one that was at the home at that time.
Q Do you know where -- where Owen was?
A She stated that Owen was with grandmother at that time.
Q And, at this point on the 17th, had you seen Owen?
A No.
Q And did you know where the grandmother lived?
A At that time, I thought that the grandmother was living at the home with Kayla and Owen along with Michael.
Q Okay. And when did you find out -- or did you find out that she did not live there?
A I found out she did not live there the date of our

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face-to-face on the 21st.
Q Okay. So that was the first date that you met with the entire family; is that fair?
A Yes.
Q Okay. And when I say "the entire family," I mean the mother, the father, and Owen.
A And the -- yes.
Q Okay. Okay. So it appears you put a safety plan in place, at least as to Kayla; is that fair? We're still looking at that note on -- on 00247.
A Yes.
Q Okay. And I want you to do this. Hold that page and go to Tab 14 for me, please, and look at Defense-produced 00285.
Is this the safety plan that you put in place with Kayla?
A Yes.
Q And what's -- what's the date that she signed it? Can you tell?
A It says "12." I can't make out. Is that a zero or a "1"?
Q That's the problem I have too.
MS. HARRILL: (To Mr. Todd) We're on 14285.
A 7/09.
Q Okay. And your signature is dated 12/8; is that

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correct?
A That's correct.
Q Is that the date that you prepared this document?
A It is.
Q And was Kayla aware that this safety plan -- I mean -- or let me ask you this: Is the safety plan considered in place until the family has signed it?
A Is it considered in place until the family has signed it?
Q Right.
A Meaning?
Q Meaning if we assume that that -- if we assume that the date that she signed it is the 17th on the date that you met with her. We were talking about the dictation on the 17th.
A Yes.
Q Is she -- is this safety plan in place, as far as the family is concerned, until she signs it?
A The safety plan goes into effect whenever the family signs it.
Q Okay. So this -- the safety plan itself says, "Start date, today, Tuesday, December the 8th, 2009," but it doesn't, in fact, go into effect until the family has signed it; is that correct?
A Until then, she was up under the first safety plan.

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Q Okay. Okay. Turn to the next page, 246.
A Okay.
Q Or the previous page, I should say. The bottom note here appears to also be a note from you for the same date, 12/17/2009. Input date also 1/13/2010, but I'm confused. Is this related to the same meeting?
A With the safety plan?
Q Yes, ma'am.
A Yes. Different entry.
Q Why would there be two different entries?
A At times you can -- it depends on the case manager. Sometime the case manager place the action, face-to-face with child client, the dictation by itself, and sometimes it can be a separate entry.
Q Okay. So how do you do it? How -- what is your habit of doing it?
A Usually, I put -- it -- it varies.
Q Okay.
A It varies. At times, I have put the dictation with the safety plan, and at times, I have put the dictation with the safety plan and also did another injury with a safety plan.
Q But it's the same sort of entry; is that fair? They're both face-to-face with child client?

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A The action that we usually put in place for a safety plan is the face-to-face with child --
Q Okay.
A -- client.
Q Which is the same as the one -- okay. So we have two entries that are dated --
A Yes.
Q -- 12/17/2009?
A Yes.
Q Both input on 1/13/2010? Both face-to-face with child client; is that fair?
A It's the same action code, face-to-face with child client, but different dictation entries. We have action codes that we have to put certain things under the action. So a safety plan for -- whenever -- after contact has been made, if you have a safety plan, it usually will fall up under the action code, the face-to-face with child client.
Q I'm just confused as to why there's two entries about the same thing.
A Where's the other . . .
Q Because this one is about the safety plan, and this one, too, says, "Put safety plan in place."
A It states, "Case manager informed Kayla about the concern, and put a safety plan in place with

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Kayla." On the 12/17 entry, one of them. However, the other one goes into detail regarding what the safety plan consists of.
Q Okay.
A In which Michael and Kayla agreed to supervise Owen Carduff at all times and follow up with all medical appointments.
Q And it also says, "Start date today, Tuesday, December 8th."
A Yes.
Q Even though it would have been -- well, whatever day --
A It would have been --
Q -- December 17th --
A -- 17.
Q Okay. Okay. Okay. If you turn to -- we kind of have to look at both of these pages, 244 and 245. 244 shows that this is a face-to-face with the client. Action date 12/21. Input on 1/12, correct?
A Correct.
Q And, on the next page, it lists a meeting which, apparently, is with the whole family; is that fair?
A Yes.
Q And it says -- and, I think we said just a minute

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ago, is this the first time that you met with the whole family?
A. This is the first time for a face-to-face contact with the entire family.
Q. Okay. So you'd had a face-to-face contact with Kayla --
A. Yes.
Q. -- previously? And -- but this is the first time you've met the child, Owen, and Michael, correct?
A. Yes.
Q. Okay. And then do you have to do a new safety plan at this meeting?
A. There were -- there was already a safety plan -- actually, two safety plans in place at that time.
Q. Do you recall whether or not Michael Carduff had ever signed a safety plan?
A. I cannot recall.
Q. Okay. Okay. All right. If you will turn to Tab 5 for me, please.
A. Okay.
Q. This is Defense-produced 002971, is what I'm looking at. Let me ask you this: When do you-all print out these dictations?
A. You can print out the dictation at any time. Usually we print out the dictation at the end of

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the case or during case decision --
Q. Okay.
A. -- in which all entries -- all entries, basically, should be in after the case decision.
Q. Okay.
A. Because, until then, we're continuing to assess. Usually, it's initial -- initial face-to-face.
Q. Right.
A. And, at that initial time, get the information. And then usually it's a 30-day visit to follow up with the family regarding the information.
Q. Okay. So the initial visit would've been done by Chandra Tyler, right?
A. Correct.
Q. So how many days do you have to see the child after the on-call worker sees the child?
A. There's not a -- I cannot -- I -- I can't recall that information.
Q. Okay. Whether or not there's a time --
A. Usually it's been best practice to follow up with the family after a child is discharged or --
Q. But best practice would be how long after a child is discharged?
A. Usually, I -- I cannot -- I cannot recall that --
Q. Okay.

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A. -- information.
Q. All right. So let me -- let's look at this entry here. And I -- I believe this is the same entry as the one we were just looking at on 245. This is your initial face-to-face contact, and I -- I don't want to use the word "initial," because you used that for something else. This is the first time that you met with the entire family. Is that -- is this the same entry?
MR. FRAWLEY: Which one are we referring to?
MS. HARRILL: We're looking at 2971 in Tab 5.
MR. FRAWLEY: Okay.
A. Yes. This was a face-to-face with the family members of the household.
Q. Okay. Let me ask you a question: You talked about staffing these cases with legal when -- in -- when there are physical injuries sustained or if it's a sexual abuse case. Do you also automatically refer those cases to law enforcement?
A. Yes.
Q. And who decides what cases are referred to law enforcement, or do you just know that, as general practice, injuries go to law enforcement?
A. Usually it's a recommendation.
Q. Okay. And when it -- in a staffing?

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A. Yes.
Q. And, when it's recommended, how long do you have to refer the case to law enforcement?
A. Twenty-four hours.
Q. And, when you do that, are you expecting that law enforcement will investigate?
A. I don't know how to answer that question.
Q. Well, why do you refer them to law enforcement?
A. We refer to law enforcement due to -- if there's any injuries or excessive abuse or sexual abuse in which they can investigate regarding those events.
Q. Okay. And, if they do investigate, do you-all staff the cases together?
A. We follow up with them.
Q. Okay.
A. To collaborate.
Q. In this particular case, do you ever recall, prior to the second injury, having any conversations with law enforcement or with Lieutenant Miller, specifically?
A. I know that my supervisor at the time, she had a lot of contact with the collaterals with Lieutenant Miller.
Q. Okay. Did you have any conversations with Lieutenant Miller prior to the second injury?

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A Not to my knowledge.
Q Okay. And turn to Tab 9 for me, please, which may be where we get -- let's see. Nope. We're right. Are these staffing sheets?
A Yes.
Q Okay. And I have two of them in this tab. One is 1353. It appears to be a staffing between A. Woods, which is Adrienne Woods; is that right?
A Yes.
Q Yourself, and your supervisor, Krista Hinnant. Is this -- this -- to your recollection, is this the staffing where you-all decided to send the child home with the family?
A That is what I am seeing the recommendation.
Q Okay.
A Yes.
Q And it says, "Refer to law enforcement." Do you recall how -- when you did that?
A When referring to my dictation, the referral was not made until the 16th.
Q Okay.
A December 16th.
Q Okay. And on the next -- on the next page, 130 -- unh-unh. Sorry. 1355.
A Yes.

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Q This is a staffing -- another staffing on the same date; is that correct?
A Yes. This was the first staffing.
Q So this is the staffing where you transferred the case from the on-call people to your --
A Yes.
Q -- to you, I guess I should say?
A Yes.
Q Okay. And that one also says, "Refer to law enforcement"? It's terribly hard to read. Apparently somebody highlighted it. But I believe that says, "Refer to LE."
MR. FRAWLEY: We'll stipulate that it does.
MS. HARRILL: Okay.
MR. FRAWLEY: It's on the second page. Second of the two pages, right?
MS. HARRILL: It's this right here. "Refer to LE."
Q But this is the initial staffing that transfers the case to you; is that fair?
A Yes.
Q Who is -- the last recommendation on that page, 1356, says, "Talk to Laura McDowell." Tell me who that is; do you know?
A Laura McDowell is a social worker at Levine's.

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Q Okay. And I forgot my glasses today. I'm going to have to go get them, but I think it says, out beside that, "Does doctor think trauma is non-accidental?" Is that right?
A That's what it looks like it says.
Q Whose handwriting is this?
A Well, I know it's not Lola's writing. Looks like Krista's writing.
Q Okay. And these recommendations -- would these be things for you to do?
A Usually, the recommendations are the things that are recommended for the worker to do.
Q And you were the caseworker, right?
A Yes.
Q And did you ever talk to Laura McDowell?
A I cannot recall.
Q Would it be in your dictation if you had?
A If I have -- yes. It would be in my dictation.
Q Did you talk with the grandmother separately from the family?
A I talked to the grandmother later on in the case.
Q Did you ever talk to the grandmother prior to the second injury?
A No. I tried to get in contact with her with the phone number, and left a message.

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Q But now, when you called and left a message with her, were you trying to reach her or were you trying to reach the mother and the father?
A I was trying to reach the family altogether.
Q Okay. So, as you sit here today, do you know if you ever talked with the grandmother separately, prior to the second incident?
A To my knowledge, no.
Q Did you talk with Owen's doctor or doctors?
A I cannot recall.
Q Okay. When you -- did you have a release of information to get medical records?
A If I had a release, it would have been in the file.
Q Do -- sorry. I don't want to interrupt you.
A It would be in the file.
Q Do you know whether or not you requested medical records for Owen?
A I believe that I -- I will have to look in the file to see.
Q If you requested medical records, is that something you would document?
A No.
Q Okay. If you received medical records, is that something you would document?
A No.

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Q Okay. What would you need to look at to know whether or not you had requested them?
A Look and see if there are records in the file.
Q Okay. Would those records say when they came in?
A If a fax was sent.
Q Okay.
A If not, then -- at times, we do call and pick up the records, so there would not be a fax that's sent.
Q Do you recall whether or not you picked up records from Levine's or Piedmont or the pediatric --
A I cannot recall --
Q Okay.
A -- that information.
Q Because we can go and look at that. I just don't have it in here. So we'll talk about that a little bit later.
A Okay.
Q If you sent a request for medical records, would -- would a copy of your request be in the file?
A I don't know how to answer that because at times, if I have already received the records, then -- are you asking regarding a faxed confirmation?
Q No. I'm asking if you sent out a medical request --

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A Uh-huh.
Q -- whether you faxed it, or mailed it, or however --
A Uh-huh.
Q I don't -- I don't know what your standard practice is. I'm going to ask you that next.
A Uh huh.
Q If you sent out a request for records, would a copy of that request be in the file? Like, if I send a letter to you, I will have a copy of it in my file. Would you have a copy of that request in the client's file?
A If it was sent off faxed, yes.
Q Okay.
A If it was picked up, no.
Q If it was mailed, would you have --
A Well, we typically -- we don't mail.
Q Okay. How do you normally request records from medical?
A We request -- we fax medical records. And at times, we pick up medical records.
Q Okay.
A So we can make a phone call and inform them that we, you know, need medical records.
Q How long does it normally take for you-all to get

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medical records when you request them?
A It varies. At times, we receive medical records that week. And at times, it might not be until almost the end of the case that we receive medical records.
Q Uh-huh. Turn to the next tab for me, please, which is 10. And Defense-produced 00401. Tell me what this is.
A This is a home-attempt letter.
Q Do you have any idea when it was sent?
A I do not. Know that it was sent before December the 31st, and I do know that it was received before December the 17, because she was aware of the home-attempt letter in which we discussed the appointment for the 21st.
Q When you saw her on the 17th, is that what you're saying?
A Yes.
Q Okay. If you had scheduled this meeting for the 21st, were you still going out to the house to try and meet with them prior?
A Yes.
Q Okay.
A I was going out to the home to try to follow up with them.

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Q And this meeting was going to be in their house or at your office?
A At their home.
Q Okay. And -- okay. So we don't know what date this was sent?
A I do not see a date.
Q Okay. And would you document, in your records anywhere, when you sent this letter?
A It should have been documented.
Q In the dictation?
A At times, home-attempt letters are -- are documented. This one slipped.
Q Let me ask you this: What -- as a case manager for York County DSS, what are you supposed to document, related to your case files?
A Initial face-to-face --
Q Okay.
A -- brochure given --
Q Okay.
A -- safety plan face-to-face, if there are any attempts, face-to-face with child client, collateral contacts, or collateral statements, telephone contact --
Q Uh-huh.
A -- and the case decision.

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Q Okay.
A And staffings in which -- and supervisor entered the staffings.
Q The supervisors entered the staffings?
A Yes.
Q Okay. So any time there's a staffing done, that's not yours to enter; is that fair?
A We do not enter the staffings. The case manager --
Q And --
A For York County.
Q Sorry. Okay. When you have a Child Protective Services case -- I'm assuming you only do Child Protective Services; is that fair?
A Yes.
Q Okay.
A CPS.
Q If you do -- have a Child Protective Services case, who is the client?
A Who is the client?
Q Yes, ma'am.
A Can you rephrase that? I'm -- I'm confused.
Q Well, if you have an open case -- if you have -- say this case, a case regarding Owen Carduff, who is your client?
A The entire family.

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Q Okay. And would you agree with me that the purpose of an investigation is to identify safety concerns and insure the immediate safety of all children in the home?
A Yes.
Q And to make a determination whether or not the children were abused or neglected?
A Yes.
Q And to make a decision regarding the future risk of maltreatment?
A Yes.
Q And to plan for agency service intervention?
A Yes.
Q How do you ensure, during the course of your investigation, that children in the home are safe?
MR. TODD: Objection.
MR. FRAWLEY: Object to the form. Answer the question if you can.
A We continue to assess the home.
Q And how do you do that?
A Speaking with the family, speaking with collaterals -- excuse me -- to find out information to support the allegation that came in.
Q Okay. Is that it?
A We'll continue to assess the situation.

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Q Is that it?
A (Nods head up and down.)
Q Okay. I just don't want to talk over you.
All right. So we're looking at this letter here that you sent. And is it fair to say that whenever this letter was sent, you have not spoken to the family at that point?
A I have not. Yes. I was the -- yes. I had not spoken with the family at that time that the letter was sent. However, the on-call worker --
Q -- had spoken with the family? Let me -- the -- is it fair to say that the on-call worker had spoken with the family while the child was in the hospital?
A Yes.
Q Okay. But when the child was discharged from the hospital, no one had seen the child until the 21st; is that fair?
A Yes.
Q Okay.
MS. HARRILL: Let's go ahead and take a break.
(Off the record from 10:51 a.m. until 11:05 a.m.)
THE EXAMINATION BY MS. HARRILL CONTINUES.
Q Okay. While we were on break, I was looking at

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your notes and the documents that you brought with you, which appear to be your dictation; is that fair?
A Yes.
Q And with your notes -- of course, I didn't give you a copy of your notes. Have you got her originals?
MR. FRAWLEY: I'll give her originals back.
MS. HARRILL: Just don't hold them up where I can see the backs.
Q Where did -- where did you get these notes from?
A Out of the dictation?
Q So is this just like a review of the dictation? Would that be fair?
A Yeah. Like a little timeline, or if you want to call it.
Q Okay. And I see on the first page, the -- which is the first page you have in front of you, December 6th, 2009. There's a note on there about a safety plan.
A Yes.
Q Would that be the safety plan that was in place with the hospital?
A That's the safety plan that the on-call worker put in at the hospital.
Q Okay.

Exhibit 6

DSS

Serving Children and Families

KATHLEEN M. HAYES, PH.D.
STATE DIRECTOR

MARK SANFORD
GOVERNOR

YORK COUNTY DEPARTMENT OF SOCIAL SERVICES
REFERRAL TO LAW ENFORCEMENT

Date: December 16, 2009

To: York County Sheriff Department

Pursuant to the South Carolina's Children Code 20-7-650 (K), our agency is notifying your department that there appears to be a violation of criminal law in the following case.

Offender's Name and Address:

Victim(s) Name and Address: Owen [redacted] (Dob [redacted]
[redacted]

Offense: R/S 2 month old male baby has two subdural hematoma(size 3mm and 2mm). R/S there is a Fatx subdural Hematoma which raises the possibly of no accidental trauma. R/S parents behavior has been appropriate with the child.

We are requesting an investigation be made into this matter. You may contact Dirvondra Hill at the York County Department of Social Services, 684-8148 for additional information.

Exhibit 7

to --

CHRISTA: Uh-oh. You worried about Kayla?

LIEUTENANT MILLER: Yeah.

CHRISTA: Uh-oh.

LIEUTENANT MILLER: I'm going to let them deal with that.

CHRISTA: Okay. Well, I'll -- I'll have Tasha call him and let him know what -- what happened today.

LIEUTENANT MILLER: Okay. I got a DSS report this morning when I came in from Devondra.

CHRISTA: Uh-huh. In reference to?

LIEUTENANT MILLER: Owen [redacted]

CHRISTA: Owen [redacted]

LIEUTENANT MILLER: [redacted]

CHRISTA: The child that was with the subdural hematomas --

LIEUTENANT MILLER: Right.

CHRISTA: -- at the hospital?

LIEUTENANT MILLER: Right.

CHRISTA: The hospital is not going to make a statement whether or not they feel as if that -- those injuries are accidental or non-accidental, period.

LIEUTENANT MILLER: Okay.

CHRISTA: I staffed it with our attorney, and we had let the child go home because the hospital's not making

any determination.

LIEUTENANT MILLER: Right.

CHRISTA: And they're saying they don't know what happened. And the hospital says mostly they have concern for lack of supervision.

LIEUTENANT MILLER: Uh-huh.

CHRISTA: They think that maybe nobody was supervising him and he bumped his head or they were holding him and walking him around a door and banged his head or something. But they're -- they're not really giving us a whole lot. You know how they won't make statements.

LIEUTENANT MILLER: Uh-huh.

CHRISTA: Because that was the first thing I asked them. And what happened is the social worker made the report on this, and the doctor did not advise the social worker --

LIEUTENANT MILLER: Right.

CHRISTA: -- to make the report. They made that real clear to me when I called and spoke with them at the hospital. But I have -- I -- I should have dictation on where I, you know, spoke with them. I can, you know, certainly send you that.

LIEUTENANT MILLER: Well, I -- I guess the thing that bugs me the most is getting it ten days after --

CHRISTA: I asked her to make the referral, and I fussed at her today about it.
LIEUTENANT MILLER: -- you know, and then expect us to do something with it, you know.
CHRISTA: Uh-huh.
LIEUTENANT MILLER: I don't --
CHRISTA: She should've made it as soon as she got the report when we staffed it from on-call. But she -- so she did just send it to you today?
LIEUTENANT MILLER: I got it at --
CHRISTA: What's the -- what's the date on it?
LIEUTENANT MILLER: It came in here at 6:59 last night.
CHRISTA: I can't believe she took that long. She's supposed to make them within 24 hours.
LIEUTENANT MILLER: Right.
CHRISTA: I know she didn't make it within 24 hours, but I didn't know she'd waited until --
LIEUTENANT MILLER: And, you know, I don't really have a problem with it if somebody will call me and say, "Hey, look, I'm" -- I know y'all are covered up now; there's no doubt about it.
CHRISTA: Uh-huh.
LIEUTENANT MILLER: And if -- if they've got one and they're covered up and they just can't get the paperwork over here, if they'll drop me a phone

call --

CHRISTA: Yeah.

LIEUTENANT MILLER: -- and say, "Hey, W.J., we've got this. I don't have anything else. I'm just going to send you the name and stuff right now. It's the best I can do for you right now" --

CHRISTA: Right.

LIEUTENANT MILLER: -- "unless I work 12 hours today."

CHRISTA: Right.

LIEUTENANT MILLER: If they'll do that, then I don't have a problem with this stuff. But it coming in ten days behind --

CHRISTA: Yes.

LIEUTENANT MILLER: -- is just --

CHRISTA: It's unacceptable.

LIEUTENANT MILLER: Well, it's -- and especially with that because, you know, now I get it and I can't get in touch with anybody this morning. And -- other than I called Lola to talk to her because she was the one that was on call that night.

CHRISTA: Uh-huh.

LIEUTENANT MILLER: And I talked to her, but I knew nothing about -- and -- and it does state in here -- it gives you some suspicions about -- because it says -- hold on -- "two-month old baby boy has two

subdural hematomas, sizes" -- and -- and there -- or it -- there's a falx subdural hematoma, which raises the possibility of no accidental trauma.

CHRISTA: Uh-huh.

LIEUTENANT MILLER: You know, so I'm sitting there reading that in a meeting, and I'm going, What the hell? You know?

CHRISTA: Yeah.

LIEUTENANT MILLER: And then so my thing is automatically, "We've got somebody that's done hurt this child."

CHRISTA: Right.

LIEUTENANT MILLER: But evidently, you know, from what you're saying and talking to the doctors and stuff there's not going to be, you know, any input.

CHRISTA: Nobody -- you're not going to have anything to -- to work with basically.

LIEUTENANT MILLER: Right.

CHRISTA: Because -- I mean, we're not either. I know --

LIEUTENANT MILLER: And, see, that's -- and, see, that's -- my thing is then, why wait -- if you're going to wait ten days to send it to me and y'all -- and then all that -- all that work's already been done --

CHRISTA: She should've sent you all the information that we had.
LIEUTENANT MILLER: Yeah, that. And, plus, why even send it at all if there's nothing there?
CHRISTA: Yeah. We're -- we -- with a child -- because our -- we staffed it with our attorney.
LIEUTENANT MILLER: Uh-huh.
CHRISTA: But she advised us we needed to make a referral, and you guys would make that determination whether or not you're going to investigate. We have to send it to you when --
LIEUTENANT MILLER: Yeah. I know but --
CHRISTA: -- an injury is like that, per our policy.
LIEUTENANT MILLER: Right.
CHRISTA: But, what I do when I have sent them that way -- and I've found it out -- I send you all the dictation and everything, you know, explain to you what I've already found out.
LIEUTENANT MILLER: Right.
CHRISTA: And you can make the decision whether or not you want to investigate based on all the information, rather than the allegations that come in.
LIEUTENANT MILLER: Right.
CHRISTA: Because 90 percent of the allegations aren't

usually true on reports that we send over to you guys.

LIEUTENANT MILLER: Yeah.

CHRISTA: And I know that.

LIEUTENANT MILLER: There's no doubt about some of them.

CHRISTA: Yeah. No. Some of them are just ridiculous.

LIEUTENANT MILLER: But, you know, if I can get all that information, then, you know, it gives me a whole lot clearer -- like, right off of what I'm reading right here, you know, I'm going out head-hunting.

CHRISTA: Yeah, I know.

LIEUTENANT MILLER: You know, and in all actuality, I probably don't need to be doing that. They just -- you know, that's something -- they need some parenting skills or something, you know.

CHRISTA: Right. And that's what mostly the hospital is stating, that they feel like it's just some issues with lack of supervision. You know, they're not -- you know, they won't make statements.

LIEUTENANT MILLER: Yeah.

CHRISTA: You know, I've had a case like this before and the baby really was being shaken, and, I mean, it took -- it took like three -- three separate cases of the baby getting shaken before the doctors would say it is because of this and, you know, give us

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

LIEUTENANT MILLER: Yeah. And plus, they've already carried this child four times to doctors before they ever took it to the hospital again, you know.

CHRISTA: See, yeah. I know. They took -- you know, took the child to PMC, Riverview, to pediatric doctors.

LIEUTENANT MILLER: Sunshine or whatever.

CHRISTA: Levine. Yeah.

LIEUTENANT MILLER: You know --

CHRISTA: Yeah. They took the kid all over the place. So it's not that they're not trying to -- you know, they're not neglecting it --

CHRISTA: Right.

LIEUTENANT MILLER: -- as far as being sick, but, you know, let's just --

CHRISTA: I'll --

LIEUTENANT MILLER: If you can get me all that paperwork --

CHRISTA: I will.

LIEUTENANT MILLER: -- over here, I'll --

CHRISTA: I'll get it to you today.

LIEUTENANT MILLER: -- I'll look at it and I'll -- I'll

let you know what we're going to do with it.
CHRISTA: Okay.
LIEUTENANT MILLER: At the most -- at the most I see maybe tracking the uncle down, talking to him.
CHRISTA: Yeah. Yeah. And, shoot, I know Devondra kept going out there. We -- we -- I mean, she was out -- I don't know if she's made contact with them again yet or not, but she's been having a hard time every time she goes out, they're not -- they're not there or either the grandmother's there and says they're not there.
LIEUTENANT MILLER: Well, and my thing is, I'll be leaving them a message: Somebody better be there at a certain time --
CHRISTA: Uh-huh.
LIEUTENANT MILLER: -- and, you know, either show up, or next time I show up, I'm going to have some paperwork with me.
CHRISTA: Yeah, I know. Well, I'm going to talk to her about it. She's pretty bad about doing that, and I figured that she had. I had mentioned it to her earlier this week -- you know, asked her if she had sent it over to you guys.
LIEUTENANT MILLER: Yeah.
CHRISTA: She's supposed to make it with 24 hours, so --

LIEUTENANT MILLER: Right.
CHRISTA: -- if that happens, please let me know because that's a big problem.
LIEUTENANT MILLER: Well, again, like I told you, if -- if they're working on it and maybe in two days they're going to have all the information and they're working that hard on it --
CHRISTA: Uh-huh.
LIEUTENANT MILLER: -- I don't have a problem with -- don't send -- you know, I'd rather them do that than send me the front cover sheet --
CHRISTA: Yeah, I know.
LIEUTENANT MILLER: -- you know, with just everybody's name on it and what was alleged instead of any follow-up with it.
CHRISTA: Uh-huh.
LIEUTENANT MILLER: You know, I'd rather them do that. And I know 24 hours -- you can't do that stuff sometimes in 24 hours.
CHRISTA: Yeah, I know that.
LIEUTENANT MILLER: So I don't have a -- I'm not complaining about the problem -- the problem was that I got it today ten days late --
CHRISTA: Uh-huh.
LIEUTENANT MILLER: -- and to me -- the -- without that

other paperwork that you're talking about, it was an emergency to me.

CHRISTA: Right. And it's not.

LIEUTENANT MILLER: Right.

CHRISTA: Yeah.

LIEUTENANT MILLER: So that's all I'm asking for is if I can get the paperwork. You know, if you're going to send me something late, send me all of it.

CHRISTA: Okay. I will send it to you, Lieutenant Miller. I'll get it to you this afternoon.

LIEUTENANT MILLER: Okay. I thank you very much.

CHRISTA: All right. You're welcome.

LIEUTENANT MILLER: Thanks for calling me back.

CHRISTA: Oh, no problem. You have a good day.

LIEUTENANT MILLER: You too.

CHRISTA: All right. Bye-bye.

LIEUTENANT MILLER: Bye-bye.

(End of recording.)

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Exhibit 8

WSOCTV.com

Social Services Actions Questioned In Abuse Case

Posted: 6:01 pm EST January 13, 2010

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ROCK HILL, S.C. -- Four-month-old Owen [redacted] young life is moment to moment. He's in intensive care at Levine Children's Hospital following what sheriff's investigators call an assault by his father. They believe he was violently shaken at the family's Rock Hill home.

"He's fighting for his life," said the baby's grandfather, Larry Williams. On Wednesday, Williams and his wife Charlotte told Eyewitness News that their grandson would not be in the hospital if the Department of Social Services had acted sooner.

"If they had done an investigation my grandson would not be fighting for his life," Williams said. "It should've never gotten this far."

That's because the infant was at Levine Children's Hospital before, in early December. At that time he had bleeding on the brain, which doctors told the family was an injury caused by shaking. Larry and Charlotte Williams said DSS of York County spoke to their daughter and her boyfriend after that first incident, but didn't do enough.

"At that point right there they could've interviewed him at the hospital, and possibly gotten a confession then for that incident, and we wouldn't be in critical condition now," Charlotte Williams said.

On Monday, the father, 18-year-old Michael [redacted] and the child's 19-year-old mother brought the baby to Piedmont Medical Center in Rock Hill.

They told police the baby was jerking and shaking uncontrollably.

The baby was transferred to Levine Children's Hospital, and within hours [redacted] was arrested and charged with unlawful conduct toward a child. He is in jail with no bond.

The Williams' want to know why action wasn't taken after the first time the baby was hospitalized.

Eyewitness News contacted officials at the state DSS office in Columbia. They told us they could not comment on the case, and gave us this statement:

"The Department of Social Services is prevented by confidentiality laws from releasing information about its involvement with this family. The department is looking into the questions the grandparents have raised," said DSS spokeswoman Virginia Williamson.

It's not clear if the DSS investigation was still active following the infant's injuries and hospitalization five weeks ago.

Larry Williams says he knows there is blame for what deputies say [redacted] did, but he didn't want to speak badly about the father of his grandchild.

"He knows what he did was wrong. He knows that." Williams said.

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Teen dad sentenced to 8 years for shaking infant son

Father inflicted brain damage in last year's incident

By Kimberly Dick - kdick@heraldonline.com

Michael [redacted] has seven more years behind bars to think about the life sentence he imposed on his son.

[redacted] now 19, pleaded guilty Thursday to charges related to nearly shaking his son to death when he was 4 months old at their Rock Hill home.

His son, Owen, now 16 months old, faces a lifetime of rehabilitation and care as a result of brain injuries suffered after being shaken last January, said 16th Circuit Assistant Solicitor Erin Joyner.

JIM STRATAKOS

Michael [redacted] leaves the courtroom Thursday at Moss Justice Center after being sentenced to eight years in prison for shaking his 4-month-old son last January. Below, Owen [redacted] is shown at Piedmont Medical Center on Jan. 11, 2010. At top, now-16-month-old Owen has developed slowly because of severe brain damage.

"I do think Owen has a life sentence," his mother Kayla Lythgoe said, before asking the judge not to let her son's father be put on probation. "I think Michael should be punished."

[redacted] pleaded guilty to inflicting great bodily injury on a child and unlawful conduct toward a child.

Circuit Court Judge Michael Nettles sentenced [redacted] to eight years in prison, with credit for the year he has spent in jail since his son was injured.

Nettles said it was difficult to determine a sentence for [redacted] because he wasn't a criminal by nature. The inflicting great bodily harm charge carries a maximum sentence of 20 years.

"You made an error in judgment and need to be held responsible," Nettles told [redacted] before announcing his decision. "What you've done has altered a human being's life forever."

There were no negotiations or sentencing recommendations in this plea.

[redacted] originally denied any part in his son's injuries, and then changed his story, saying he dropped Owen and the baby was injured tumbling down stairs, Joyner said. After investigators confronted him, [redacted] admitted to getting frustrated with his crying son and shaking him.

[redacted] said he didn't immediately take his son to the hospital because he didn't want the child's mother to be angry with him.

Owen was having seizures and had refused feedings when he was taken to Piedmont Medical Center on Jan. 11, 2009. He was moved to Levine Children's Hospital in Charlotte, where he spent several days in intensive care.

Brain scans showed severe brain damage from lack of oxygen, Joyner said, and Owen had scratches and bruises on his body.

Doctors decided to remove him from life support. After a few days, he started to improve. He has made modest improvement over the past

year. Doctors say Owen might never walk, talk or eat on his own.

Defense attorney Melissa Inzerillo said her client has been remorseful since the incident and has wanted to do whatever is best for Owen.

[redacted] parents spoke in court, and letters were written to the judge about how the incident was "out of character for him."

"Unfortunately, what we see in this case is a moment of frustration," Inzerillo said, "a moment with (repercussions) through many people's lives."

Owen's maternal grandparents, Larry and Charlotte Williams, said they would have preferred a more severe punishment.

"The sentence was a little bit light simply because if Owen had died, it would have been more of a sentence," Larry Williams said. "He didn't die, but his quality of life did."

Kimberly Dick 803-329-4082

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After being shaken, Rock Hill baby is alive but faces years of rehab

Kimberly Dick - The Herald - Kdick@heraldonline.com

The January attack so badly injured Owen [redacted] brain that doctors said the 4-month-old "would basically be a vegetable."

Owen couldn't move, eat or drink, and tests showed damage to most of his brain.

His mom and grandparents agreed to end life-support efforts. They moved Owen to a Rock Hill hospice, and they learned about baby caskets.

Owen [redacted] smiles for a photo before being injured. Photo courtesy of Charlotte Williams.

"Going into the hospice, we were really fearful," said Larry Williams, Owen's grandfather. "We knew we were going there to watch our grandbaby die."

Then Owen's mouth made a sucking motion.

Shaking uncontrollably

Just days earlier, Owen's parents – Michael [redacted] 18, and Kayla Lythgoe, 19 – had taken the infant to Piedmont Medical Center because he was having seizures, according to a police incident report. He was jerking and shaking uncontrollably.

Owen also was bleeding from the brain. Doctors at PMC sent the baby by helicopter to Levine Children's Hospital in Charlotte, where he spent several days in critical condition.

Back in York County, police said Owen had been shaken. On Jan. 12, a day after Owen was taken to the hospital, authorities charged Michael [redacted] with unlawful conduct toward a child. [redacted] remains in jail without bond, awaiting an initial court hearing later this month.

[redacted] attorney, Melissa Inzerillo, declined to comment.

Lythgoe has not been charged in the incident, York County Sheriff's Office Capt. Jerry Hoffman said. Her mother, Charlotte Williams, said Lythgoe was not home when the baby was injured.

Charlotte and Larry Williams said they would speak for the daughter for this story.

At Levine Children's Hospital, doctors told Owen's family that tests showed 70 percent of the baby's brain was damaged.

"If we chose to keep him alive, the doctors told us Owen would basically be a vegetable," Charlotte Williams said.

On the advice of doctors, the 4-month-old's family removed the tubes that fed Owen and supported his breathing. "They said eventually he'll just get exhausted and stop breathing," Charlotte Williams said.

His family took him to the Wayne T. Patrick Hospice House in Rock Hill for the baby to live what they thought would be his final days on a morphine drip.

Going to hospice

Dr. Amy Robbins, Owen's attending physician at hospice, said that when the baby arrived a week after being injured, he appeared to be a normal 4-month-old. But his brain wasn't telling his body to do the things it should -- he couldn't eat or drink on his own.

Charlotte Williams recalled the moment she and her daughter realized that the covers of baby caskets aren't split in half like adults'.

"I remember my daughter and I saying, 'Oh no, he needs new shoes for the funeral,'" she said.

But after Owen's first 24 hours in hospice care, the family got a flicker of hope. Owen started to form a sucking motion with his mouth, which he hadn't done since the injury, Robbins said.

"It was clearly a change for the better," Robbins said.

They started giving Owen small drops of water, unsure of whether his body knew how to swallow, Robbins said.

"They told us his body wouldn't know what to do with food," Charlotte Williams said. "That it could end up in his lungs and kill him."

From the moment he started sucking, Robbins said, Owen continued to get better. He began to take a bottle, which he couldn't do at the hospital, she said.

"Over the 24-to-48 hours after he got here, he just dramatically changed to where he was crying and fussing when he had a messy diaper," Robbins said. "He was acting more like a normal baby."

He started using parts of his body that doctors said he'd never use, Charlotte Williams said.

A touching moment for Robbins came during one of her examinations of Owen.

"I was holding him," she said, "listening to his heart with a stethoscope, and he moved his arm and pinched the skin on the back of my hand -- hard. He had no movement in that hand and arm before that."

That helped convince Robbins that Owen didn't need hospice; he needed a rehabilitation center.

Just six days after he entered the Rock Hill hospice, Owen was driven back to Levine Children's Hospital, part of the Carolinas Medical Center system.

He cried the whole way.

"You don't normally walk out of hospice with life," Larry Williams said. "That was the brightest day of the experience. We've been excited since."

Robbins said the Wayne T. Patrick Hospice House has had many adults "graduate" to other facilities and live meaningful lives. But Owen was the first baby the hospice has cared for.

Why did he get better?

"I think my best medical explanation is that babies and their brains are incredible and resilient," said Robbins, medical director of the hospice. "They just have the ability to overcome insults that adults can't."

Rehabilitation

Owen remains at the Levine Children's Hospital, where he undergoes daily physical therapy. The staff works with him on motor skills and coordination.

He breathes and eats on his own, and he no longer has seizures, according to his grandparents. But simple tasks for a 4-month-old, like lifting his head or chewing on his hand, need to be re-learned after those muscles are strengthened.

Owen can hear, but his grandparents are worried about his eyesight. Charlotte Williams said the baby has about 25 percent vision. He can see shadows and lights, but his eyes aren't following items, she said.

"He's a survivor; he beat death, like, four times," said Larry Williams, senior pastor at Family Faith Christian Center in Rock Hill.

He attributes a lot of Owen's recovery to the power of prayer and faith.

"We've really gone through a whole lot," Larry Williams said. "Fear can paralyze faith; just have to have faith in God. He performs miracles."

Charlotte Williams said the family has received a lot of support from family and friends.

"We had a prayer chain going all over the country for him," Williams said. "For him to be alive and doing what he's doing now, it's a miracle."

She described her daughter as "devastated, but strong."

"She's lost a lot," she said. "Her boyfriend's in jail, and she almost lost her son."

Owen was never in day care, Charlotte Williams said, and there was no indication that anything was wrong at home or that Owen was injured before he started having seizures.

Despite Owen's injuries, his grandparents preach forgiveness. But they believe justice needs to be done.

The infant faces years of rehabilitation. Doctors have told the family he might not sit up until he's 2 years old. Babies typically can do that

between 4 and 7 months.

"He has a long way to go," Charlotte Williams said. "He's beaten all the odds so far, so he'll make it."

Owen is scheduled to clear another major hurdle on Friday.

Less than a month after the baby was removed from life support, his mom and grandparents plan to take Owen home.

Raising awareness

Charlotte and Larry Williams want to help educate young parents on the dangers of shaking a baby.

They've started the Owen [redacted] Foundation to help raise money for Owen's rehabilitation and the education of other teenage parents.

"We want to raise awareness for shaken baby syndrome," Charlotte Williams said. "You'd hear the phrase, 'never shake a baby,' and now that it's hit our family, it's much more than a phrase.

"Many lives changed because of one decision that was made."

Charlotte plans to raise awareness with a program and skit that first preaches abstinence. It also teaches about the risks and side effects of shaking babies.

"It's OK to put the child down and walk out. Get a neighbor, friend, relative to help. Parents lose it, and they are just not aware of what shaking can do."

Charlotte's goal is convince lawmakers to make it mandatory for teenage parents to take a class.

"They shouldn't be released from the hospital if not educated on the dangers," Charlotte said. "If we end up raising awareness cross-country, it would be so cool. We never thought about it, but here we are."

WANT TO HELP?

Donations for the Owen [redacted] Foundation can be made at Founders Federal Credit Union.

What happens with shaken baby syndrome

The brain rotates within the skull cavity, injuring or destroying brain tissue.

When shaking occurs, blood vessels feeding the brain can be torn, leading to bleeding around the brain.

Blood pools within the skull, sometimes creating more pressure within the skull and possibly causing additional brain damage.

— From the National Center on Shaken Baby Syndrome

Long-term consequences

Learning and physical disabilities

Visual disabilities or blindness

Hearing impairment and speech disabilities

Seizures

Behavior disorders

Cognitive impairment

— From the National Center on Shaken Baby Syndrome

Want more?

For more on shaken baby syndrome, go to dontshake.org.

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Abused Rock Hill baby showing signs of recovering

Local case helps raise awareness about detection

By Kimberly Dick - kdick@heraldonline.com

A baby shaken nearly to death earlier this year continues to improve.

Owen [redacted], now 6 months old, was removed from life support and taken into hospice care days after his father, 19-year-old Michael [redacted], was charged in his assault.

Today, months after his hospice stay, Owen is recovering. Even the hospice doctor couldn't explain Owen's recovery.

Baby Owen while in hospice care in Rock Hill.

His grandmother, Charlotte Williams, said, "He's doing really well. He has a lot of his movement back. He's kicking, swinging his arms, laughing and giggling."

Owen is one of several area children abused this year whose parents face abuse-related charges. In one of those cases, a Rock Hill baby girl was killed after being injured by her father, police say.

Today starts National Child Abuse Awareness Month, and Owen's family and area officials urge those in contact with children to look for signs of abuse and neglect.

"The hardest thing is to recognize that there's anything happening, even if it's in your own home," Williams said. "It's good to learn to recognize signs of abuse."

Owen's eyesight, which was something doctors worried about when he was at Levine Children's Hospital in Charlotte a couple months ago, is returning, Williams said. Owen is tracking light and should be seeing normally in a few months, she said.

However, he still struggles to pick up his head and is fed from a tube, she said.

Mary Everhart, a retired law enforcement officer who investigated nearly 300 child deaths with the State Law Enforcement Division, works for the Children's Law Center at the University of South Carolina and trains people how to spot and interview a possibly abused child. She spoke this week in Rock Hill's Community Performance Center to a group of women - mostly educators - who have contact with children regularly.

"For there to be child abuse, there needs to be a child and an adult that did something or failed to do something that resulted in the child being hurt," Everhart said.

Most reported abuse happens to a child 3 years old and younger, Everhart said. And that's the case in recent York and Lancaster County abuse arrests.

Last weekend, a Catawba woman was charged with child neglect in a case where a toddler was taken to Carolinas Medical Center in Charlotte with injuries. The 1-year-old girl was bruised and had possible head and neck injuries that 22-year-old Meagan Shelley attributed to falls on cement and off a porch last week, according to York County Sheriff's Office reports.

Christian Brown, 23, of Indian Land was charged in February with unlawful conduct toward a child after his 2-year-old was hospitalized with first- and second-degree burns.

In January, Curtis Randall Sweatt Jr., now 27, was charged with homicide by child abuse in the Friday death of his 4-month-old daughter. Sweatt is accused of injuring the child before she died.

A few days later, Michael [redacted] was charged with unlawful conduct in the shaking of his son, Owen, that caused near-fatal injuries. [redacted] remains in jail awaiting the prosecution of this case.

Owen is being cared for by a foster family while his mother works with the Department of Social Services, Williams said. Owen's mother is taking parenting classes and participating in therapy in hopes of being cleared by DSS to have full custody again. DSS could not be reached for comment Wednesday.

There are fewer reports of abuse of older children, Everhart said, but that doesn't mean it's not happening.

"They learn to tell stories to cover it up," Everhart said. "They often tell lies about injuries, and it's easier for someone to believe that than ask more questions."

But asking questions is all someone needs to do to identify possible abuse, she said. A lot of injuries to children are accidental, so people need to question the

But asking questions is all someone needs to do to identify possible abuse, she said. A lot of injuries to children are accidental, so people need to question the child about what happened.

Peggy Payne, executive director of Safe Passage, a domestic abuse advocate, said a dramatic change in a child's behavior is often a sign of abuse. Also, she said to look for warning signs such as bruises or becoming accident prone.

"Don't ignore the obvious," Payne said. "Even if it's a good family that goes to church. ... Abuse happens in all families. I want people to realize that if they feel something is wrong, they need to act. It could be only hope a child has."

Reports of suspected abuse should be made to DSS or a local law enforcement agency, Payne said.

In South Carolina, neglect is the No.1 reported type of abuse, Everhart said.

"Poverty by itself is not neglect," she said. It's failing to provide a basic need such as food, shelter or medical care if the family has the financial means to do so.

This year, there have been abuse charges in Rock Hill in cases where children were left home alone.

A Rock Hill man was charged in early March with unlawful neglect after he told police his 3-month-old daughter was alone in an apartment. In February, a 42-year-old mom was charged with unlawful conduct toward a child after her three children, ages 10, 9 and 6, were left alone overnight.

There's no law in the state that says how old a child needs to be to stay home alone, Everhart said, it depends on the circumstances.

For National Child Abuse Month, Williams said her family is making blue ribbons to pass out at Family Faith Christian Center in Rock Hill, where her husband is a pastor, to raise awareness.

"A lot of the community pitched in and prayed for Owen when he was hospitalized," Williams said. "Our prayer is to get him home and work with him to eat and drink like a normal child."

Signs of maltreatment

Sudden changes in behavior or school performance

Untreated physical or medical problems

Always watchful, as though preparing for something bad to happen

Overly compliant, passive or withdrawn

Comes to school or other activities early, stays late or does not want to go home

Signs of physical abuse

Unexplained burns, bites, bruises, broken bones or black eyes

Injuries in the shape of an object

Bruises in various stages of healing

Attempts to hide injuries

Shrinks at the approach of adults

Signs of neglect

Frequently absent or late to school, scheduled events

Always hungry, begs or steals food

Consistently tired

Slow physical development or underweight

Lacks needed routine medical or dental care

Poor hygiene

Lacks appropriate clothing for weather

SOURCE: The Children's Law Center

Kimberly DICK HDS: 329-4082

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Exhibit 9

700 **Introduction**
Revision Number: 10-01, Effective Date: 01/14/2010

STATUTES AND REGULATIONS

Statutes and Regulations 766 that relate directly to the contents of the Child Protective and Preventive Services Manual are: South Carolina Code of Laws, Title 63 - South Carolina Children's Code; 27 South Carolina Code Annotated Regulations 114-4510 through 114-4550 (Governs Child Protective Services Involving Institutions).

OTHER AGENCY POLICIES

Related guiding principles and policies which govern the Department of Social Services follow.

The guiding principles mandate the following:

Principle: 1. To respect the humanity and dignity of each person for whom the agency delivers quality services.

Principle: 2. To respect the humanity and dignity of each staff person.

Quality Service
It is the policy of the Department of Social Services to promote a work environment that encourages each staff person in the Department of Social Services to perform each duty exactly as required or cause the requirement to be officially changed to what the agency and its clients really need.

MISSION STATEMENT FOR CHILD PROTECTIVE AND PREVENTIVE SERVICES

Child Protective and Preventive Services are offered to families by the South Carolina Department of Social Services which is mandated by law to protect children from abuse or neglect within their families, in foster care, or by persons responsible for the child's welfare as defined by statute. Services are provided to strengthen families; to enable children to remain safe in the home; to temporarily remove from parental custody a child who is at imminent risk of harm; or to pursue termination of parental rights and assure the child permanency in a substitute family if the custodial family cannot be preserved without serious risk to the child. The child is our primary client in child protection cases and the following goals for children and families have been defined by federal law and good practice standards.

• **Safety.** All children have the right to live in an environment free from abuse and neglect. The safety of children is the paramount concern that must guide child protection efforts.
• **Permanency.** Children need a family and a permanent place to call home. A sense of continuity and connectedness is central to a child's healthy development.
• **Child and family well-being.** Children deserve nurturing environments in which their physical, emotional, educational, and social needs are met. Child protection practices must take into account each child's needs and should promote healthy development.

PHILOSOPHICAL TENETS OF CHILD PROTECTION

The importance of the family in U.S. society is central to the Nation's history and tradition. Parents have a fundamental right to raise their children as they see fit, and society presumes that parents will act in their children's best interest. When parents do not protect their children from harm and meet their basic needs—as with cases of child abuse and neglect—society has a responsibility to intervene to protect the health and welfare of these children. Any intervention into family life on behalf of children must be guided by State and Federal laws, sound professional standards for practice, and strong philosophical underpinnings. This section presents key principles underscored in Federal legislation and the philosophical tenets on which the community's responsibility for child protection is based.

The following philosophical tenets expand upon the principles set forth in the Adoptions and Safe Families Act enacted in 1997 and in subsequent federal law, and the values that underlie sound practices in community responses to child abuse and neglect.

• **Prevention programs are necessary to strengthen families and reduce the likelihood of child abuse and neglect.** Child maltreatment results from a combination of factors: psychological, social, situational, and societal. Factors that may contribute to an increased risk for child abuse and neglect include, for example, family structure, poverty, substance abuse, poor housing conditions, teenage pregnancy, domestic and community violence, mental illness, and lack of support from extended families and community members. To reduce the occurrence of maltreatment, communities should develop and implement prevention programs that support children and families.

• **The responsibility for addressing child maltreatment is shared among community professionals and citizens.** No single agency, individual, or discipline has all the necessary knowledge, skills, or resources to provide the assistance needed by abused and neglected children and their families. While public child protective services (CPS) agencies, law enforcement, and courts have legal mandates and primary responsibility for responding to child maltreatment, other service providers working with children and families—along with community members—play important roles in supporting families and protecting children. To be effective in addressing this complex problem, the combined expertise and resources of interdisciplinary agencies and professionals are needed.

• **A safe and permanent home is the best place for a child to grow up.** Most children are best cared for in their own families. Children naturally develop a strong attachment to their families and when removed from them, they typically experience loss, confusion, and other negative emotions. Maintaining the family as a unit preserves important relationships with parents, siblings, and extended family members and allows children to grow and develop within their own culture and environment.

• **When parents (or caregivers) are unable or unwilling to fulfill their responsibilities to provide adequate care and to keep their children safe, CPS has the mandate to intervene.** Both laws and good practice maintain that interventions should be designed to help parents protect their children in the least intrusive manner possible. Interventions should build on the family's strengths and address the factors that contribute to the risk of maltreatment. Reasonable efforts must be made to maintain child safety and keep the children with their families except when there is significant risk to child safety. Referral to court and removal of children from their families should only be done when it is determined that children cannot be kept safely in their own homes.

• **Most parents want to be good parents and have the strength and capacity, when adequately supported, to care for their children and keep them safe.** Underlying CPS intervention is the belief that people have the strength and potential to change their lives. Professionals must search for and identify the strengths and the inner resiliencies in families that provide the foundation for change.

• **To help families protect their children and meet their basic needs, the community's response must demonstrate respect for every person involved. All people deserve to be treated with respect and dignity.** This means showing respect for a person, while not necessarily approving or condoning his or her actions. In addition to caregivers and children, service providers should demonstrate respect for mothers, fathers, grandparents, other family members, and the family's support network.

• **Services must be individualized and tailored.** While people may have similar problems, there are elements that will vary from family to family. In addition, each family's strengths and resources are different. The community's response, therefore, must be customized to reflect the particular circumstances, strengths, and needs of each family.

• **Child protection and service delivery approaches should be family centered.** While noting that the child is our primary client, we believe that parents, children, their extended families, and support networks (e.g., the faith community, teachers, health care providers, substitute caregivers) should be actively involved as partners in developing and implementing appropriate plans and services to reduce or eliminate the risk of maltreatment. Tapping into the strengths and resources of a family's natural support network is fundamental to enhancing family functioning.

• **Interventions need to be sensitive to the cultures, beliefs, and customs of all families.** Professionals must acknowledge and show respect for the values and traditions of families from

diverse cultural, ethnic, and religious backgrounds. To become culturally competent, professionals must first understand themselves and the effects of their own background on their values, behaviors, and judgments about others. In working with children and families different from themselves, professionals need to be aware of the context of the family's culture and background in order to help provide access to culturally relevant services and solutions.

• **To best protect a child's overall well-being, agencies must assure that children move to permanency as quickly as possible.** Along with developing plans to facilitate reunification of children, agencies must develop alternative plans for permanence from the time the child enters care. For those children who cannot be safely reunified with their families, timely efforts must be made to ensure a stable, secure, and permanent home for the child through adoption or other permanent living arrangements.
Note: The mission statement and philosophical tenets of foster care are contained in Chapter 8.

701 Policies

Revision Number: 10-01, Effective Date: 01/14/2010

This section specifies the policies of the Department of Social Services that guide all practice and procedure associated with Child Protective and Preventive Services.

1. Persons referred for child protective services are eligible without regard to income.

2. Staff must successfully complete the agency's child welfare services certification program prior to being assigned the child protective services intake or assessment function.

   After successful completion of the program specific component of the child welfare services certification program (currently Phase 1 & 2), staff may provide treatment services under close supervision of certified program management staff. Under close supervision, staff who have not completed any certification training may provide case support services such as transportation of clients, arranging and observing visits, making referrals, follow up on medical reports, and other similar duties.

   All staff are expected to maintain a level of professional expertise through ongoing training on child abuse and neglect.

3. Only certified staff of the Department are authorized to screen referrals made to Child Protective and Preventive Services in order to ensure that the screening decision is in compliance with SC Code of Laws and agency policy.

4. The Department shall use a standardized procedure of casework practice for assessing safety and risk, and providing, documenting and terminating child protective services to families and children.

5. When the agency receives a referral that involves the use of illegal drugs by the parent or other person responsible for the child's welfare and there is an allegation that the parent's behavior has harmed or places the child at substantial risk of harm, the agency will accept this as a report of suspected abuse and neglect and complete a thorough investigation, to include the safety assessment, to determine if children are unsafe and if parental behavior has caused harm or placed the child at substantial risk of harm. Please note that nothing in this statement is intended to minimize the importance of assessing issues of domestic violence, mental health concerns, or other family dynamics that impact on child safety.

6. The State Child Fatality Advisory Committee is established and authorized by state statute to review the circumstances surrounding the unexpected and unexplained deaths of children. (Reference SC Code of Laws Ann. §63-7-1900) The SCFAC is a multidisciplinary group composed of child advocates, medical professionals, law enforcement, coroners, and representatives of state agencies with responsibility for services to children and families. By virtue of their professional expertise and because of the direct access to law enforcement investigations of child deaths, the SCFAC may receive information that leads them to believe that surviving siblings of a deceased child are at substantial risk of harm.

   Therefore, it is the policy of DSS that when the State Child Fatality Advisory Committee has reason to believe that a risk of harm exists and makes a report, that this report shall be investigated by the Department of Social Services pursuant to SC Code of Laws Ann. §63-7-920 and agency policy.

   The DSS representative to the SCFAC will assume responsibility for ensuring that an investigation is initiated in compliance with statute and policy and will obtain and provide to the county investigating any documentation the SCFAC can by statute release to DSS. The DSS representative will be responsible for reporting back to the SCFAC at the conclusion of the investigation at the next regularly scheduled meeting of the committee.

7. The policy and practice standard of the department is that Child Protective Services staff will conduct at least one face to face interview once a calendar month with the victim child, siblings and any other children in the home, and parents, protective adult, and/or other caregiver during the time a case is open for child protective services. The purpose of this visit is to assess for child safety and to assess progress toward meeting treatment goals to reduce future risk of harm. Additional visits should be made as determined on a case by case basis given the issues specific to each family.

8. The agency should pursue removal of children from a home where:

a. parents' use or abuse of or dependence on alcohol and/or other drugs and/or any other factors such as domestic violence or mental health, leads to endangering the safety of the child **and**
b. there is no other protective caregiver in the home or otherwise available.

9. In order to close a CPS treatment case with the child in the home when parents have been abusing or are dependent on alcohol and other drugs and/or when any other factors such as domestic violence or mental health problems have caused the child to be unsafe, there must be documentation in the agency record of the following:

   1. The parent/caregiver in question must be involved in a treatment program designed to change the behaviors that made the child unsafe and demonstrated significant progress on the treatment plan goals and there is a second person in the home who is the protective caregiver **and** DSS case consultation has taken place with the treatment provider(s) and sufficient changes in behavior have been made that eliminate the safety threats and reduce risk of future harm.
   OR
   2. The parent/caregiver has completed treatment and the caregiver has demonstrated observable behavioral changes in their ability to keep the child safe **and** DSS case consultation has taken place with specific treatment provider(s) and sufficient changes in behavior have been made that eliminate the safety threats and reduce risk of future harm.

   In general, case closure requires that the parental behaviors that led to the child being unsafe have been changed and the agency can articulate the reasons that support the belief that the child is now safe in the parent's care.

10. The Department is authorized to provide a process for the review and amendment of cases indicated for child abuse or neglect pursuant to §63-7-920, which are not otherwise being brought before the family court for disposition. This process is authorized and defined under SC Code of Laws Ann. §63-7-1410.

11. It is the policy of the Department that in cases indicated under §63-7-920 where the individual determined by a preponderance of the evidence to have abused or neglected the child, disagrees with or challenges the case decision and the safety of the child is in question, the case MUST be taken to Family Court for review of the child safety concerns and a finding on the child abuse case decision.

    In cases where treatment services are to be provided or are reasonably expected to be provided and the individual or family disagrees with the indicated decision and/or the decision to deliver services, those cases MUST be taken to Family Court. There can be little effective treatment and the safety of the child is in question when there is no acknowledgement of the abuse or neglect. The Administrative Appeals process cannot coerce treatment nor address child safety.

INTRODUCTION TO PROCEDURES

The following sections, 710 through 740, include a step by step outline of procedures related to job functions of the Child Protective Services Unit in each County Office for Child Protective and Preventive Services. These procedures are written with an awareness that successful implementation requires a coordinated effort that involves a broad range of community agencies and professionals, ongoing supervision, consultation and support for staff, as well as the allocation of adequate resources as mandated by the South Carolina Code of Laws. These procedures are intended to be applied in conjunction with the Children's Code as amended, the Indian Child Welfare Act and other pertinent laws. **(See Section 750, Children's Code, South Carolina Code of Laws and the Indian Child Welfare Act (ICWA))**

NOTE: The automated system referred to in Procedures is the Child and Adult Protective Services System (CAPSS). Please refer to CAPSS Handbook for data entry guidance to navigate the system.

NOTES: The agency's safety and risk assessment and service planning document is the Child and Family Assessment and Service Planning Tool (CFASP), DSS Form 30231.

Reference Section 710.01 provides specific intake screening criteria and standards for decisions at intake, to include the urgency of response, working with reporters and families at intake.

For local operating and communications procedures between local Law Enforcement and DSS, refer to your county's DSS/Law Enforcement Protocol. This protocol is mandated by SC Code of Laws Ann. §63-7-620. This protocol should be reviewed annually and revised as needed.

Each county is to enter into a Memorandum of Agreement with the Children's Advocacy Center (CAC) or similar multidisciplinary abuse assessment facility that serves that county for the purpose of defining the referral process, forensic interviewing, and multi-agency case staffing procedures. (Reference SC Code of Laws Ann. §63-11-310)

710 Intake Process

Intake is the first step in the Child Protective Services casework process. It is the point at which referrals are received concerning children where the reporter has reason to believe that the child has been or is being abused or neglected. Referrals become reports after CPS intake screening criteria is applied to the information received and the decision is made to initiate a CPS investigation. From the point the decision is made to accept a CPS report, the agency is

required by state law to initiate an investigation in 24 hours. Agency policy requires that situations of an emergency nature be initiated within 2 hours.

Intake Screening Criteria

1. The person alleged to have been maltreated must be a person under the age of 18 years.
2. The person alleged to have injured the child must be a parent, guardian, caretaker or other person defined in SC Code of Laws §63-7-20.
3. There must be an allegation or a description of actual harm that has occurred to a child or is concurrently occurring with the report or the acts or omissions present a significant risk of harm in the immediate or foreseeable future to the child as defined by §63-7-20.
4. There must be reasonable means of locating the child and family.

   NOTE: Because reports can come to the agency from persons who may not know the family but who have witnessed acts of abuse, the agency has an obligation to attempt to identify and/or locate a family when the address is incomplete or vague. **The absence of a clear and specific address is not grounds to screen out what otherwise would be a report of abuse or neglect.** This can include situations such as an incomplete address or a car tag only or only a description of the location of the home. We should request assistance from law enforcement or utility services or post office or other collaterals in our efforts to identify and/or locate the family. The worker and supervisor must make and document legitimate and genuine efforts to locate a family prior to screening out the referral based on no reasonable means of locating the child and family.

Purpose: To assist the reporter in giving information needed for the Department to make a decision regarding:

a. whether or not the information shared meets the screening criteria for a child abuse or neglect investigation;

b. the urgency of the response (immediate danger or less urgent); and

c. the manner of the response - conduct CPS investigation and/or make referral (law enforcement, regulatory staff, other agencies as appropriate). Refer non-CPS situations to community resources for services as needed.

County Director

1. Ensures compliance with the state statute.

2. Ensures 24 hour coverage for child protective services referrals.

Social Service Worker/Intake Worker

3. Gathers from the reporter information necessary to determine the agency's response. Determines if the caller intends to make a report of child abuse or neglect or is requesting other services or information. Makes appropriate referrals to community services, Family Independence, law enforcement, or others as appropriate when the call is a request for assistance that is clearly not abuse or neglect related.

   Gathers information from reporter to determine if family or individual has any culturally specific concerns and/or a communication limitation (i.e., limited English proficiency, speech or hearing impaired). If such a situation exists, refers to Limited English Proficiency/Sensory Impairment (LEP/SI) Policy and Procedures in Directive Memo D02-39, dated September 23, 2002, for specific guidelines to assist the department to communicate with the family and to respect the individual's rights.

   Documents on the intake when the reporter has reason to believe that the child is a member of a federally recognized Native American tribe or nation. If report is accepted for investigation, notifies the tribal office in order to coordinate the investigation and assess for possible placement with tribal authorities. (Reference Section 754 - Indian Child Welfare Act)

4. As deemed necessary, informs the person making the referral of the provisions of §63-7-390 - Immunity for Reporters and/or §63-7-2000 - Disclosure of Bad Faith Reporting, S. C. Code of Laws, regarding immunity and disclosure.

5. Initiates intake process on automated system using CAPSS intake worksheet, completes intake on CAPSS by the end of the next working day after decision to accept referral as report. Documents on CAPSS as an intake, all calls where the reporter intends to make a report of child abuse or neglect and clearly documents the agency decision regarding the referral in the Intake Dictation section of CAPSS. Maintains records of information and referral calls as deemed appropriate by the county director for local auditing, statistical, and resource development purposes. Records of I & R calls may be entered into CAPSS or maintained on independent logs.

6. Researches any CPS or other human services involvement found in the search process to include data base, Central Registry, paper files and any prior screened out calls (any information received pursuant to §63-7-310 but not investigated by the department and classified as Unfounded Category IV) and information contained in Unfounded Categories I, II, & III reports. The purpose of this search is to use all available agency information on a family to assess for immediate safety for both child and worker and future risk issues and to make the most appropriate agency decision according to the statute. Documents results of systems search in CAPSS Intake tab. **(See S. C. Code of Laws, §63-7-340)**

7. As deemed necessary, checks other agency systems (CHIP, CSES) for prior agency records or to determine if the family is known to the agency and considers the impact of

any prior involvement on this referral. Document results of systems search in CAPSS Intake dictation. These records searches can help to identify or confirm information such as family addresses, individual's birthdates, and household composition.

8. Makes collateral contacts with professionals, such as but not limited to, school teachers, law enforcement officers, Department of Juvenile Justice, Department of Health and Environmental Control staff as necessary and appropriate to obtain information regarding the allegation. Documents contacts in dictation.

9. In consultation with supervisor, reviews and applies guidelines for referrals involving substance (includes alcohol and drugs) exposed infants and viable fetuses (currently defined by medical authorities as 24 weeks gestation) when information suggests substance abuse by the parent or pregnant woman, or person responsible. A fetus is considered to be viable if it can live outside the mother's womb, generally accepted to require a minimum of 24 weeks of gestation. **(See S. C. Code of Laws, §63-7-1660, and Section 710.01.14 and 710.01.15)**

10. Staffs with supervisor and attorney all other referrals involving the behavior of a pregnant woman who is at 24 weeks or more gestation which do not allege the use of an illegal substance but which may place the unborn child in imminent danger. Contacts Child Protective Services assigned technical assistance staff at (803) 898-7318 for assistance as needed. CPS will communicate with Foster Care and Office of General Counsel staff and coordinate technical assistance to county staff as appropriate.

11. Accepts for investigation referrals of educational neglect when it is evident that the parents have not cooperated with school officials and the school has made efforts to get the child to school and the efforts were unsuccessful due to the parents' refusal to cooperate. An example of school's efforts may include a petition to family court by the school requiring the child to attend school and the parents to cooperate with the school.

Referrals to Law Enforcement - Non-DSS

Social Service Worker/Supervisor

12. Refers allegations of suspected child abuse and neglect by school personnel involving students in nonresidential school settings to law enforcement for the purposes of police investigation. School personnel are not considered to be a "person responsible for child's welfare" as defined by §63-7-20. Allegations of suspected child abuse/neglect in foster homes, group homes, and residential child care facilities are referred to OHAN. (Refer to Section 721, Out of Home Investigations)

13. Informs mandated reporters of the mandated reporters' requirement to report to law enforcement allegations which involve persons other than the parent, guardian, or other

person responsible for a child's welfare as defined by §63-7-20. **(Reference §63-7-310, S. C. Code of Laws)**

14. Assists other reporters to refer information to law enforcement when the alleged perpetrator is not a person responsible for child's welfare by providing telephone numbers or other actions **(Reference §63-7-310, S. C. Code of Laws.)**

15. Makes report to law enforcement when, as mandated reporter, staff believes a child has been abused or neglected by a non-parent or guardian as outlined in the amended Law Enforcement/DSS Protocol **(Reference S. C. Code of Laws, §63-7-310 and §63-7-620)**

Intake Decisions

Social Service Worker/Supervisor for Intake Decision

16. In consultation with supervisor, carefully reviews and considers all information gathered to decide whether to accept the referral as a CPS report, not to accept, or place in pending status, and completes CAPSS intake process.
NOTE: when the referral involves the use of illegal drugs by the parent or other person responsible for the child's welfare and a concern for child safety, the agency will accept this as a report of suspected abuse or neglect and complete a thorough investigation, which includes the safety assessment, to determine if that parental behavior has caused harm or placed the child at substantial risk of harm. Remember that this does not minimize the importance of considering information about domestic violence or mental health or other family issues in making the intake decision.

17. Provides a response to the reporter regarding the acceptance of the report and documents whether a summarized outcome of the investigation/assessment is requested as authorized in §63-7-1990.

18. PENDS a referral only if it is clear that an involved and personally knowledgeable professional (child's school teacher, doctor, therapist, or other) has information that directly impacts on the intake decision and the referral does not already meet intake screening criteria at this point in time without that information. A referral may be pended for a maximum of 24 hours if the information is critical to the decision and can be obtained in that time. If the information will not be available in 24 hours, a decision on the referral must be made immediately and not pended. If information at intake suggests imminent risk of harm, Pending can not be used. If the referral **is placed in pending status**:

    a. In consultation with supervisor, documents the rationale for pending the referral. (Note: The documentation must specify information necessary for the referral to be accepted for investigation/assessment). Discusses with the reporter the decision to pend and helps the reporter to understand the decision.

19. Assists attorney with case preparation.

20. Assists family and youth to prepare for court by providing general information about the court process and answering questions they might have about what to expect.

21. Testifies in court.

22. If the local legal representative refuses to initiate court action or refuses to otherwise present the agency's position in court, documents the refusal in the case record along with the reasons and notifies the supervisor.

Social Service Supervisor

23. Initiates conflict resolution procedure as provided in "Attorney-Client Relationship" section of the DSS Local Legal Services Chapter in the Administration Manual. **(Refer to the DSS Local Legal Services Chapter in the Administration Manual).**

719 Child Protective Services Investigation/Assessment

Revision Number: 10-01, Effective Date: 01/14/2010

Purpose: To outline procedures: (1) to identify safety concerns and ensure the immediate safety and safety throughout the investigation/assessment of all children in the household and under the control of the alleged perpetrator; (2) to make a determination whether or not the children were abused or neglected; (3) to make a decision regarding future risk of maltreatment; and (4) to plan for agency service intervention. The order of the steps provided in the section may vary given the specifics of the report. (See Section 750, §63-7-20, §63-7-620, §63-7-920, S. C. Code of Laws)

NOTES: The agency's safety and risk assessment and service planning document is the Child and Family Assessment and Service Planning Tool (CFASP), DSS Form 30231. It has not yet been incorporated into CAPSS so documentation, unless otherwise specified, will be in the dictation sections.

For general instructions about using the automated system, see the CAPSS handbook.

For local operating and communications procedures between local Law Enforcement and DSS, refer to your county's DSS/Law Enforcement Protocol. This protocol is mandated by SC Code of Laws Ann., §63-7-620.

Refer to the Memorandum of Agreement with the Children's Advocacy Center (CAC) or similar multidisciplinary abuse assessment facility that serves that county for the purpose of defining the referral process, forensic interviewing, and multi-agency case staffing procedures.

By mutual agreement between and among state agencies and entities involved in the investigation of and services to children exposed to the manufacture of methamphetamines, the South Carolina Drug Endangered Children Protocol (SCDEC) is to be incorporated as an addendum to the DSS/LE Protocol and its provisions used in conjunction with Section 719 when investigating such situations. The county protocols are to be reviewed and revised annually and a copy sent to the Office of Community Services.

While the need for Emergency Protective Custody (EPC) must be assessed case-by-case, virtually every child exposed to the manufacture of methamphetamines will be in substantial and imminent danger and should be taken into EPC unless there is a relative identified as willing and able to protect. This action will be taken because of the significant health hazards and physical dangers presented by the actual manufacture of methamphetamines. Reference Chapter 8, Section 815.05 for specific procedures when children are removed by EPC as a result of exposure to manufacture of methamphetamines.

Social Service Worker

1. Receives report as assigned, reviews intake information with supervisor as necessary to plan for initial contact, child safety, personal safety, and to prioritize activities of initial assessment according to needs of the specific report.

2. If not completed by intake, notifies law enforcement as soon as possible but within 24 hours of receipt of all reports that include allegations of sexual abuse/assault, regardless of primary typology of the report. **(See Section 750, S. C. Code of Laws Ann. - §63-7-920)**

   Checks to see if law enforcement has made a referral to CAC. If not, makes referral as soon as possible after receipt of report, but in no more than 5 working days, to local Children's Advocacy Center (CAC) or similar multidisciplinary abuse assessment facility for medical examination by a physician, or by an advanced practice registered nurse or physician assistant who is working under the supervision of a physician who has been trained in child abuse and neglect when presenting issues include:

   a. Head injury in children less than 3 years of age, burns in children 3 years of age or younger, or fractures in a child 5 years of age or younger;

   b. bruises located on the face, neck, chest, back, buttocks with a pattern or multiple in number;

   c. any report alleging sexual abuse of a child;

d. any report involving the sexually transmitted disease in a child eleven years of age or younger; or

e. any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home.

A medical evaluation by the CAC may not be necessary:

1. if the child has already had a medical examination by a physician or other licensed healthcare provider; or

2. if the county Department of Social Services caseworker, with supervisory approval, has determined, after conducting a child safety assessment, that there are no indications of injuries as described in subsection 26(a) - (e); or

3. after consultation with the Children's Advocacy Center or similar multidisciplinary abuse assessment facility.

(See Section 750, SC Code of Laws Ann, §63-11-310)

3. Makes contact with the Family Independence/~~Food Stamp~~ Supplemental Nutrition Assistance Program (FI/SNAP) staff who might be involved with the family to gather pertinent information to assist in locating the family or in planning for worker safety at initial contact. Uses DSS Form 1600 to document communication with FI/FS staff.

4. Notifies Foster Care staff of an infant coming into the custody of DSS under the Safe Haven Act. Reference Chapter 8, Section 812.01 for additional guidance.

5. In consultation with supervisor, considers any barriers to communication known at intake, such as limited English proficiency, speech or hearing impairment. If such a situation exists, refers to Limited English Proficiency/Sensory Impairment (LEP/SI) Policy and Procedures in Directive Memo D02-39, dated September 23, 2002, and to county protocols for specific guidelines to assist in the initial and subsequent contacts with the family.

6. After consultation with supervisor, makes initial contact within two hours to start the investigation/assessment of reports where the information received at intake suggests an emergency with immediate present danger threats to children in order to assess for child safety and future risk and take steps to ensure the safety of all children in the household. Initial contact is about assessing immediate present danger. Evaluates referral for concerns related to worker safety and plans initial contact so as to minimize personal danger, to include but not limited to, requesting assistance from law enforcement when contact after normal working hours is necessary. (Reference Section 710.01.18 and .19)

Note: Consults with law enforcement as outlined in the DSS/LE and Drug Endangered Children (DEC) Protocol when report suggests imminent danger in order to plan initial contact and subsequent investigative and placement action. (Reference County DSS/LE and DEC Protocol)

Follows DEC Protocol when the report involves children at a lab site where methamphetamines are being manufactured. (Reference DEC Protocol and Chapter 8, Section 815.05)

Note: The first attempt at contact is always for direct and personal contact with the child to determine if the child is safe. If the child is not available, then immediate and personal contact with the parent, guardian or other person responsible for the child's care and welfare is to be made, with personal contact with the child to follow as soon as possible. If the attempted personal contact with the parent, guardian or other person responsible for the child's care and welfare is unsuccessful, then there must be direct contact with someone who knows about the child's situation and condition so that an informed assessment of safety can be completed with personal contact with the child to follow as soon as possible. The items below (a - d) rank the contact by order of importance. Item #c below is acceptable only when all other efforts have been exhausted without success. Documentation must clearly reflect all efforts to see the child.

a. Initiates an investigation in situations of an emergency (immediate danger) with personal contact with the involved children; or

b. Initiates the assessment by personal contact with the parent, guardian or other person responsible for the child's care and welfare when unable to see the child; for example, child hospitalized in another county; or

c. Documents attempted personal contact with the parent, guardian or other person responsible for the child's care and welfare which was unsuccessful, such as incorrect or incomplete directions, the family was not at home when an unannounced visit occurred, or efforts to coordinate the initial contact with law enforcement was unsuccessful. Documents specific attempts to locate family such as through the post office, utilities, school, Department of Corrections, Inmate Search at www.state.sc.us/scdc.

d. Attempts to locate school age children through contact with school in county or through Department of Education, Ombudsman, fax # (803) 734-0796. Sends request for search on agency letterhead stationery and include child's name, Social Security number (if known) and DOB of child in question. Also include parents or guardian's names and the last known place of school enrollment. The DOE Ombudsman will provide any information available in the school's records.

7. Initiates an assessment of all other reports as soon as possible but no later than 24 hours from receipt of the report. (Reference Section 710.01.13)

During initial contact or as soon as possible, gathers information from the child and family to identify the ethnicity (defined to include race, religion, national origin, or cultural group) and immigrant status of the child and family to determine what services might be necessary and appropriate, such as translation/interpreting, attending to specific culturally sensitive issues.

and/or for meeting state and federal law regarding unqualified or undocumented immigrants. Undocumented immigrants are eligible for protective services but may not qualify for other federally funded services.

If the information gathered supports or confirms that the child is a member of a federally recognized Native American tribe or nation, notifies the tribal office for the purpose of coordinating the investigation and possible placement with tribal authorities. Immediately staffs the case with the county attorney to assure that Indian Child Welfare Act (ICWA) required notices are provided and other procedures are followed in the event of removal of the child. See Chapter 8 Foster Care for removal and placement guidance. (Reference Section 754 - Indian Child Welfare Act)

Documents ethnicity and Native American affiliation in CAPSS.

8. Follows procedures outlined in Section 736: Death of a Child, when the investigation involves suspected abuse or neglect resulting in a child fatality.

Supervisor

9. Provides the assigned worker with guidance as necessary given worker's level of experience and expertise and the allegations contained in the report.
Ensures that an initial contact is made by the assigned worker by meeting one of the standards in #6 of this section. If the initial contact was unsuccessful, the worker must continue to try to make personal contact as appropriate considering the allegations.

Note: If personal contact has not been made by the third day or within 72 hours of receipt of a report, a staffing with the supervisor is required to consider necessary actions to locate the child and/or the child's family.
Note: Do not leave notes for the family if they are not at home. Notes raise anxiety, can make the situation unstable and possibly increase concerns for child safety.

Social Service Worker

10. Notifies the subject of the report that pursuant to §63-7-920, allegations of child maltreatment are being investigated and provides details but withholds identifying information on the reporter **(See Reference Data - S. C. Code of Laws, §63-7-920)**

11. As notice of the investigation, provides to and discusses with parents DSS Brochure 3034, Child Protective Services: A Guide for Parents, which provides information about the investigative assessment process, parents' rights and responsibilities, and possible court action as a result of this situation as required in **§63-7-920.** Answers any questions the parents may have about the process. **(See Section 750 - S. C. Code of Laws, §63-7-920)**

As mandated by federal law, also provides to the parents or other caregivers being investigated the handbook on parents' legal rights entitled Child Abuse, Child Neglect - What Parents Should Know If They Are Investigated, DSS Brochure 30230. This handbook provides parents with information on legal rights which includes but is not limited to: the CPS process; the reporter's protection and rights; the right to a lawyer; the right to be informed of court hearings; how to contact the clerk of court; the possibility of temporary placement of the children; the process for appointment of a guardian ad litem (GAL); and what information the parents need to share with the agency. (Reference Child Abuse Prevention and Treatment Act)

12. Identifies any present or impending danger threats at initial contact using guide in Part I: Assessment of Present Danger At Initial Contact. If protective action can control the threats so that the child can remain in the home, completes with the family prior to leaving the home on the initial contact a Safety Plan (DSS Form 3087) that identifies:
    a. the specific present or impending danger threats to be controlled,
    b. the parents' willingness to cooperate,
    c. description and confirmation of who can and will be the protector of the children,
    d. description of the safety services that will control the threats, and
    e. timeframes for action and oversight.

    NOTE: The initial Safety Plan is to be used at this point to control immediate present danger safety threats (threats acting now, readily identifiable, serious and threaten immediate safety of child) if identified and must be completed before leaving the setting. If no present danger is identified, a Safety Plan is not required at initial contact. The Safety Plan developed at initial contact is immediate, short-term, and sufficient to provide responsible adult supervision and care to allow for the completion of the investigation. Its purpose is to suspend what is going on in the family long enough to complete an investigation,

    Documents reasonable efforts to prevent removal by identifying the safety services or actions necessary for each child to live safely at home or with a relative or friend. Documents on the Safety Plan when a child is at imminent risk of removal by checking YES or NO.

    Note: The Safety Plan at initial contact may include an alternative caregiver arrangement as described in SC Code of Laws Ann., §63-7-920 when a child can be diverted from foster care. See # 20 for steps to determine if the agency can agree to the alternative caregiver arrangement.

13. Documents the information regarding the initial contact including the date, time, individuals present, location of the meeting and the outcome in the CAPSS automated system within five working days.

14. Completes formal staffing of assessment with supervisor no later than ~~five~~ seven working days after the report is received and as necessary throughout the investigation/assessment.

Documents staffing in CAPSS using format of DSS Form 3062 (summary of current situation, recommendations for next steps, persons involved in staffing). Use of the DSS Form 3062 in supervisory staffing is at discretion of supervisor.

If necessary, requests DSS attorney to prepare and submit an affidavit and petition for an inspection warrant if the investigation/assessment cannot be completed without it. **(See Section 750, S. C. Code of Laws,** §63-7-920)

15. Gathers information necessary to analyze the current functioning of the children and family and determine if children are safe using the six fundamental assessment questions that inform the safety assessment decision.

1. What is the extent of maltreatment?

- The kind and specific description of the maltreatment
- The severity of the maltreatment
- The specifics of the events, injuries and conditions present.

2. What are the circumstances surrounding the child maltreatment?

- The caretakers' explanation of what happened, the injuries and related conditions including the child's condition.
- History and duration of the situation
- Co-existing factors and conditions such as substance abuse or mental health
- Contextual issues, such as use of instruments, acts of discipline, threats, and caregiver intentions
- Caregiver acknowledgement and attitude about the maltreatment

3. How does the child function on a daily basis?

- Capacity for attachment
- General mood and temperament
- Intellectual functioning
- Communication and social skills
- Expressions of emotions/feelings
- Behavior
- Peer relations
- School performance
- Physical and mental health
- Vulnerability
- Functioning within cultural norms

4. What are the disciplinary approaches and typical context used by the caregiver?

- Disciplinary methods
- Concept and purpose of discipline
- Context in which discipline occurs
- Cultural practices

5. What are the overall pervasive parenting practices used by caregivers?

- Satisfaction in being a caregiver
- Caregiver knowledge and skill in parenting and child development
- Caregiver expectations and empathy for a child
- Decision making in parenting practices
- Parenting style
- History of parenting behavior
- Protectiveness

6. How does the caregiver function with respect to daily life management and general adaptation including substance use and mental health functioning?

- Communication and social skills
- Coping and stress management
- Self control
- Problem solving
- Judgment and decision making
- Independence
- Home and financial management
- Employment
- Rationality
- Substance use
- Mental health
- Physical health and capacity
- Functioning within cultural norms

See Section 1 of DSS Form 30231, the Child and Family Assessment and Service Planning Tool (CFASP) – Initial Assessment, Safety Assessment and Safety Planning.

16. Assesses the family situation to make a case determination about maltreatment, present and impending safety concerns and future risk of maltreatment. Uses the following steps to complete this assessment. The information gathered through these interviews, observations, records review, etc. will provide the information necessary to answer the six assessment questions described in #15.
Note: the order of these specific steps may vary given the specific needs of an investigation.

a. Interviews the alleged victim(s), parents (mothers and fathers), alleged perpetrator, siblings, collateral contacts, and any other involved party. Interviews family in home setting and observes interaction between and among family members. Interviews an absent or non-resident parent or documents why the absent/non-resident parent can not be interviewed and/or involved in the investigation. Reviews information on agency automated system (Human Services and Economic Services), for indicated and unfounded case information and in agency paper files.

Note: Discusses with resident or custodial parent (usually mother) that father involvement is good for children.
Children with involved fathers:
· show more confidence and less anxiety,
· perform better in school, and
· are less likely to be involved in destructive behaviors.

Father involvement benefits mothers. An involved father:
· teaches sons to respect women,
· is more likely to have positive communication with the mother, and
· is more likely to provide economic support.

Fathers benefit too by knowing they are having a lifelong impact on a child's life and by enjoying an irreplaceable relationship. All this supports and enhances the opportunity for positive interaction with a family.

b. Considers the safety of all other children in the home and in alternative placement, including children in the family who are placed at Department of Juvenile Justice (DJJ), and assesses the need to investigate suspected abuse or neglect of children not named in the original report. Initiates reports as appropriate and necessary. Contacts DJJ staff to gather information, to include but not limited to family history, any safety concerns known, evaluations completed by DJJ, child's release date, court involvement and to arrange for interviews with child at DJJ regarding the allegations of abuse or neglect and any other pertinent information.

c. Gathers information to consider any issues of domestic violence, substance abuse, mental illness and/or criminal activity and the impact of these behaviors on the child's immediate safety and future risk of maltreatment.
Note: The GAIN-SS screening tool should be used by those counties trained in its use to screen for substance and alcohol use, mental health concerns, and criminal behavior. The GAIN-SS is formatted for use with adolescents and other tools should be used for adults.

When conducting the safety assessment, considers the following indicators of alcohol and drug involvement as part of the on-site investigation. If there are indications of alcohol or drug abuse, a comprehensive evaluation from a qualified substance abuse counselor should be considered.
1. substance use is part of the CPS report
2. paraphernalia is found in the home (syringe kit, pipes, charred spoon, foils, large number of liquor or beer bottles, etc.)
3. home or parents smell of alcohol, marijuana, or drugs
4. a child reports alcohol or other drug use by parents or other adults in the home
5. a parent or other adult appears to be actively under the influence of alcohol or drugs (slurred speech, inability to mentally focus, physical balance is affected, extremely lethargic or hyperactive, etc.

6. parent shows signs of addiction (needle tracks, skin abscesses, burns on inside of lips, etc.)
7. parent admits to abuse of substances or alcohol (see guide for indicators of use, abuse, or dependence in Section 702, item #3)
8. parents shows or reports experiencing physical effects of addiction or being under the influence, including withdrawal (nausea, euphoria, slowed thinking, hallucinations, or other symptoms)

d. When screening adults, uses the following simple screening questions to guide decision to refer for formal AOD assessment when substance or alcohol use is not clear from indicators present in the home or at any time deemed appropriate by the situation.

The CAGE Questionnaire (amended for drug use)
C - Have you ever felt the need to **C**ut down on your drinking or drug use?
A - Have you ever felt **A**nnoyed by people criticizing your drinking or drug use?
G - Have you ever felt bad or **G**uilty about your drinking or drug use?
E - Have you ever had a drink or used a drug first thing in the morning to steady your nerves or get rid of a hangover? (**E**ye-opener)
Scoring: If the answer is "yes" to one or more questions, the responder should receive a formal alcohol and drug assessment. Answering "yes" to one or two questions may indicate alcohol and drug-related problems. Answering "yes" to three or four questions may indicate alcohol or drug dependence.83

OR

UNCOPE (for both drinking and drug use)
U - Have you spent more time drinking or **U**sing than you intended?
N - Have you ever **N**eglected some of your usual responsibilities because of alcohol or drug use?
C - Have you ever felt you wanted or needed to **C**ut down on your drinking or drug use in the past year?
O - Has your family, a friend, or anyone else ever told you they **O**bjected to your alcohol or drug use?
P - Have you found yourself thinking a lot about drinking or using? (**P**reoccupied)
E - Have you ever used alcohol or drugs to relieve **E**motional discomfort, such as sadness, anger, or boredom?
Scoring: Two or more positive responses indicate possible abuse or dependence and a need for further assessment by an Substance Use Disorder treatment provider.

e. With the assistance of and consultation with drug abuse specialists, makes decision about what type of drug test is appropriate under any given set of conditions. The expectation is that DSS staff will work with drug abuse specialists to determine what tests are necessary and what the test results mean in the context of child safety.

~~d. As part of the safety assessment and because of the high correlation between violence toward humans and cruelty to animals, explores with the child(ren) and adults, the care and treatment of companion animals in the home, using the information to assess for violence and intimidation in the home. Reports suspected animal abuse to law enforcement or animal control officer. (Reference DSS/LE Protocol for local procedures).~~

f. Observes and investigates/assesses any other maltreatment which may not have been included in the initial report.

g. Assesses children for indicators of developmental delays or exposure to illegal drugs (withdrawal symptoms or other medical effects from exposure as diagnosed by medical personnel) and considers the impact of a developmental delay and/or illegal substance exposure on the child's safety and well being. This determination of developmental delays or illegal substance exposure can come from information obtained:

1. through an analysis by the caseworker and parents of the child's developmental level using the Developmental Milestones Chart;
2. through the required medical screening of a child going into foster care;
3. through an EPSDT screening of any Medicaid eligible child; or
4. any other medical evaluation of a child in the course of a child abuse or neglect investigation.

NOTE: Any child believed to have been exposed to illegal substances (prenatally or after birth) must have a medical examination.

Provides to parents with children under age of three, a BabyNet card with developmental milestones information or DSS Form 30242 and contact number of BabyNet for assistance with voluntary self-referrals.

Completes a BabyNet referral form within 2 working days of determining the need for a referral. (See Section 719.01 for specific guidelines.)

h. Considers the educational needs of children three years of age and older and assists family with referrals to school for special services. Assesses the performance, attendance, and behaviors of the children in the educational setting and considers the impact of educational issues on safety of child. Cross reference Chapter 8, Section 819.03, for specific guidance on educational needs of foster children.

i. Assesses the responses of the parent/guardian to the abuse or neglect to include the acts, omissions or failure to protect by the parent or guardian.

j. Takes or causes to be taken color photographs, appropriate and adequate medical examinations, X-rays, and other tests as required in order to assess a situation and to

document child maltreatment. **(See Section 750 - S. C. Code of Laws, §63-7-380)** ~~If injuries are to the genital area~~

If there is suspected injury to the genital area or suspected sexual abuse involving genital contact, the child should be examined by a physician, and photographed as appropriate by or in the presence of medical personnel. If the allegation is about diaper rash on an infant or toddler, the worker may photograph the very young child who has a diaper rash in the genital area in the presence of the parent or other caregiver or medical personnel.

CPS workers should not examine children's genitals. Such examinations are intrusive and potentially traumatic and should be conducted by medical personnel. CPS workers are not medical personnel and are not authorized to conduct medical examinations.

k. Documents observations of adults and/or children present in the household and of siblings placed in alternative placement such as DJJ who may or may not be suspected of being abused or neglected. The assessment should include but not be limited to family history and functioning, the specific abuse, and other components as outlined in the six questions relating to maltreatment, nature of abuse, child functioning, parenting - discipline, parenting - general and adult functioning.

l. Documents information gathered in the assessment in CAPSS dictation.

17. Considers and discusses with the parent or guardian the safety issues identified for the victim child when the abuse or neglect is determined to have been perpetrated by a person who is not responsible for the child's welfare as defined by §63-7-20, and facilitates or refers the parent to appropriate service provider to meet identified treatment needs for the child and family.

18. As more information about the family and situation is gathered and as any additional present or impending danger threats are identified, revises the existing Safety Plan as needed or develops a safety plan with the family's active participation and agreement. The Safety Plan describes the specific actions to be taken to control for the safety threats that are identified as part of the assessment. Documents the specifics of the ongoing Safety Plan in the CAPSS automated system within five working days. The safety plan is a written arrangement between a family and the agency that establishes how present and impending danger threats to child safety will be managed. The safety plan must be implemented and active as long as threats to child safety exist and the caregiver protective capacities are insufficient to assure a child is safe. The safety plan should:

a. identify a protector who has sufficient protective capacities;

b. ensure that all parties understand their roles and are capable of carrying out their responsibilities; and

c. document ways in which the child) must be protected using safety services and actions only, no promissory commitments;

d. services must have immediate effect, be immediately accessible and available;

e. document reasonable efforts to prevent removal by identifying the safety services or actions necessary for each child to live safely at home or with a relative or friend. This information will be documented on the Safety Plan. Document on the Safety Plan when a child is at imminent risk of removal by checking YES or NO.
Note: If child is determined to be at imminent risk of removal absent these services (a "candidate" for IV-E foster care), the case must be staffed every three months until risk is reduced and every six months thereafter. A re-assessment of the child's safety must be made at the three month staffing to determine if the child continues to be at imminent risk of removal and what steps the agency must take to address these continuing concerns. Documentation must clearly show this assessment and the determination in order to document IV-E eligibility. Use DSS Form 30229, CPS In-Home Treatment Supervisory Review Checklist as guide for the review and document in the Case Evaluation/Case Closure section.

Note: Reasonable efforts are not required when one or more of the following exists: severe or repeated abuse/neglect; sexual abuse; torture or abandonment; the parent committed or conspired to commit murder, manslaughter or physical abuse resulting in death or hospitalization of a child with subsequent criminal convictions; or parental rights to another child were involuntarily terminated. See S. C. Code of Laws, §63-7-1640), and Section 726, Emergency Protective Custody.

19. Documents the plan to control for safety on the safety plan and have all parties sign, including the identified protector. Files copy of signed safety plan in paper file, provides original to family (copy to each person if multiple signers). If there is no protector identified and/or the family refuses to participate, assesses immediate safety concerns and the likelihood of future maltreatment to child in the home and initiates appropriate actions to protect, such as request evaluation by LE for emergency protective custody or initiate an Ex Parte action. **When the facts support that the child is in present danger or impending danger such that the child would be placed in foster care without effective services to prevent placement, documents this by checking the appropriate box on the form.**

NOTE: A Safety Plan cannot modify the provisions of an existing court order. A parent may agree to a safety plan that changes how his rights established in the order are temporarily exercised, however, all parties should understand that the order is not altered by the agreement. If critical to the safety of the children and the affected parent will not agree, DSS can seek an Ex Parte action through family court to temporarily stay the preexisting order or a removal through the emergency protective custody process. Questions regarding existing court orders should be referred to the county attorney.

NOTE: The safety plan should be modified as necessary to control for safety and remain in force as long as there are threats to the child's safety and the caregiver protective capacities are insufficient to assure a child is safe. The safety plan controls the conditions that results in a child being unsafe. The worker must discuss the safety plan with the family every time the worker is with the family to ensure that the safety plan is controlling/managing the identified safety threats.

While it is expected and desired that a child is safe by the time a case decision is made or shortly thereafter, there may continue to be safety threats. Court intervention may be needed if the agency's safety plan does not result in the child being safe.

Treatment cannot begin until the threat is under control. The Treatment Plan is designed to change behavior or conditions that caused the child to be unsafe or at a substantial risk of future harm.

20. If the identified plan to control for safety involves informal placement with a relative to divert the child from foster care, a family meeting must be held within 24 hours to include the parent, guardian, extended family and other relevant persons to discuss the family's problem that led to intervention and possible corrective actions including, but not limited to, an alternative caregiver for the child. If an alternative caregiver is identified, the following steps must be completed.

    a. Provides the alternative caregiver with information necessary to support placement, including, but not limited to, the child's condition, financial support information, agency expectations regarding safety and other pertinent information;

    b. Completes evaluation of alternative caregiver site within 24 hours of placement using DSS Form 30212 and document findings in CAPSS;

    c. Obtains signed affidavit using the DSS Form 3042 from each adult in the home; and

    d. Completes necessary background checks on relative and all adults in the home to ensure that DSS does not agree to a placement with a person who has a criminal and/or a child abuse or neglect history. Access criminal history as authorized under SC Code of Laws, §63-7-990, (Reference SC Code of Laws, §63-7-990 and local DSS/LE Protocol). **NOTE: do not consider as an alternative caregiver any person who uses/abuses/addicted to illegal substances or who abuses or is addicted to legal substances.**

    e. Summarizes in CAPSS the information documented on the Alternative Caregiver Site Visit and the background screenings. Provides a copy to parents and alternative caregiver.

21. If child cannot be protected in the home and has to be taken into emergency protective custody as part of an out-of-home safety plan, follows procedures in Section 726 and in

Chapter 8, Section 817.03, Foster Care. If a relative is identified as placement resource and wants to be licensed, advises the relative of the foster care licensing procedures outlined in Chapter 9, Foster Care Licensing Manual.

Considers placement resources and documents efforts to coordinate with the child's Native American nation or tribe when the victim child is a member of a federally recognized Native American nation or tribe. If not already documented, documents Tribe Affiliation in CAPSS. (Reference Section 754 - Indian Child Welfare Act)

22. As soon as possible, completes a search of the data base and Central Registry on any individual who is named as a protector and not already included in the case record to determine if the individual is named on the Child Abuse and Neglect Central Registry or has other child abuse or neglect history with the agency that might impact on the child's safety.

23. Completes full assessment of family and allegations of abuse or neglect. The use of a safety plan to assure that the child is in safe placement does not relieve the department of responsibility to complete the assessment and provide services to the family that may be appropriate.

Social Service Worker/Supervisor

24. If the safety threats cannot be controlled by use of an in-home safety plan, pursues an out-of-home safety plan by requesting assistance from law enforcement for Emergency Protective Custody. **(See Section 750 - S. C. Code of Laws, §63-7-620; Section 726, Emergency Protective Custody)**
Note: Supervisory consultation should take place prior to initiating removal actions or as soon as possible thereafter. Outcome of staffing must be documented in the automated system. Ensures medical testing of children coming into foster care to include testing for AIDS, drugs, etc., if recommended by medical personnel. **(See Chapter 8, Foster Care Manual)**

Social Service Worker

25. If a child is believed to be unsafe and a safety plan cannot be created that will control or manage the safety threats and a change in custody is anticipated:

    a. Explores possibility of relative placement, including non-custodial parent, by convening a family conference.

    b. Ensures relatives are given advance information to understand the process of becoming licensed as foster parents. (Reference Chapter 9, Foster Care Licensing Manual)

    c. Conducts diligent search for absent parent through the Child Support Enforcement Division by completing DSS Form 2738, Foster Care - Child Support Referral Form. Also,

completes a Central Registry and SLED background check, Department of Corrections' Inmate Search at www.state.sc.us/scdc to search for parents who might be incarcerated.

d. Considers whether the adult/parent in the home is safe if domestic violence is an issue involving the absent parent. For example, consider if there a restraining order in place against the absent parent.

e. Considers the safety of and likelihood of future risk to any child at DJJ who will be returning to the home and if removal of this child is indicated by the facts of the family situation.

26. Maintains photographs, X-rays of the child, copies of medical records and psychological reports on the family in the case record. **(See Section 750, S. C. Code of Laws, §63-7-380)**

27. Reviews with involved medical personnel and consults as needed with other medical experts the findings from any medical procedure or information from medical records.

28. Initiates and coordinates a mandatory multidisciplinary staffing prior to the case decision for a child who is admitted to the hospital due to severe injuries or for situation considered to be near death (diagnosed by medical personnel as serious or critical condition) believed to have been the result of the acts or omissions of the parent, guardian, or other caregiver. Arrangements for this staffing can be part of the MOA with the Children's Advocacy Center or other similar multidisciplinary abuse assessment center serving the county.

    a. Includes, but does not limit the staffing to: the attending physician, pertinent hospital staff, law enforcement and/or military police, other professionals who have information on the case, the DSS caseworker and supervisor.

    b. Holds staffing in-face to face forum with all involved parties present. If necessary, involved persons listed may be included through telephone conference call.

    c. Ensures the sharing of **all** available information on a child with severe injuries so that a thorough and complete assessment can be made.

    d. Documents the outcome of multidisciplinary staffing on DSS Form 3062 with all participants signing document to indicate their agreement, and documents the staffing information fully in CAPSS.

29. Coordinates and reviews case information with involved law enforcement (to include, but not limited to, information contained on the Sex Offenders Registry, contacts with SLED, etc.) or other professionals (to include FI/FS staff - see DSS Form 1600) to ensure the sharing of information.

30. Consults with involved professionals outside the department to ensure communication and clarity of information.

31. If additional information is received during the initial investigation/assessment that alleges a new incident of abuse or neglect, follows procedures as outlined in **Section 711, Recurrent Referrals** to evaluate the information and determine if a new investigation is necessary.

Social Service Worker/Supervisor

32. Ensures that a case decision staffing is held so that a case decision is made within 45 days of receipt of the report.
    a. Involves county attorney in the staffing for sexual abuse cases so that any decisions about the need for family court petitions can be made at the time of the case decision. Documents reason why attorney is not involved in staffing and what has been or will be done to ensure legal input and timely court actions.
    b. If the sexual abuse case is indicated, provides legal staff with necessary documentation and reports so that legal staff can prepare and file a petition for a hearing on the Central Registry question within 60 days of the decision to indicate.
    c. Involves county attorney in staffing of any case when it is believed at the time of the staffing that there is a likelihood that the case will go to family court.
    d. Ensures that a multidisciplinary staffing or consultation with involved professionals is held before a case decision is made. For example, when the evidence gathered supports that parental/caretaker use or abuse of or dependence on alcohol and/or other drugs has led to endangering the safety and welfare of the child, the staffing or consultation must include, at a minimum, a drug abuse specialist in order to fully consider the impact of the alcohol or drug use/abuse/addiction on the allegations of abuse or neglect. Or in the case of domestic violence or serious mental health issues, you must include a DV specialist or a mental health specialist in order to have sufficient and accurate information on which to base a decision. The staffing or consultation may be face-to-face or can be by telephone or through other means of communication.

NOTE: The definition of physical neglect consists of two parts – the failure of the parent to do something **and** that the failure has caused actual harm or has placed the child at substantial risk of physical or mental injury. It is not enough to find that circumstances suggest the parent **might** engage in conduct in the future that is a failure to supply food, clothing, shelter, etc. for us to indicate maltreatment. (Reference SC Code of Laws Ann., Section 63-7-20(4) (c) and (f)).

33. If necessary, submits justification to the County Director or designee for a one-time extension of 15 days if the decision cannot be made within the 45 days but is reasonably expected to be made within the 60 days. Documentation of a staffing of the case with the supervisor must be included with the justification. An extension may be granted at the discretion of the County Director or designee if:

a. the child or other relevant party who could not be located within the 45 days, despite the best efforts of the department, is expected to be located within the next 15 days; or

b. specific diagnostic information which was initiated or requested within the initial 45 days will not be available within the 45 days, but can reasonably be completed within the next 15 days; or

c. other compelling reasons as presented by staff on a case by case basis that there is a reasonable expectation that the investigation can be completed in an additional 15 days; **and**

d. the request has been made prior to the 45th day of the investigation. **An extension shall not be granted by the County Director or designee if requested on or after the 45th day.**

Note: Upon request, the State Director or state/regional designee may grant a one-time good cause extension (not to exceed 60 days from the date of the report) for a request not made prior to the 45th day of the investigative/assessment.

Director/Designee

34. Based upon the criteria listed above, makes a decision regarding the request for an extension of 15 days to the investigative/assessment period. The decision must be made by the 45th day of the investigative/assessment.

Social Service Worker

35. Documents extension of time line in the automated case record (CAPSS) within two working days of the decision by the Director/Designee to grant the 15 day extension.

36. In consultation with supervisor, makes an agency finding regarding the validity of the report as soon as all information necessary to make a decision is gathered. A finding **must** be made within 45 days from receipt of the report (unless an extension is granted).

Notifies the family and perpetrator of the indicated case decision in person within 5 working days of the decision and prior to the mailing of the notice letter. This must be done face to face in order to assess the parents' response to the case decision and gauge the impact of their response on the child's safety as well as determine the parents' willingness to cooperate with treatment and/or their desire to appeal the decision. The face to face discussion about the indicated decision encourages engagement of the family as it is respectful of families' rights and feelings. It also can set the stage for a more positive introduction of the treatment worker to the family. The parents' responses in this face to face discussion about the case decision will help the worker, supervisor, and county attorney to make decisions about the agency's

need to petition family court and therefore determine which notice letter is appropriate for the specific situation.

If the decision is not made before 45 days (no more than 60 days), the agency's decision becomes unfounded according to state statute. The case record dictation must reflect the date and outcome of the agency decision staffing to serve as official documentation of the date of the decision. CAPSS must be updated in 5 days of the case decision staffing to reflect the decision and the information that constitutes the preponderance of evidence.

Note: The re-reporting of a situation by agency staff because the agency is unable to complete the investigation in the 60 days maximum allowed by state law for an investigation is not supported by state law. State law specifies that the agency must make a decision within 60 days or the decision becomes unfounded.

SC Code of Laws §63-7-930(A) "By the end of the sixty-day time period, suspected reports must be classified as either unfounded or indicated pursuant to the agency's investigation," and §63-7-930(C) "All reports that are not indicated at the conclusion of the investigation and all records of information for which an investigation was not conducted pursuant to §63-7-310 must be classified as unfounded." **(See Section 750, S. C. Code of Laws,** §63-7-930)

Reminder: If a child is taken into custody by EPC or Ex Parte action and in order to provide investigative and case planning information to the Family Court at the 35 Day Removal Hearing, the worker should complete the investigation as quickly as possible.

Social Service Worker

37. After the case decision, completes the DSS-3070, Determination Fact Sheet outlining the facts supporting the agency decision. The appropriate notice letter as referenced on the DSS-3070 should be completed after the face to face discussion with the family. The notice letter provides specific information regarding the right to appeal an agency decision and the appropriate process for that appeal given the unique case situation. Both documents are mailed to the subject of the report (person alleged or named as the perpetrator) within five working days of the decision to indicate or unfound.

Persons responsible for the child's welfare as defined under §63-7-20 and who are directly involved in this case which includes the non-residential/non-custodial parent also must be notified of the outcome of the investigation by copy of the DSS-3070 but do not have a legal right to appeal the decision unless they are named as the subject of the report.

NOTE: If the case is not going to be taken to Family Court for oversight on treatment and/or safety issues and the individual found to have abused or neglected the child is not being offered treatment services, the individual must be offered an administrative appeals under §63-7-1410. The notice letter must be sent by certified mail. (Reference SC Code of Laws, §63-7-1410)

38. Documents the specifics of the case decision staffing in CAPSS automated system in five working days of the decision. Documents routine case activity in CAPSS no later than thirty calendar days after the activity.

Social Service Supervisor

39. Reviews and signs off on the case decision and notification letters as necessary. Ensures case documentation in CAPSS is completed.

Social Service Worker

40. If the report is unfounded, classifies the report as Category I, Category II, or Category III according to the evidence identified. **(See Section 750, SC Code of Laws, §63-7-920 and §63-7-20)**

    a. Informs the subject of the report that the report is unfounded. Also mails the subject of the report a copy of DSS-3070, Determination Fact Sheet and unfounded notice letter within five working days. Updates CAPSS and files a copy of DSS-3070 and notice letter in paper file. Persons responsible for the child's welfare as defined under §63-7-20 and who are directly involved in this case which includes the non-residential/non-custodial parent also must be notified of the outcome of the investigation by copy of the DSS-3070.

    b. Notifies FI/FS staff of the case decision immediately using the DSS Form 1600, Referral to Human Services, so that all material about the unfounded case can be removed from the FI/FS case record.

    c. Updates data base within five working days of the case decision.

    d. Maintains the unfounded case record according to statute. Uses information in unfounded case records only as allowed by statute. All unfounded case material in the paper record will be deleted/purged at the end of five years unless the record has been secured by the Office of General Counsel for legal reasons or a need to maintain the record has been identified by the County office or the Division of Human Services for reasons related to CPS or LE investigations. **(See Section 750 - S. C. Code of Laws Ann., §63-7-920 & 930)**

    e. Makes a referral to BabyNet on a child under age three in an unfounded report who appears to need early intervention services by completing the BabyNet Referral Form within two working days of determining need to refer. Discusses with family the BabyNet service and why a referral is believed to be appropriate. This determination of developmental delays can come from information obtained:

1. by an analysis by the caseworker of the child relative to the Developmental Milestones Chart - DSS Form 30242;
2. through the required medical screening of a child going into foster care;
3. through an EPSDT screening of any Medicaid eligible child; or
4. any other medical evaluation of a child in the course of a child abuse or neglect investigation.

BabyNet will assess and evaluate a child referred by DSS to determine if early intervention services are appropriate for that particular child. BabyNet services are not coercive services and the parents have the right to refuse to participate.

41. If the report is classified as "indicated" for abuse or neglect by a preponderance of the evidence: **(See Section 750, S. C. Code of Laws Ann., §63-7-920 and §63-7-20)**

a. Informs family of case decision. Discusses with the family the impact of the indicated case decision, any planned court action (to include a request to family court to order person's name be placed on the Central Registry and the potential impact of this action on individual), and the treatment planning process. Provides any information requested or needed to help the family understand DSS intervention.

b. Notifies law enforcement within 24 hours when the facts indicating child abuse or neglect also appear to indicate a violation of criminal law for the purposes of police investigation. Refers a case to law enforcement if there is evidence of drug manufacture, drug dealing, the presence of illegal drugs in the home, or other illegal use of drugs. (See Section 750 - SC Code of Laws §63-7-920)

c. Discusses with the family the agency's responsibility for providing or coordinating services and the need for the family's cooperation and participation.

d. Makes the federally mandated referral to BabyNet on any child under age three who is identified as the victim of child abuse or neglect in a substantiated (indicated) case of child abuse or neglect or who is identified as affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure by completing the BabyNet Referral Procedure as outlined in Section 719.01. . If the parents refuse to participate with BabyNet, the worker must pursue alternative services for concerns identified as safety issues that will be addressed within the service plan. The parents have the right to refuse to participate with BabyNet and DSS must then assess if alternative services are necessary.

e. Provides the family with a copy of the DSS-3070, Determination Fact Sheet, and other notice letters as appropriate within five working days of the case decision.

Social Service Worker/OHAN Investigator

f. Notifies the subject of the report by certified mail that for cases indicated pursuant to §63-7-920 which are not going to Family Court, or for those cases indicated under §20-7-670, the individual determined to have abuse or neglected the child may appeal the decision as outlined in **Section 725, Appeals Process. (See Section 750, SC Code of Laws Ann., §63-7-1410)**

NOTE: **It is the policy of the Department that in cases indicated under §63-7-920 where there are safety threats and/or where treatment services are to be provided or are reasonably expected to be provided and the individual or family disagrees with the indicated decision and/or the decision to deliver services, the case MUST be taken to Family Court. There can be little effective treatment and the safety of the child is in question when there is no acknowledgement of the acts or omissions that led to the abuse or neglect. This process allows Family Court to consider the facts of the situation in totality whereas the Administrative Appeals process cannot coerce treatment nor address child safety.**

g. Notifies service providers such as DJJ, DMH, DHEC, etc., of the outcome of the investigation/assessment in order to coordinate services as needed. When treatment services are appropriate for a family, and the subject of the report disagrees with the results of the investigation, the case should be taken to Family Court under §63-7-1650 for CPS intervention. In this action, DSS must present evidence to support its case determination and the proposed treatment services. This will provide the subject of the report with an opportunity to contest the case decision and is the individual's avenue of appeal.

h. For OHAN cases needing treatment services (for example, licensed foster parents with biological children who are found to be abused or neglected), transfers the case to the county of residence for follow up treatment services. (See Section 721 – Out Of Home Abuse Investigations)

Social Service Worker

i. If the subject of the report challenges the agency decision that he/she abused or neglected the child, or if the Department needs to take the case to family court to compel services, and/or to request that an individual's name be listed on the Central Registry, presents case to DSS attorney for interventio. **(See Section 750, S. C. Code of Laws Ann., §63-7-920 and §63-7-1650)**

j. Informs the family that at any time during the delivery of services by the agency, the department may petition the Family Court in its jurisdiction for authority to intervene and provide protective services without removal of the child. **This step must be taken in instances where the family indicates a refusal to participate and the agency determines by a preponderance of the evidence that the child cannot be protected from harm without intervention. (See Section 750, S. C. Code of Laws, §63-7-1650)**

k. Discusses with the family possible outcomes of a hearing pursuant to §63-7-1650.

l. Informs the family of the time frame for the destruction of the record containing their names and other identifying information. Information in unfounded records will be maintained and used by the department in assessment of risk in subsequent reports for not less than five years. Indicated case information will be maintained for seven years from the date services are terminated. The names of individuals legally on the Central Registry as of June 7, 2002, will continue to be listed. **(See Section 750, S. C. Code of Laws, §63-7-920 and §63-7-1910)**

m. If a court hearing is deemed necessary, follows requirements of statute. **(See Section 750, S. C. Code of Laws, §63-7-1650)**

n. Completes DSS-3058, Court Information Sheet, or equivalent summary as needed and appropriate to provide information to the DSS attorney to prepare for the court hearing.

o. Immediately notifies FI/FS staff of the case decision using the DSS Form 1600, Referral to Human Services.

County Office Staff

p. Files copies of signed forms, medical or psychological evaluations, court documents or other pertinent information that must be preserved in a paper file. Maintains the case record (paper file) for seven years from the date services are terminated including the actual record and CPS Log. **(See Section 750, S. C. Code of Laws, §63-7-920 and §63-7-1910)**

q. **Updates the Central Registry to reflect any court order pursuant to §63-7-920 or appeals process action pursuant to §63-7-1410 that results from a county case action.**

r. Maintains a county tracking system to ensure compliance with all court orders to include entering a person's name in the Central Registry. Designates a person to have direct responsibility for this task. Uses the tracking system to ensure that when the agency determines that there is a preponderance of evidence that a person committed an act of sexual abuse, the case is taken to Family Court for consideration of the Central Registry listing and any other treatment concerns.

State Office Program Staff

42. Monitors indicated sex abuse cases and Central Registry for compliance with state statute. Notifies program technical assistance or county operations staff of any concerns that may require follow up with county offices.

State Office Central Registry Staff

43. Receives DSS Form 30165, a copy of the indictment and the sentencing order from county clerks of court and enters into the Central Registry the names of individuals ordered onto the Central Registry of Child Abuse and Neglect by the criminal court pursuant to SC Code of Laws 17-25-135.

Social Service Worker or Assigned Staff

44. In situations where the department has an interest in receiving information regarding persons who are incarcerated due to a conviction on abuse or neglect charges, pursuant to **§16-3-1520 and §16-3-1530 of the Victim's and Witnesses' Bill of Rights,** requests notification of the perpetrator's pending release from the solicitor by completing and forwarding the DSS-3032, Victim Impact Statement for Child Protective Services, to the solicitor and Department of Probation, Parole and Pardon Services.

45. Conducts a search of the Central Registry when contacted by law enforcement investigating abuse/neglect of a child or any other crime against a child, attempting to locate a missing child, investigating or prosecuting the death of a child, or investigating or prosecuting any other crime established in or associated with activities prescribed in the Children's Code. (Reference §63-7-1990) **Central Registry information is not subject to HIPAA, so procedures associated with HIPAA do not apply to a request that DSS determine whether a person is on the Central Registry.**

All Staff

46. Maintains all information concerning child abuse and neglect reports in a confidential manner ensuring that information is given only to those parties specifically named and authorized in §63-7-1990 and §63-7-920.

47. Ensures that all documentation of actions in a case is completed in the CAPSS automated case record no later than 30 days after the action. Documents critical case activity, such as removals, court actions, or other as directed by supervisor, in no more than 10 days.

48. Ensures that other specified timelines (such as the initiation of investigation, notification of case decision, and documentation of monthly visit in open treatment cases) are met,

County Director

49. Approves any entry into CAPSS that exceeds any established timelines for data entry. Refer to Policy Section 701 #8, Procedures Section 719 #13, #35, and #42, and Section 730 Purpose for specific established timelines.

Exhibit 10

NASW
National Association of Social Workers

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

EXHIBIT 2

The primary mission of the social work profession is to enhance human wellbeing and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual wellbeing in a social context and the wellbeing of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence.

This constellation of core values reflects what is unique to the social work profession. Core values, and the principles that flow from them, must be balanced within the context and complexity of the human experience.

Purpose of the NASW Code of Ethics

Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The *NASW Code of Ethics* sets forth these values, principles, and standards to guide social workers' conduct. The *Code* is relevant to all social workers and social work students, regardless of their professional functions, the settings in which they work, or the populations they serve.

The *NASW Code of Ethics* serves six purposes:

1. The Code identifies core values on which social work's mission is based.
2. The *Code* summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice.
3. The *Code* is designed to help social workers identify relevant considerations when professional obligations conflict or ethical uncertainties arise.
4. The *Code* provides ethical standards to which the general public can hold the social work profession accountable.
5. The *Code* socializes practitioners new to the field to social work's mission, values, ethical principles, and ethical standards.
6. The *Code* articulates standards that the social work profession itself can use to assess whether social workers have engaged in unethical conduct. NASW has formal procedures to adjudicate ethics complaints filed against its members.* In subscribing to this *Code*, social workers are required to cooperate in its implementation, participate in NASW adjudication proceedings, and abide by any NASW disciplinary rulings or sanctions based on it.

The *Code* offers a set of values, principles, and standards to guide decision making and conduct when ethical issues arise. It does not provide a set of rules that prescribe how social workers should act in all situations. Specific applications of the *Code* must take into account the context in which it is being considered and the possibility of conflicts among the *Code's* values, principles, and standards. Ethical responsibilities flow from all human relationships, from the personal and familial to the social and professional.

Further, the *NASW Code of Ethics* does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict. Reasonable differences of opinion can and do exist among social workers with respect to the ways in which values, ethical principles, and ethical standards should be rank ordered when they conflict. Ethical decision making in a given situation must apply the informed judgment of the individual social worker and should also consider how the issues would be judged in a peer review process where the ethical standards of the profession would be applied.

Ethical decision making is a process. There are many instances in social work where simple answers are not available to resolve complex ethical issues. Social workers should take into consideration all the values, principles, and

standards in this *Code* that are relevant to any situation in which ethical judgment is warranted. Social workers' decisions and actions should be consistent with the spirit as well as the letter of this *Code*.

In addition to this *Code*, there are many other sources of information about ethical thinking that may be useful. Social workers should consider ethical theory and principles generally, social work theory and research, laws, regulations, agency policies, and other relevant codes of ethics, recognizing that among codes of ethics social workers should consider the *NASW Code of Ethics* as their primary source. Social workers also should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly. For additional guidance social workers should consult the relevant literature on professional ethics and ethical decision making and seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agencybased or social work organization's ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

Instances may arise when social workers' ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, social workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards expressed in this Code. If a reasonable resolution of the conflict does not appear possible, social workers should seek proper consultation before making a decision.

The *NASW Code of Ethics* is to be used by NASW and by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, professional liability insurance providers, courts of law, agency boards of directors, government agencies, and other professional groups) that choose to adopt it or use it as a frame of reference. Violation of standards in this *Code* does not automatically imply legal liability or violation of the law. Such determination can only be made in the context of legal and judicial proceedings. Alleged violations of the *Code* would be subject to a peer review process. Such processes are generally separate from legal or administrative procedures and insulated from legal review or proceedings to allow the profession to counsel and discipline its own members.

A code of ethics cannot guarantee ethical behavior. Moreover, a code of ethics cannot resolve all ethical issues or disputes or capture the richness and complexity involved in striving to make responsible choices within a moral community. Rather, a code of ethics sets forth values, ethical principles, and ethical standards to which professionals aspire and by which their actions can be judged. Social workers' ethical behavior should result from their personal commitment to engage in ethical practice. The *NASW Code of Ethics* reflects the commitment of all social workers to uphold the profession's values and to act ethically. Principles and standards must be applied by individuals of good character who discern moral questions and, in good faith, seek to make reliable ethical judgments.

Ethical Principles

The following broad ethical principles are based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. These principles set forth ideals to which all social workers should aspire.

Value: *Service*

Ethical Principle: *Social workers' primary goal is to help people in need and to address social problems.*
Social workers elevate service to others above selfinterest. Social workers draw on their knowledge, values, and skills to help people in need and to address social problems. Social workers are encouraged to volunteer some portion of their professional skills with no expectation of significant financial return (pro bono service).

Value: *Social Justice*

Ethical Principle: *Social workers challenge social injustice.*
Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

Value: *Dignity and Worth of the Person*

Ethical Principle: *Social workers respect the inherent dignity and worth of the person.*
Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible selfdetermination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

Value: *Importance of Human Relationships*

Ethical Principle: *Social workers recognize the central importance of human relationships.*
Social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the wellbeing of individuals, families, social groups, organizations, and communities.

Value: *Integrity*

Ethical Principle: *Social workers behave in a trustworthy manner.*
Social workers are continually aware of the profession's mission, values, ethical principles, and ethical standards and practice in a manner consistent with them. Social workers act honestly and responsibly and promote ethical practices on the part of the organizations with which they are affiliated.

Value: *Competence*

Ethical Principle: *Social workers practice within their areas of competence and develop and enhance their professional expertise.*
Social workers continually strive to increase their professional knowledge and skills and to apply them in practice. Social workers should aspire to contribute to the knowledge base of the profession.

Ethical Standards

The following ethical standards are relevant to the professional activities of all social workers. These standards concern (1) social workers' ethical responsibilities to clients, (2) social workers' ethical responsibilities to colleagues, (3) social workers' ethical responsibilities in practice settings, (4) social workers' ethical responsibilities as professionals, (5) social workers' ethical responsibilities to the social work profession, and (6) social workers' ethical responsibilities to the broader society.

Some of the standards that follow are enforceable guidelines for professional conduct, and some are aspirational. The extent to which each standard is enforceable is a matter of professional judgment to be exercised by those responsible for reviewing alleged violations of ethical standards.

1. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO CLIENTS

1.01 Commitment to Clients

Social workers' primary responsibility is to promote the wellbeing of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised. (Examples include when a social worker is required by law to report that a client has abused a child or has threatened to harm self or others.)

1.02 SelfDetermination

Social workers respect and promote the right of clients to selfdetermination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to selfdetermination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent

(a) Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.

(b) In instances when clients are not literate or have difficulty understanding the primary language used in the practice setting, social workers should take steps to ensure clients' comprehension. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible.

(c) In instances when clients lack the capacity to provide informed consent, social workers should protect clients' interests by seeking permission from an appropriate third party, informing clients consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with clients' wishes and interests. Social workers should take reasonable steps to enhance such clients' ability to give informed consent.

(d) In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service.

(e) Social workers who provide services via electronic media (such as computer, telephone, radio, and television) should inform recipients of the limitations and risks associated with such services.

(f) Social workers should obtain clients' informed consent before audiotaping or videotaping clients or permitting observation of services to clients by a third party.

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.

(c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

1.05 Cultural Competence and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.

1.06 Conflicts of Interest

(a) Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients' interests may require termination of the professional relationship with proper referral of the client.

(b) Social workers should not take unfair advantage of any professional relationship or exploit others to further their personal, religious, political, or business interests.

(c) Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client. In instances when dual or multiple relationships are unavoidable,

social workers should take steps to protect clients and are responsible for setting clear, appropriate, and culturally sensitive boundaries. (Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business. Dual or multiple relationships can occur simultaneously or consecutively.)

(d) When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients and the nature of social workers' professional obligations to the various individuals who are receiving services. Social workers who anticipate a conflict of interest among the individuals receiving services or who anticipate having to perform in potentially conflicting roles (for example, when a social worker is asked to testify in a child custody dispute or divorce proceedings involving clients) should clarify their role with the parties involved and take appropriate action to minimize any conflict of interest.

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social workerclient relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to thirdparty payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

(m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.

(n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.

(o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(q) Social workers should not disclosé identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

(r) Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.

1.08 Access to Records

(a) Social workers should provide clients with reasonable access to records concerning the clients. Social workers who are concerned that clients' access to their records could cause serious misunderstanding or harm to the client should provide assistance in interpreting the records and consultation with the client regarding the records. Social workers should limit clients' access to their records, or portions of their records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both clients' requests and the rationale for withholding some or all of the record should be documented in clients' files.

(b) When providing clients with access to their records, social workers should take steps to protect the confidentiality of other individuals identified or discussed in such records.

1.09 Sexual Relationships

(a) Social workers should under no circumstances engage in sexual activities or sexual contact with current clients, whether such contact is consensual or forced.

(b) Social workers should not engage in sexual activities or sexual contact with clients' relatives or other individuals with whom clients maintain a close personal relationship when there is a risk of exploitation or potential harm to the client. Sexual activity or sexual contact with clients' relatives or other individuals with whom clients maintain a personal relationship has the potential to be harmful to the client and may make it difficult for the social worker and client to maintain appropriate professional boundaries. Social workers—not their clients, their clients' relatives, or other individuals with whom the client maintains a personal relationship—assume the full burden for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in sexual activities or sexual contact with former clients because of the potential for harm to the client. If social workers engage in conduct contrary to this prohibition or claim that an exception to this prohibition is warranted because of extraordinary circumstances, it is social workers—not their clients—who assume the full burden of demonstrating that the former client has not been exploited, coerced, or manipulated, intentionally or unintentionally.

(d) Social workers should not provide clinical services to individuals with whom they have had a prior sexual relationship. Providing clinical services to a former sexual partner has the potential to be harmful to the individual and is likely to make it difficult for the social worker and individual to maintain appropriate professional boundaries.

1.10 Physical Contact

Social workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact.

1.11 Sexual Harassment

Social workers should not sexually harass clients. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

1.12 Derogatory Language

Social workers should not use derogatory language in their written or verbal communications to or about clients. Social workers should use accurate and respectful language in all communications to and about clients.

1.13 Payment for Services

(a) When setting fees, social workers should ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration should be given to clients' ability to pay.

(b) Social workers should avoid accepting goods or services from clients as payment for professional services. Bartering arrangements, particularly involving services, create the potential for conflicts of interest, exploitation, and inappropriate boundaries in social workers' relationships with clients. Social workers should explore and may participate in bartering only in very limited circumstances when it can be demonstrated that such arrangements are an accepted practice among professionals in the local community, considered to be essential for the provision of services, negotiated without coercion, and entered into at the client's initiative and with the client's informed consent. Social workers who accept goods or services from clients as payment for professional services assume the full burden of demonstrating that this arrangement will not be detrimental to the client or the professional relationship.

(c) Social workers should not solicit a private fee or other remuneration for providing services to clients who are entitled to such available services through the social workers' employer or agency.

1.14 Clients Who Lack DecisionMaking Capacity

When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

1.15 Interruption of Services

Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted by factors such as unavailability, relocation, illness, disability, or death.

1.16 Termination of Services

(a) Social workers should terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

(b) Social workers should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects. Social workers should assist in making appropriate arrangements for continuation of services when necessary.

(c) Social workers in feeforservice settings may terminate services to clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

(d) Social workers should not terminate services to pursue a social, financial, or sexual relationship with a client.

(e) Social workers who anticipate the termination or interruption of services to clients should notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences.

(f) Social workers who are leaving an employment setting should inform clients of appropriate options for the continuation of services and of the benefits and risks of the options.

2. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO COLLEAGUES

2.01 Respect

(a) Social workers should treat colleagues with respect and should represent accurately and fairly the qualifications, views, and obligations of colleagues.
(b) Social workers should avoid unwarranted negative criticism of colleagues in communications with clients or with other professionals. Unwarranted negative criticism may include demeaning comments that refer to colleagues' level of competence or to individuals' attributes such as race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability.
(c) Social workers should cooperate with social work colleagues and with colleagues of other professions when such cooperation serves the wellbeing of clients.

2.02 Confidentiality

Social workers should respect confidential information shared by colleagues in the course of their professional relationships and transactions. Social workers should ensure that such colleagues understand social workers' obligation to respect confidentiality and any exceptions related to it.

2.03 Interdisciplinary Collaboration

(a) Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the wellbeing of clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established.

(b) Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels. If the disagreement cannot be resolved, social workers should pursue other avenues to address their concerns consistent with client wellbeing.

2.04 Disputes Involving Colleagues

(a) Social workers should not take advantage of a dispute between a colleague and an employer to obtain a position or otherwise advance the social workers' own interests.

(b) Social workers should not exploit clients in disputes with colleagues or engage clients in any inappropriate discussion of conflicts between social workers and their colleagues.

2.05 Consultation

(a) Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interests of clients.

(b) Social workers should keep themselves informed about colleagues' areas of expertise and competencies. Social workers should seek consultation only from colleagues who have demonstrated knowledge, expertise, and competence related to the subject of the consultation.

(c) When consulting with colleagues about clients, social workers should disclose the least amount of information necessary to achieve the purposes of the consultation.

2.06 Referral for Services

(a) Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional service is required.

(b) Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

(c) Social workers are prohibited from giving or receiving payment for a referral when no professional service is provided by the referring social worker.

2.07 Sexual Relationships

(a) Social workers who function as supervisors or educators should not engage in sexual activities or contact with supervisees, students, trainees, or other colleagues over whom they exercise professional authority.

(b) Social workers should avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.

2.08 Sexual Harassment

Social workers should not sexually harass supervisees, students, trainees, or colleagues. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

2.09 Impairment of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's impairment that is due to personal problems, psychosocial distress, substance abuse, or mental health difficulties and that interferes with practice effectiveness should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague's impairment interferes with practice effectiveness and that the colleague has not taken adequate steps to address the impairment should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.10 Incompetence of Colleagues

(a) Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action.

(b) Social workers who believe that a social work colleague is incompetent and has not taken adequate steps to address the incompetence should take action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

2.11 Unethical Conduct of Colleagues

(a) Social workers should take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

(b) Social workers should be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. Social workers should be familiar with national, state, and local procedures for handling ethics complaints. These include policies and procedures created by NASW, licensing and regulatory bodies, employers, agencies, and other professional organizations.

(c) Social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive.

(d) When necessary, social workers who believe that a colleague has acted unethically should take action through appropriate formal channels (such as contacting a state licensing board or regulatory body, an NASW committee on inquiry, or other professional ethics committees).

(e) Social workers should defend and assist colleagues who are unjustly charged with unethical conduct.

3. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES IN PRACTICE SETTINGS

3.01 Supervision and Consultation

(a) Social workers who provide supervision or consultation should have the necessary knowledge and skill to supervise or consult appropriately and should do so only within their areas of knowledge and competence.

(b) Social workers who provide supervision or consultation are responsible for setting clear, appropriate, and culturally sensitive boundaries.

(c) Social workers should not engage in any dual or multiple relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee.

(d) Social workers who provide supervision should evaluate supervisees' performance in a manner that is fair and respectful.

3.02 Education and Training

(a) Social workers who function as educators, field instructors for students, or trainers should provide instruction only within their areas of knowledge and competence and should provide instruction based on the most current information and knowledge available in the profession.

(b) Social workers who function as educators or field instructors for students should evaluate students' performance in a manner that is fair and respectful.

(c) Social workers who function as educators or field instructors for students should take reasonable steps to ensure that clients are routinely informed when services are being provided by students.

(d) Social workers who function as educators or field instructors for students should not engage in any dual or multiple relationships with students in which there is a risk of exploitation or potential harm to the student. Social work educators and field instructors are responsible for setting clear, appropriate, and culturally sensitive boundaries.

3.03 Performance Evaluation

Social workers who have responsibility for evaluating the performance of others should fulfill such responsibility in a fair and considerate manner and on the basis of clearly stated criteria.

3.04 Client Records

(a) Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.

(b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.

(c) Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.

(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

3.05 Billing

Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.

3.06 Client Transfer

(a) When an individual who is receiving services from another agency or colleague contacts a social worker for services, the social worker should carefully consider the client's needs before agreeing to provide services. To minimize possible confusion and conflict, social workers should discuss with potential clients the nature of the clients' current relationship with other service providers and the implications, including possible benefits or risks, of entering into a relationship with a new service provider.

(b) If a new client has been served by another agency or colleague, social workers should discuss with the client whether consultation with the previous service provider is in the client's best interest.

3.07 Administration

(a) Social work administrators should advocate within and outside their agencies for adequate resources to meet clients' needs.

(b) Social workers should advocate for resource allocation procedures that are open and fair. When not all clients' needs can be met, an

allocation procedure should be developed that is nondiscriminatory and based on appropriate and consistently applied principles.

(c) Social workers who are administrators should take reasonable steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision.

(d) Social work administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the *NASW Code of Ethics*. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the *Code*.

3.08 Continuing Education and Staff Development

Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics.

3.09 Commitments to Employers

(a) Social workers generally should adhere to commitments made to employers and employing organizations.

(b) Social workers should work to improve employing agencies' policies and procedures and the efficiency and effectiveness of their services.

(c) Social workers should take reasonable steps to ensure that employers are aware of social workers' ethical obligations as set forth in the *NASW Code of Ethics* and of the implications of those obligations for social work practice.

(d) Social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the *NASW Code of Ethics*.

(e) Social workers should act to prevent and eliminate discrimination in the employing organization's work assignments and in its employment policies and practices.

(f) Social workers should accept employment or arrange student field placements only in organizations that exercise fair personnel practices.

(g) Social workers should be diligent stewards of the resources of their employing organizations, wisely conserving funds where appropriate and never misappropriating funds or using them for unintended purposes.

3.10 LaborManagement Disputes

(a) Social workers may engage in organized action, including the formation of and participation in labor unions, to improve services to clients and working conditions.

(b) The actions of social workers who are involved in labormanagement disputes, job actions, or labor strikes should be guided by the profession's values, ethical principles, and ethical standards. Reasonable differences of opinion exist among social workers concerning their primary obligation as professionals during an actual or threatened labor strike or job action. Social workers should carefully examine relevant issues and their possible impact on clients before deciding on a course of action.

4. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES AS PROFESSIONALS

4.01 Competence

(a) Social workers should accept responsibility or employment only on the basis of existing competence or the intention to acquire the necessary competence.

(b) Social workers should strive to become and remain proficient in professional practice and the performance of professional functions. Social workers should critically examine and keep current with emerging knowledge relevant to social work. Social workers should routinely review the professional literature and participate in continuing education relevant to social work practice and social work ethics.

(c) Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics.

4.02 Discrimination

Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

4.03 Private Conduct

Social workers should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities.

4.04 Dishonesty, Fraud, and Deception

Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception.

4.05 Impairment

(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.

(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.

4.06 Misrepresentation

(a) Social workers should make clear distinctions between statements made and actions engaged in as a private individual and as a representative of the social work profession, a professional social work organization, or the social worker's employing agency.

(b) Social workers who speak on behalf of professional social work organizations should accurately represent the official and authorized positions of the organizations.

(c) Social workers should ensure that their representations to clients, agencies, and the public of professional qualifications, credentials, education, competence, affiliations, services provided, or results to be achieved are accurate. Social workers should claim only those relevant professional credentials they actually possess and take steps to correct any inaccuracies or misrepresentations of their credentials by others.

4.07 Solicitations

(a) Social workers should not engage in uninvited solicitation of potential clients who, because of their circumstances, are vulnerable to undue influence, manipulation, or coercion.

(b) Social workers should not engage in solicitation of testimonial endorsements (including solicitation of consent to use a client's prior statement as a testimonial endorsement) from current clients or from other people who, because of their particular circumstances, are vulnerable to undue influence.

4.08 Acknowledging Credit

(a) Social workers should take responsibility and credit, including authorship credit, only for work they have actually performed and to which they have contributed.

(b) Social workers should honestly acknowledge the work of and the contributions made by others.

5. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE SOCIAL WORK PROFESSION

5.01 Integrity of the Profession

(a) Social workers should work toward the maintenance and promotion of high standards of practice.

(b) Social workers should uphold and advance the values, ethics, knowledge, and mission of the profession. Social workers should protect, enhance, and improve the integrity of the profession through appropriate study and research, active discussion, and responsible criticism of the profession.

(c) Social workers should contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the social work profession. These activities may include teaching, research, consultation, service, legislative testimony, presentations in the community, and participation in their professional organizations.

(d) Social workers should contribute to the knowledge base of social work and share with colleagues their knowledge related to practice, research, and ethics. Social workers should seek to contribute to the profession's literature and to share their knowledge at professional meetings and conferences.

(e) Social workers should act to prevent the unauthorized and unqualified practice of social work.

5.02 Evaluation and Research

(a) Social workers should monitor and evaluate policies, the implementation of programs, and practice interventions.

(b) Social workers should promote and facilitate evaluation and research to contribute to the development of knowledge.

(c) Social workers should critically examine and keep current with emerging knowledge relevant to social work and fully use evaluation and research evidence in their professional practice.

(d) Social workers engaged in evaluation or research should carefully consider possible consequences and should follow guidelines developed for the protection of evaluation and research participants. Appropriate institutional review boards should be consulted.

(e) Social workers engaged in evaluation or research should obtain voluntary and written informed consent from participants, when appropriate, without any implied or actual deprivation or penalty for refusal to participate; without undue inducement to participate; and with due regard for participants' wellbeing, privacy, and dignity. Informed consent should include information about the nature, extent, and duration of the participation requested and disclosure of the risks and benefits of participation in the research.

(f) When evaluation or research participants are incapable of giving informed consent, social workers should provide an appropriate explanation to the participants, obtain the participants' assent to the extent they are able, and obtain written consent from an appropriate proxy.

(g) Social workers should never design or conduct evaluation or research that does not use consent procedures, such as certain forms of naturalistic observation and archival research, unless rigorous and responsible review of the research has found it to be justified because of its prospective scientific, educational, or applied value and unless equally effective alternative procedures that do not involve waiver of consent are not feasible.

(h) Social workers should inform participants of their right to withdraw from evaluation and research at any time without penalty.

(i) Social workers should take appropriate steps to ensure that participants in evaluation and research have access to appropriate supportive services.

(j) Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.

(k) Social workers engaged in the evaluation of services should discuss collected information only for professional purposes and only with people professionally concerned with this information.

(l) Social workers engaged in evaluation or research should ensure the anonymity or confidentiality of participants and of the data obtained from them. Social workers should inform participants of any limits of confidentiality, the measures that will be taken to ensure confidentiality, and when any records containing research data will be destroyed.

(m) Social workers who report evaluation and research results should protect participants' confidentiality by omitting identifying information unless proper consent has been obtained authorizing disclosure.

(n) Social workers should report evaluation and research findings accurately. They should not fabricate or falsify results and should take steps to correct any errors later found in published data using standard publication methods.

(o) Social workers engaged in evaluation or research should be alert to and avoid conflicts of interest and dual relationships with participants, should inform participants when a real or potential conflict of interest arises, and should take steps to resolve the issue in a manner that makes participants' interests primary.

(p) Social workers should educate themselves, their students, and their colleagues about responsible research practices.

6. SOCIAL WORKERS' ETHICAL RESPONSIBILITIES TO THE BROADER SOCIETY

6.01 Social Welfare

Social workers should promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers should advocate for living conditions conducive to the fulfillment of basic human needs and should promote social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.

6.02 Public Participation

Social workers should facilitate informed participation by the public in shaping social policies and institutions.

6.03 Public Emergencies

Social workers should provide appropriate professional services in public emergencies to the greatest extent possible.

6.04 Social and Political Action

(a) Social workers should engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully. Social workers should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice.

(b) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

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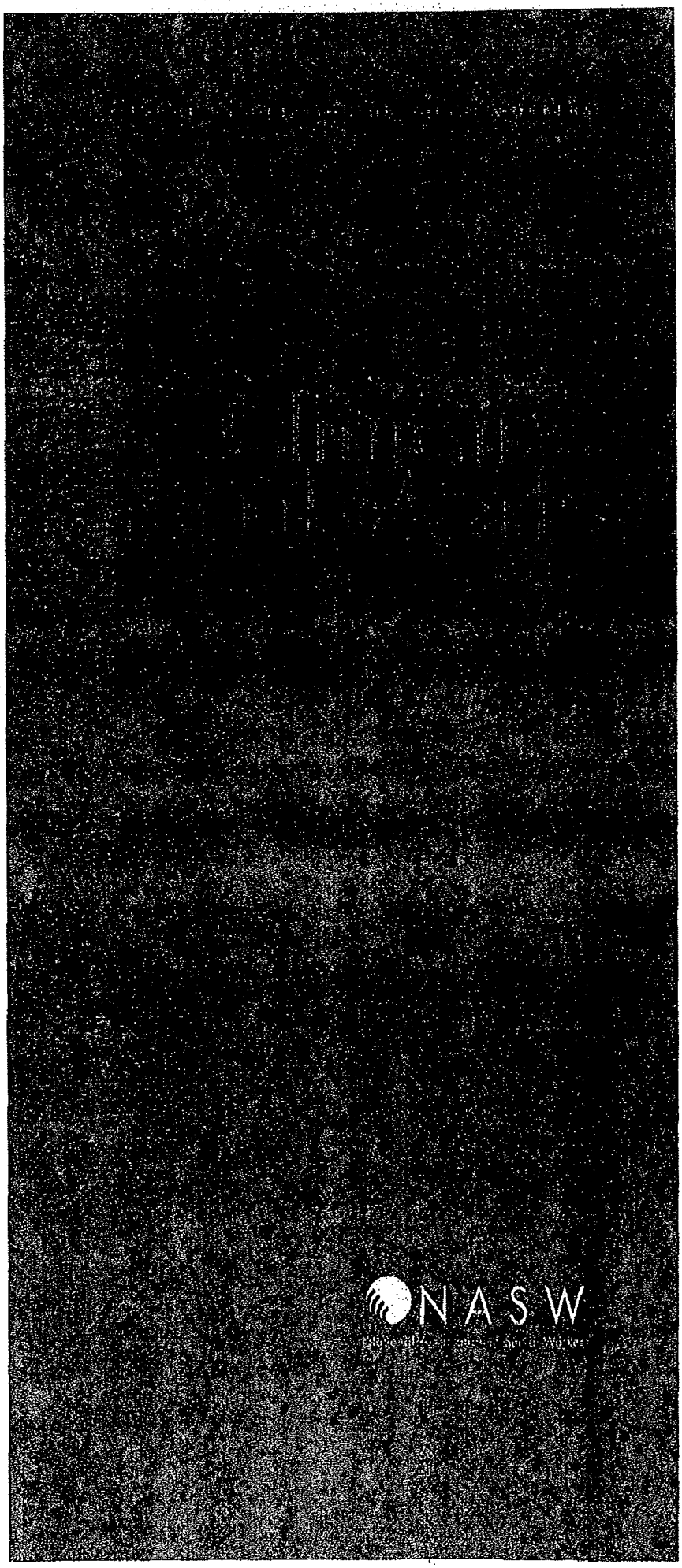

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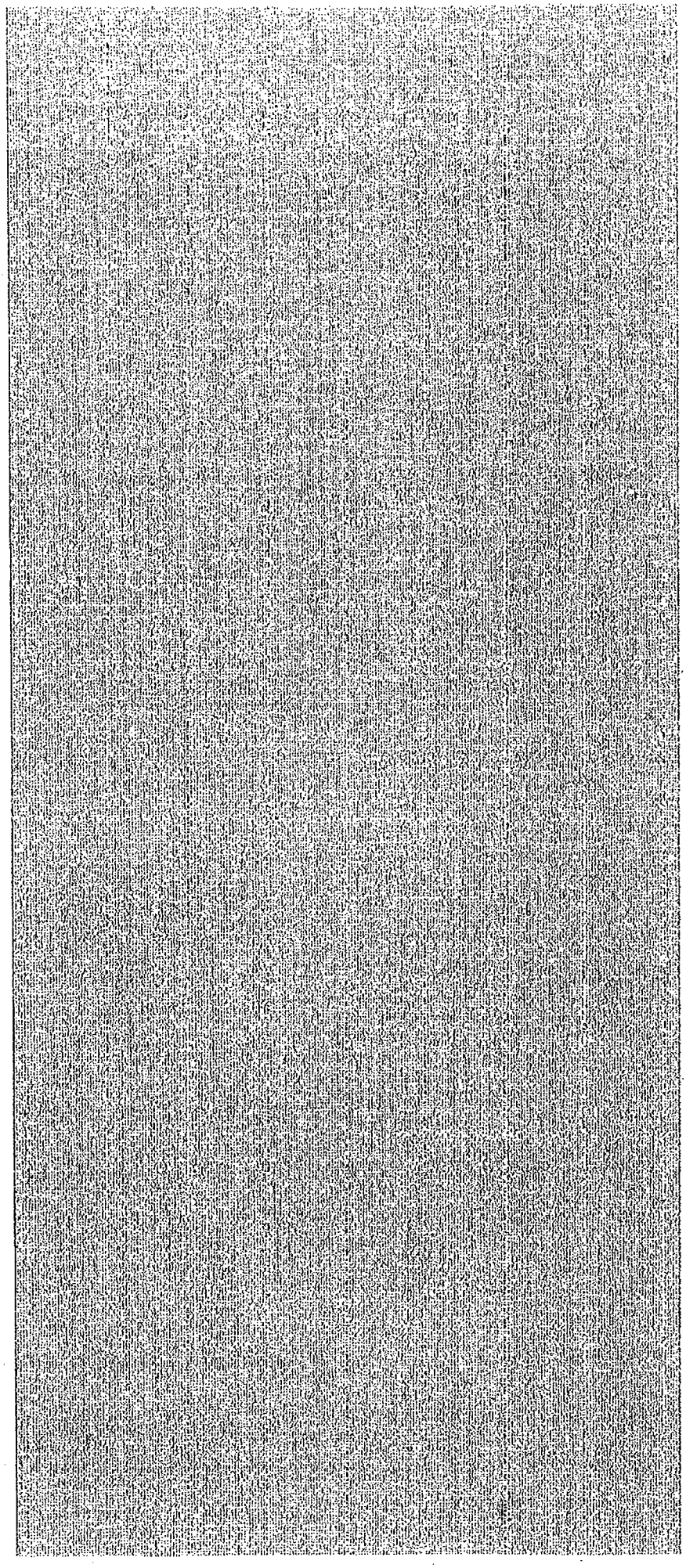

NASW Standards for

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.

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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

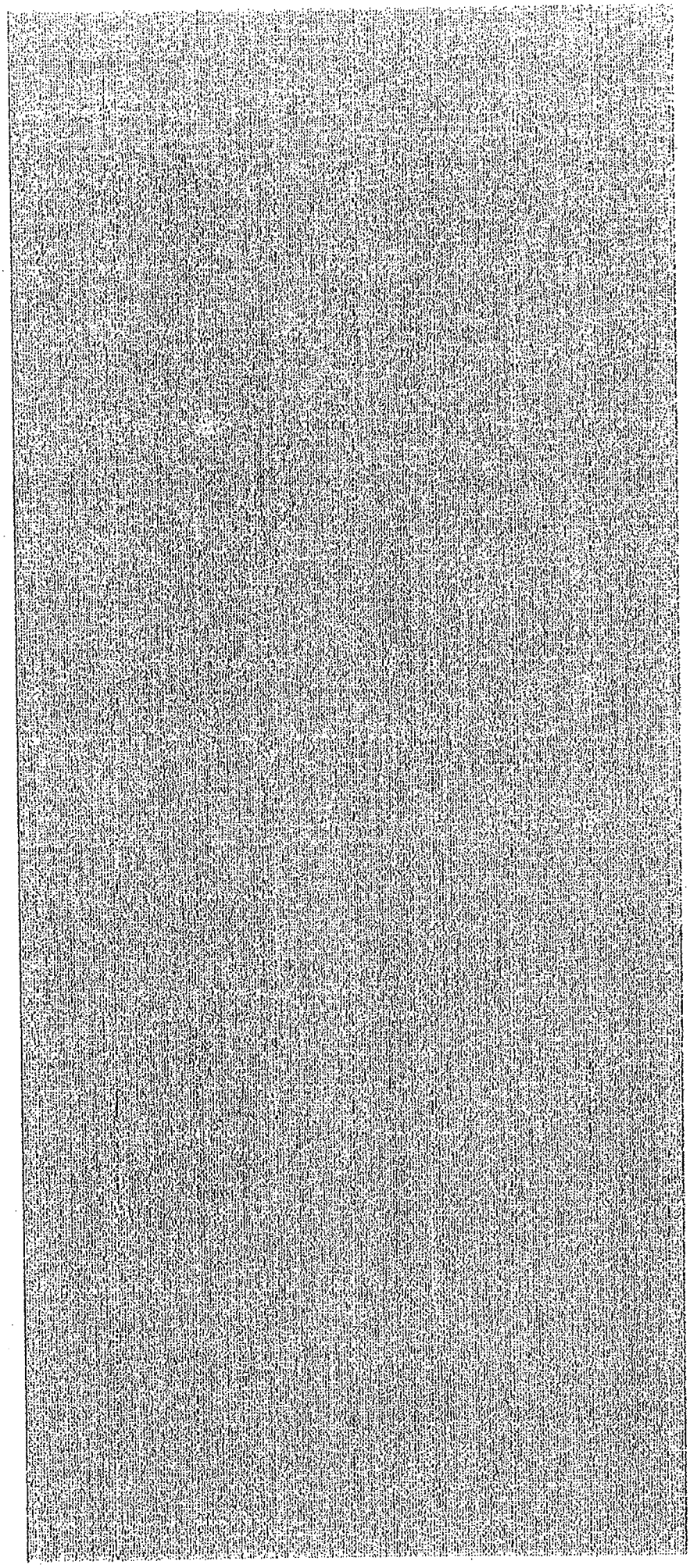
Clinical social workers shall assume personal responsibility for their continued professional development in accordance with the *NASW Standards for Continuing Professional Education* and state requirements.

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.

00 298



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.

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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.

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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).

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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,

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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,

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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

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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.

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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

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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

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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

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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

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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

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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.

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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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00 315

Exhibit 11

LEMS Web

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ICHR REQUEST FOR RAP SHEET
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ATN-CARTER, AMANDA

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PAGE-01 DATE-02/03/2010 TIME-12:51:33
REQ ORI-SC0460000 YORK CNTY SO
SID-SC01823901 FBI-452651XB0
NAME-JAEGGI, CHARLOTTE LYTHGOE SEX-F RACE-W
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FPC- HENRY-

PHOTOGRAPH AVAILABLE
PALM PRINTS AVAILABLE
1-FINGERPRINT IMAGES ON THIS SUBJECT ARE STORED ON SCAFIS

DATE RECORD ENTERED--05/30/2008 DATE OF LAST UPDATE--11/18/2008

ADDITIONAL IDENTIFIERS NAME	BIRTH DATES	MARKS	SOC SEC	MISC NUM
JAEGGI, CHARLOTTE L	[redacted]		[redacted]	

CONTRIBUTOR/SUBJECT DOA/RCVD CHARGE/DISPOSITION/ETC

JAEGGI, CHARLOTTE LYTHGOE 05/30/2008
SC0460000 YORK CNTY SO
CASE-200800003314
ATN-46X008151028
WARR-060649EL
CIT-16-25-20(A)-MISDEMEANOR

ARREST CHARGE 01-CRIMINAL DOMESTIC VIOLENCE 1ST OFFENSE
OFFENSE DATE-05/30/2008
PHOTOGRAPH AVAILABLE
PALM PRINTS AVAILABLE

JAEGGI, CHARLOTTE L 06/22/2008
SC0460300 ROCK HILL PD
CASE-0806221351
ATN-46D300508640
WARR-64435EI
CIT-56-1-440-MISDEMEANOR

ARREST CHARGE 01-DRIVING WITHOUT A LICENSE

A For this case, Mr. Hood and Mr. Shaw.
Q I'm going to ask you this because it makes a difference in what I can ask you or it may.
A Okay.
Q Do you consider Mr. Hood or Mr. Shaw to be your attorneys?
A Yes, or - - - I mean - - - I understand - - -
Mr. Hood - She's on retainer with us.
A Yes.
Q Okay.
A I'm sorry, I didn't understand if it's - - - they're representing Owen so I didn't know if they're technically his lawyer, but we've retained them. I retained them.
Q Who is Elizabeth Hope Rainey?
A Well, I think now she's the Guardian ad Litem for Owen. I know she's an attorney.
Q Do you know her?
A Yes, sir.
Q How do you know her?
A Coincidentally, she did my divorce to my second husband and my husband's divorce, my current husband, to his first wife.
Q Have you had any discussions with her about this case?

A No, sir.
Q Do you know how it was that she became the guardian for Owen?
A I do not know that.
Q Did you have any input into the decision to have her named guardian?
A No, sir.
Q Do you know who made the decision to have her named guardian?
A No, I don't.
Q Do you know whether she has any knowledge, first-hand knowledge, about this case?
A I do not know what she knows.
Q What's your maiden name?
A Charlotte Lythgoe Lavedan.
Q You might have to spell that for them, the last one for me.
A The last one is French, L-a-v-e-d-a-n.
Q What other names have you gone by?
A My first husband, my children's father, is Omohundro which is O-m-o-h-u-n-d-r-o, and I later dropped that name and took on just Charlotte Lythgoe. And my second husband's name was Thomas Jaeggi, J-a-e-g-g-i.
Q Where's Mr. Jaeggi - - - how do you pronounce it,

- - -
A Jaeggi.
Q - - - Jaeggi live?
A Yes, Rock Hill.
Q Does he still live here?
A I have no idea.
Q How long were you married to Mr. Jaeggi?
A Two years.
Q What about to Mr. - - - You were married to Mr. Omohundro?
A Yes, sir.
Q And how long were you married to him?
A Approximately 11 years.
Q And what was the reason for that divorce?
A He was abusive.
Q Physically?
A Yes, sir.
Q Where was that divorce granted?
A Texas, probably Austin.
Q And the grounds was that he physically abused you?
A Yes, sir.
Q Any other grounds?
A He, at the time, was incarcerated for check fraud, I think, so he wasn't there anyway.
Q Did he go to jail for abusing you?

A No, sir.
Q Did you ever have any criminal charges brought against him?
A No, sir.
Q What about Mr. Jaeggi, what was the basis for that divorce?
A Irreconcilable differences.
Q Was there any charge made against you for physical abuse? Although you told me about you were arrested and convicted.
A Just that. It wasn't a physical marriage - - - abusive marriage.
Q Now, did you actually hit him; is that what the criminal domestic violence charge was?
A As I was told by the police, he made the call, Mr. Jaeggi made the call, so I was - - - I was the - - - he was the victim.
Q Did you plead guilty?
A Yes, sir.
Q And you pled guilty to criminal domestic violence in Rock Hill or York?
A Yes, York.
Q And what kind of sentence did you get for that?
A I was told to take criminal domestic violence classes, but I had no means to get to those classes

Q Have you over given a deposition before?
A No, sir.
Q Well, let me tell you what's going to happen is I'm going to ask you some questions about yourself, about your daughter, and about your grandchild, and about the issues raised in this lawsuit. You've been sworn to tell the truth by the court reporter so you're under oath just as you would be before a judge and a jury; do you understand that?
A Yes, sir.
Q Now, we're across the table and if you shake your head up and down I'll understand you but the court reporters do not like to interpret so we need you to answer with words.
A Okay.
Q If you need to take a break for any reason, you let me know. You're entitled to take a break.
A Okay.
Q If I ask you a question, you don't understand it, you didn't hear it, for any reason you're not sure about the question, you have to let me know, and I will try to ask it in a way that it is understandable.
A Okay.
Q If I ask you a question you don't know the answer,

you don't remember, then the truthful answer is you don't know or you don't remember.
A Correct.
Q If you're giving me an answer that's an approximation or an estimate, if you'd let me know so the record will reflect it's an approximation or an estimate.
A Okay.
Q Your birthday?
A March 1st, 1969.
Q Where were you born?
A Yonkers, New York.
Q Where did you grow up?
A Houston, Texas.
Q What's your education?
A I made it to eleventh grade, and I got a GED later.
Q Where were you when you dropped out of high school?
A Houston, Texas.
Q Why did you drop out?
A I just wasn't getting it. I just wasn't a good student.
Q Did you not go back to the twelfth grade or at some time during the eleventh grade you said I'm tired of this, I'm out of here?
A I kind of just left school.

Q What, fall? Spring?
A Probably the middle of the year, the middle of the school year.
Q Now, when did you get your GED?
A When I was 30.
Q Where did you get that?
A In Alabama.
Q Any education since you dropped out of high school, meaning and I should say, any formal education?
A Correct. No, sir.
Q Have you ever been convicted of a crime?
A Yes, sir.
Q And what crimes have you been convicted of?
A I had a CDV charge four years ago approximately. I think if a DUI is a conviction, I've had one DUI, also four years ago.
Q One DUI?
A Yes, sir.
Q And the CDV, is that criminal domestic violence?
A Yes, sir.
Q When was that?
A Approximately 2008.
Q And where was that?
A In Rock Hill. Rock Hill, South Carolina.
Q And where was the DUI?

A Also in Rock Hill.
Q Any other criminal convictions?
A No, sir.
Q Any other arrests?
A No, sir.
Q What were the circumstances of the criminal domestic violence?
A It was, I guess you could say, the last day of my second marriage, just it didn't end well.
Q I assume there was some type of a assault against somebody else?
A Yes, sir. We had an argument. It resulted into a physical fight and when the police arrived they took me in.
Q Was your husband charged, - - -
A No, sir.
Q - - - or I should say ex-husband?
A Correct. No, sir.
Q Have you ever filed any lawsuits?
A No, sir.
Q Have you retained an attorney in this case?
A Yes, sir.
Q And who have you retained?
A Well, for Owen, correct?
Q With this case.

Exhibit 12

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

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 [redacted] 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 [redacted]

3. I have reviewed the medical records of Owen [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 [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 [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 Carduff.

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 [redacted] and the South Carolina (York County) Department of Social Services records of Owen [redacted] The factual basis of my opinions may be supplemented at a later time.

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

[SIGNATURE PAGE TO FOLLOW]

GEORGE W. SAVARESE, Ph.D., LCSW

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

Jennifer N Plohr
Notary Public

"OFFICIAL SEAL"
Jennifer N Plohr
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Commission Expires 5/26/2012

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In re: Elizabeth Hope Rainey (Guardian Ad Litem to Owen [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 [redacted] 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 [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 [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)*
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> *National Association of Social Workers (NASW) "Standards for Clinical Social Work in Social Work Practice" (2005)*
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> *National Association of Social Workers (NASW) "Standards for Social Work Practice in Health Care Settings" (2005)*
>
> *National Association of Social Workers (NASW) "Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital" (1990)*

The specific standards are outlined below, grouped by the domains of Assessment, Communication, Intervention, and Documentation corresponding to the key areas upon which the findings of this evaluation are based, as outlined in Section III.

ASSESSMENT

NASW Code of Ethics
Section 4.01: Competence

> Social workers should strive to become and remain proficient in professional practice and the performance of professional functions.

NASW Standards for Clinical Social Work in Social Work Practice
Standard 2: Specialized Practice Skills and Interventions

> Clinical social workers shall demonstrate specialized knowledge and skills for effective clinical interventions with individuals, families, couple, and groups...They shall be familiar with social, psychological, cultural, and health factors that influence the mental, emotional, and behavioral functioning of the client...They shall have the ability to gather and interpret social, personal, environmental, and health information... evaluate and treat problems within their scope of practice... [and] collaborate effectively with other social workers or allied professionals, when appropriate... They shall be accountable for all aspects of their professional judgment, behavior, and decisions.

Pre-revised Version (1989 to 2005): Clinical social workers shall have and continue to develop specialized knowledge and understanding of individuals, families, and groups and of therapeutic and preventive interventions... including the ability to ...obtain, analyze, classify, and interpret social and personal data, including assessment and diagnosis.

NASW Standards for Social Work Practice in Health Care Settings
Standard 5: Knowledge

Social workers in health care settings shall demonstrate a working knowledge of current theory and practice and integrate such information into practice...Essential areas of knowledge and understanding about health care include: the biopsychosocial needs of clients and families, the psychological... needs of clients and families and how to ensure that they can be addressed.

NASW Standards for Social Work Practice in Health Care Settings
Standard 6: Assessment

Social workers shall provide ongoing assessment, including gathering comprehensive information to use in developing interventions and treatment strategies.

COMMUNICATION

NASW Code of Ethics
Section 2.03: Interdisciplinary Collaboration

Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that effect well-being of client's by drawing on perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established...Social workers for whom a team decision raises ethical concerns should attempt to resolve the disagreement through appropriate channels.

NASW Code of Ethics
Section 2.05: Consultation

Social workers should seek the advice and counsel of colleagues whenever such consultation is in the best interest of clients.

NASW Standards for Social Work Practice in Health Care Settings
Standard 11: Teamwork and Collaboration

> Social workers shall participate in care teams and collaborate with other professionals, volunteers, and groups in and outside of their practice setting to enhance all aspects of the client and family system's care...Social workers participate in multiple care teams, which are typically interdisciplinary. As part of such teams and collaborations, social workers shall demonstrate the ability to...ensure that the social work role and responsibilities are clearly delineated and communicated to other members of the team.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
Indicator 5: Teamwork

> Patient discharge occurs with the knowledge of the social worker coordinating discharge planning...Social workers are responsible for coordination of patient's discharge plans, especially when post-hospital care is required.

INTERVENTION

NASW Code of Ethics
Section 1.16: Termination of Services

> Social workers should terminate services to clients...when such services are no longer required or no longer serve the client's needs or interests...Social workers should take reasonable steps to avoid abandoning clients who are still in need of services... [should give] careful consideration to all factors in the situation [and] taking care to minimize possible adverse effects... [and] should assist in making appropriate arrangements for continuation of services when necessary.

NASW Code of Ethics
Section 2.06: Referral for Services

> Social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that additional

service is required...Social workers who refer clients to other professionals should take appropriate steps to facilitate an orderly transfer of responsibility. Social workers who refer clients to other professionals should disclose, with clients' consent, all pertinent information to the new service providers.

NASW Standards for Clinical Social Work in Social Work Practice
Standard 3: Referrals

Clinical social workers shall be knowledgeable about community resources and make appropriate referrals, as needed...They shall maintain collaborative contacts with social work or other related professionals and make appropriate referrals, as needed.

Pre-revised Version (1989 to 2005): Clinical social workers shall be knowledgeable about the services available in the community and make appropriate referrals for their clients...When a client is being served by other agencies, the clinical social worker shall maintain collaborative contacts as necessary with the other providers to ensure the coordination of services and the client's receipt of optimal benefits from the various services...When the client is involved with more than one clinician, collaborative consultation shall be maintained as necessary to ensure delineation of the specific areas of responsibility.

NASW Standards for Social Work Practice in Health Care Settings
Standard 7: Intervention and Treatment

Social workers implement intervention and treatment plans that promote client well-being and ensure a continuum of care. Planning shall be based on a comprehensive, culturally-competent assessment with interdisciplinary input...Intervention and treatment plans include strategies to address needs identified in the assessment...discharge planning...[and] client and systems advocacy.

NASW Standards for Social Work Practice in Health Care Settings
Standard 10: Client and Community Education

Social workers act as educators for clients, families, the community, and other professionals regarding disease prevention, impact of the illness and disease progression, advocacy for benefits, health maintenance, and adherence to treatment regimens...Assessment identifies the educational needs based on the expressed needs of individuals, family members, and significant others. The social worker identifies deficiencies in the

knowledge base of the client and works with the client to obtain the needed information and resources.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
Indicator 6: Readmissions with Social Complications

Patients are readmitted with social complications. Social workers are responsible for ensuring that patients receive the immediate post-hospital care they need and adapt to the post-hospital setting. Readmission of too many patients due to social complications suggests either that they did not receive social work services or that these services were inadequate.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
Indicator 1: Follow-Up

Patient discharge care is assessed following discharge. Patients who are at high risk for developing problems with post-discharge care should receive a follow-up assessment after discharge to determine whether the aftercare plan is being implemented as planned.

NASW Clinical Indicators for Social Work and Psychosocial Services in the Acute Care Medical Hospital
Indicator 2: Problem Resolution

Patient's medically related psychosocial problems are ameliorated. The intent of social work intervention is to improve or resolve patients' psychosocial problems related to their medical care. Problem improvement or resolution is an indicator of whether the intervention has achieved its goal.

DOCUMENTATION

NASW Standards for Clinical Social Work in Social Work Practic,
Standard 8: Documentation

Documentation of services provided to, or on behalf of, the client shall be recorded in the client's file or record of services...Documentation must reflect an accurate account of services. Progress notes, reports, and summaries of services shall be regularly recorded in the client's file.

III. Specific Deviations from Standards of Care

The specific deviations from the above standards of care by CMC employees (with a specific focus on the hospital social workers) can be understood as occurring in four primary domains: Assessment, Communication, Intervention, and Documentation. These deviations include the following:

ASSESSMENT

Failure to conduct an independent, appropriate, and complete psychosocial assessment within the institutional hospital setting

- [Did you make any clinical assessment of either parent to determine if either were a risk of being or becoming abusers of their child?] "My interaction with them [the parents] would have been more brief than Katie's [Katie Harrison, MSW] was...because their story about the admission would have already been told and DSS would have already been involved, so generally we don't continue to ask them to share the story over and over again." [NEWMARK 162:20]

  Comments: It is clear that the social worker believes that her assessment is limited to simply obtaining the parents' "story" of what happened. This grossly minimizes the critical social work role of conducting a comprehensive psychosocial assessment, which includes assessing the risk potential for harm to the child in order to facilitate a safe discharge. The purpose of the psychosocial assessment is to gain a thorough understanding of the factors that may contribute to circumstances or conditions which could reasonably result in abuse/neglect or a significant risk of harm to the child. From a continuity of care perspective, by reading the weekend social worker's note [Katie Harrison, MSW], Ms. Newmark should have seen that the information contained in that initial assessment was minimal and that further assessment was necessary in this regard.

- CMC Policy & Procedures indicate that in cases with juveniles suspected of being abused or neglected the clinical team must "Consult CHS (Carolinas Healthcare System) Clinical Care Management Social Worker to aid in the assessment process...Utilize your hospital MSW's during regular business hours." [NEWMARK Exhibit 10]

  Comments: Based on the hospitals own policies and procedures, the social workers role and responsibility to conduct a comprehensive psychosocial assessment are clearly outlined.

- "The presence of risk factors should not be used as indicators of child abuse but rather to provide guidance in prevention strategies as well as management and treatment plans." [COURTLAND Exhibit 14] ["A careful and well-documented history is one of the most critical elements of the medical evaluation, right?] "Yes." [COURTLAND 90:18]

  Comments: *It is the role of the social worker to assess the presence of psychosocial risk factors in the patient's past and present history that are used to develop the risk profile in conjunction with the medical evidence. Factors which constitute the basic elements of a psychosocial assessment (which is the specific purview of the social worker), include a developmental history, pregnancy history, familial patterns of discipline, the child's temperament, social and financial stressors, demographic risk factors, parental attitudes, marital/relational issues, etc. The risk profile is then used to guide the discharge plan with regard to the level of precaution necessary to protect the child from harm. The social worker doesn't have to "solve the case" regarding abuse, per se. The social work role is to assess and comprehend the risk profile then communicate to the hospital multi-disciplinary team and outside agencies the proper degree of inherent risk based on the psychosocial assessment.*

- Laura Newmark, MSW, and Katie Harrison, MSW were the two key hospital social workers involved in the case. Ms. Harrison, the weekend social worker, has a total of 4 progress notes (dated12/06/09). Taken together, they comprise her entire psychosocial assessment. Ms. Newmark has 2 progress notes.

  With regard to Katie Harrison's assessment, the relevant psychosocial information in her 4 progress notes (dated 12/06/09) includes: "...parents do not have a home phone...Parents report that on Wednesday (12/02/09) parents noticed...baby...screaming non-stop...patient...went limp but was still breathing...patient has blood on the right side of his brain...Parents deny any trauma, that anyone dropped the baby, patient's birth was normal, full-term. Baby is only watched by parents and maternal grandmother, no daycare...baby does have South Carolina Medicaid, WIC, mom has food stamps...Both parents work... Maternal grandmother watches baby when parents are working...RN Sara did report that maternal grandmother did tell her privately that when she had picked up baby from dad and uncle that she noticed baby had a bump on his head, she asked dad and uncle about this and dad and uncle stated they had no idea why this happened...MSW will follow as needed." [NEWMARK Exhibit 1]

With regard to Laura Newmark's assessment, the relevant psychosocial information in her 2 progress notes (dated 12/07/09) includes: "...anticipate discharge hopefully this date. Owen lives with parents, no other children, does have Medicaid, WIC, transportation, frequent babysitting with maternal grandmother. Both parents employed, father has finished 10th grade, mother 11th. MSW discussed safe sleeping, other parenting education available for parents prior to discharge...will follow for safe discharge plan. Updated RN, MD." [NEWMARK Exhibit 1]

Comments: In effect, Ms. Newmark "rubberstamped" Ms. Harrison's assessment. She did not add any additional information to the chart that addressed the risk profile. Essentially, both social workers abrogated their professional duty to conduct a competent comprehensive psychosocial assessment, essentially leaving the task to be done by DSS. The information contained in the total of 6 progress notes is minimal and does not explore or probe any of the areas that a competent psychosocial assessment should, particularly in a case involving potential child abuse. This is not to say that it was not appropriate for DSS to conduct their own investigation of the case, but rather to point out that the hospital social workers have a duty to conduct a comprehensive independent psychosocial assessment as well. Despite the fact that the psychosocial assessment did not address the necessary areas, the information that was contained in the social work progress notes and in the patient's medical chart contained enough facts that indicated a high risk of harm to the child which was not recognized by the social workers. These facts are listed below.

Failure to comprehend the high-risk profile for child abuse despite the presence of numerous evidence-based clinical markers

Markers that were identified in the social workers psychosocial assessment based on interviews with parents and a review of the medical chart:

- The medical findings of subdural hematomas (bleeding of the brain) that could not be explained medically
- The possibility of non-accidental trauma could not be conclusively ruled out
- Parental explanations that did not adequately explain the injury [COURTLAND 35:7]
- A delay of 8-10 minutes to do anything at all when they thought the child "was dead" and "went limp". "Owen lethargic, not responsive and we thought he was dead." [DSS 00143]

- No call to 911/ambulance, instead driving the child to ER *(The parents had no home phone but did have a cell phone; they said they "thought it would take too long for the ambulance to arrive.")*
- No witnesses to corroborate father's story
- Father was the last person alone with the child when the injury occurred
- Adolescent, unmarried parents
- Low socioeconomic status of parents
- Low education level of parents
- An unidentified babysitter was reported to have been involved with the child on the Thursday preceding the injury
- Child "screaming non-stop"; "crying incessantly", "Irritable", "fussy"; "increased crying episodes" [COURTLAND 34:8; 98:7] in weeks preceding injury *(An inconsolable child is a classic trigger for child abuse.)*

  Comments: These factors noted above, when considered together, should have served at a minimum, to reflect a risk profile consistent with the strong possibility of child abuse. As such, the need for safety precautions should have been regarded as high from the point of admission. Given the risk profile noted and the fact that non-accidental trauma could not be definitively ruled out, the social workers should have erred on the side of caution in the discharge planning process.

- "I don't think we can predict the future on what is or what isn't going to happen in working with DSS." [NEWMARK 84:21]

  Comments: This is the very reason why the standard of care in practice is to err on the side of caution, which was not done in this case.

- "I don't agree that the parents were suspected [of child abuse]. A report was made and in terms of erring on the side of caution, we'd rather make the report to DSS than not and hope that DSS can do a complete follow-up that we can't do here in the hospital." [NEWMARK 125:19]

  Comments: How the social worker could not agree with the fact that the parents were suspected of abuse is difficult to understand. The fact that the physicians could not rule out NAT by default indicates that there was still a suspicion of abuse. The problem is that the social worker herself did not recognize this inherent risk and diminished it to the extent that all of her subsequent involvement in the case was predicated on this perception of diminished risk. Additionally, there was no reason that the social worker was unable to do a competent psychosocial assessment in the hospital. Given a four day hospitalization and full access to the family, the social worker had more than ample opportunity to interview the principle persons involved. Although assessing the home environment was

important, it was not necessary to formulate an appropriate discharge plan given the risk profile presented in the hospital. The social worker simply deferred her professional responsibilities to DSS.

Markers that were not known due to lack of probing/exploring in interviews with parents and other available collateral sources:

If the parents were independently assessed properly by the social workers (and/or DSS), collateral sources were interviewed, records were obtained, and standardized instruments were utilized, the following additional information would potentially have been elicited, indicating even a higher degree of risk in sending the child home to the parents:

Information available from Michael [redacted] (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 Own, 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 Lyhgoe (paternal grandmother), Aaron Lythgoe (father's step-brother, age 12), and the "Thursday babysitter" (This person was never identified or interviewed)

Failure to request pertinent background records

Comments: There is no documentation that any medical, police, prior treatment, or other records were requested by the social workers. Such records are invaluable in conducting a comprehensive psychosocial assessment.

Failure to utilize standardized child abuse screening tools, inventories, and testing

Comments: The use of risk assessment instruments, inventories, and/or screening tools is generally considered to be useful in assessments for potential child abuse (e.g., Child Abuse Potential Inventory, Child Maltreatment Interview Schedule, The Parent Stress Index, etc.) A request to get a psychologist to administer these or any other tools to assess the risk potential for harm of the child should have been made. Such instruments are not used to determine who committed the abuse but instead to measure parental characteristics and family conditions that are believed to be predictors or precursors of potential child maltreatment or other harm to the child in order to determine the level of safety needed before the child is returned home.

COMMUNICATION

Failure of to fully comprehend the professional social work role and responsibilities within the context of the hospital's multi-disciplinary team and the inter-collaborative relationship with DSS

- "My responsibility as the medical social worker is to communicate information to DSS from the team and back to the medical team from DSS...["...all you are is just a messenger back and forth between the two of them?] "...No, I can give my opinion to the doctors...and say that if there's anything in particular"...["Well, in this particular case, what insight did you give to the doctors?"] "I don't recall, off the top of my head..." [NEMWMARK 33:9; 55:10; 55:15]

  Comments: Communicating with the team and outside agencies is only one facet of the social worker's role and responsibilities. The information that is communicated must include the social worker's psychosocial assessment, which is an integral part of the hospital team's information that must be gathered. The social work role is clinical, not just clerical. The professional social worker's perspective and contribution to the clinical picture is central to the hospital team's workup. Not only can the social worker give an opinion, this is what the social worker must do in ensuring that the hospital team has a complete understanding of the psychosocial dimensions of the patient's concerns and needs. In this case, the social worker did not contribute the social work perspective within the standard of care.

- "Part of the safety net and working on discharge, as far as the hospital social work piece, is to get DSS involved, because they can be involved in the home community, where we can't." [NEMWMARK 31:20]

  Comments: Yes, part of the discharge "safety net" is to make a referral to DSS, but the other parts are to provide accurate information to the hospital team and other agencies based on a comprehensive psychosocial assessment, then offset that risk before the child is returned to the home/community, precisely because you don't know what might happen while DSS conducts its investigation.

- "I think that the medical team has a responsibility to do a workup on a child that comes in with an unexplained injury and part of that is calling DSS, working with them, making sure they have all the right information, doing everything we can to do a complete workup, as a way to help protect him [the child]." [NEMWMARK 47:6]

  Comments: Yes, this is a more accurate understanding of the hospital's responsibility to ensure a safe discharge back to a safe environment, but the social worker did not make sure DSS "had all the right information" or "do everything we can to do a complete workup". To do so requires that the social worker contribution begins with a comprehensive psychosocial assessment.

- "I don't have any say as to where [the child] goes upon discharge, as a hospital employee...; I'm a liaison between the medical team and DSS...I share information on the clinical status and what's going on with the patient with DSS, who has the ultimate discharge plan put in place...I give them information. I don't control the final decision...; Disposition and discharge would be at the DSS discretion...[the state's responsibility?]...yeah, it's DSS...; In my experience...DSS tells us...when there's an open investigation, where the child is going to be discharged to...; Disposition has been determined by medical social worker and DSS—the way I could read that, back to me being a liaison, that I'm making sure that the team knows that DSS is involved in what they recommend." [NEWMARK 10:15, 10:25-11:1, 11:16, 11:24, 115:11, 115:17, 116:22]

  Comments: The social worker clearly misunderstands her professional role in the multi-disciplinary team. She describes her role as primarily passing information onto DSS about the clinical status of the patient, yet diminishes her own responsibility in contributing to that information in terms of her own assessment of the patient's status. In effect, she describes her role as more clerical than clinical. In fact, as the social worker, the primary professional responsibilities include initial screening

and evaluation of patient and families, conducting comprehensive psychosocial assessments, counseling, crisis intervention, information and referral, educating hospital staff on patient psychosocial issues, promoting communication and collaboration among health care team members, and coordinating patient discharge and continuity of care planning, among other duties. The social worker is responsible for putting the medical data into a psychosocial context. While the physicians attempt to determine the etiology of the child's injuries based on the medical evidence, the medical social worker attempts to determine the etiology and intentionality of the injuries based on the psychosocial evidence. This is a key clinical and decisional responsibility, one which in the absence of conclusive medical data, becomes that much more critical.

- "When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS....MSW involved...Check with medical social worker about discharge...Extensive conversation with Dr. Morgan-Glenn [and] medical social worker regarding case...DSS to follow family with home visits, supervision...[Plan] cleared by medical social worker...[Per] DSS/social worker, OK to discharge with mom and dad. Will discharge home...Discharge home with parents with medical social work approval...Pending social work OK, patient OK to discharge" [COURTLAND Exhibits 2, 22, 23, 34, 35; COURTLAND 105-108]

  Comments: The attending pediatric physician and other medical professionals clearly rely on the input of the medical social worker with regard to the discharge planning process. Although there is a liaison component to the social work position, this is in regard to the responsibility to communicate relevant information with the team and outside agencies only. In arriving at a discharge disposition, the content of the social work psychosocial assessment is in large measure the key information that must be communicated to DSS in addition to the medical data as reported to the social worker by the physicians and other ancillary staff. The social work role is clearly much more than that of a liaison passing along information to DSS. The medical professionals within the hospital's multidisciplinary team distinctly recognize the decisional component of the social work role. In cases of suspected child abuse, the decision to discharge is the joint responsibility of both the social worker AND DSS, not either one independent of the other.

Failure to collaborate, consult, and follow-up appropriately with the hospital multi-disciplinary team, Department of Social Services (DSS), and/or others to effectively ascertain and communicate the nature of the high-risk for child abuse

Comments: There is no documentation anywhere in the record that the social worker communicated to any member of the hospital multi-disciplinary team, to DSS, or to law enforcement, any specific concerns regarding the family risk profile that would alert anyone among the inter-collaborative agencies involved, to the need for exercising caution in the discharge plan other than making a referral to DSS. This reflects the social workers lack of comprehension of the risk factors themselves. The referral to DSS was legally mandated based on the suspicion of abuse and does not reflect any degree of appropriate caution in protecting the child by recommending to anyone a more structured discharge plan and/or safety plan. In failing to appropriately assess, comprehend, and then communicate the inherent risk profile to the hospital multi-disciplinary team and DSS, the social worker set into motion a causal chain of misinformation that, passed from agency to agency, distorted and minimized the true nature of the high inherent risk for abuse and the need for more structured precautions.

- "I think the hospital fulfilled its duty in making the report to DSS and providing them with up-to-date- information." [NEWMARK 35:20]

  Comments: The hospital's, and more specifically the social workers', duty was to conduct a competent psychosocial assessment, communicate accurately the potential risk of harm to the child, make a referral to DSS, then implement a safe discharge plan while DSS conducted its investigation. The ability to provide "up-to-date information" from the social work perspective assumes that a competent psychosocial risk assessment was conducted and communicated in addition to the medical findings. This, however, was not the case.

- [Regarding the role the hospital plays in DSS's investigation] "...we would certainly interview them and take into consideration any concerns that they have." [Do you look to them to help make your case decisions?] "Absolutely." [HINNANT 26:8]

  Comments: The DSS supervisor highlights the fact that they depend on the input of the hospital staff to make their dispositions. The social work input is critical with regard to the psychosocial aspects of the case.

- "...If there had been something else that was of concern [as communicated by the hospital social worker], we may still have indicated our case...there were concerns that the parents were young and that they were immature and, maybe...concerns of lack of supervision." [HINNANT 64:5-12]

  Comments: The concerns communicated to DSS indicate that the hospital's understanding of the risk to harm was grossly diminished, despite the numerous risk factors present and documented. The focus of "concerns" was around the parents' immaturity and lack of supervision of the child. This indicates that the hospital's understanding of the injuries (as communicated by the social worker) were skewed toward an interpretation and assumption of accidental trauma, when the risk of non-accidental trauma had not yet been ruled out. This tainted assessment of the facts significantly compromised an accurate communication of the facts to DSS.

- [We let the child go home because] "...the hospital wouldn't make a statement whether or not it was accidental or non-accidental...we had nothing...They said their concern was a lack of supervision...that someone wasn't watching the baby...somehow his head could've been bumped...they wont go on record saying it was either accidental trauma or non-accidental trauma. They weren't going to tell me...The hospital, they have implications in their case record that grandmother knew this was happening and di nothing...she had an idea...saw marks...I wish she had called us...They [the hospital] weren't giving us any indications that they had any real concerns, all those things that would indicate that the baby had been shaken, they didn't have any...See they [the hospital] should've been calling and making a report to us...had they any concerns...see, we could have looked at it a lot differently...that they [the parents] were acting suspicious and Kayla had called one day and made a remark that she was going to lose it, to come get the baby...so they didn't tell us any of this until afterwards...They're not giving us a whole lot. You know they won't make statements...And what happened is the social worker made the report on this and the doctor did not advise the social worker to make the report. They made that real clear to me when I called and spoke with them at the hospital...In this case they're not [giving us enough reason to remove the child] They don't have any suspicions." [AUDIO TRANSCRIPTS, CHRISTA DSS, 01/19/10]; [HINNANT 83:10-22]

  Comments: The DSS supervisor clearly indicates the diminished sense of risk that was communicated by the hospital social worker. The social worker essentially reported only the medical findings to DSS, indicating that they could not rule out non-accidental trauma. None of the contextual

psychosocial risk factors were communicated. As a result, beyond simply reporting a lack of conclusive finding of abuse, the sense of risk was further diminished in conveying that the injury was more likely than not, accidental. Beyond not giving DSS a specific finding of abuse, the key is here is that the sense of risk was specifically minimized. This miscommunication of the potential risk was based on both the inadequate psychosocial assessment and the lack of comprehension of the significance of the available information by the hospital social worker.

- ["...(W)hat input does the hospital have into that (discharge) decision?"] "...any concerns that they have had for us to address." [HILL 42:20]

  Comments: DSS clearly relies on the hospital to communicate "any concerns" they may have with regard to their assessment of the child's needs.

- "Along with all that and what y'all had told me...I felt comfortable with it [not sending out a police investigator]. Maybe I shouldn't have...I didn't ever see that stuff that the grandfather or whoever it was said...they had seen all these mysterious bruises, and they even went so far as to photograph a bruise on the child at some point. See we weren't even made aware of any of that...If I can get all the information then it gives me a whole lot clearer [picture]...like what I'm reading here [about the subdural hematomas]...I'm going head-hunting!...But that one [the subdural hematoma] that went behind the...skull...you know that's not something they usually get by just falling, Lola....There's no consistency [in this case as to the parent's explanation of the injuries]...We definitely need to find out what the uncle's deal is, who he is, you know, all that good stuff...We're supposed to work as a team, we're not supposed to be pulling away from each other." [AUDIO TRANSCRIPTS, CHRISTA DSS, 01/19/10; LOLA DSS PART 1 & 2, 12/17/09]

  Comments: After the child was re-injured in January,2010, law enforcement (Lt. Miller) describes clearly how he was influenced by the diminished sense of risk and lack of information communicated to DSS by the hospital and then by DSS to him to the extent that the York County Sheriff's Office never initiated an investigation into the matter in December, 2009. Additionally, he articulates the suspicions he would have had regarding the case and how he would have explored these more fully than was already the case by both DSS and the hospital.

- "I think I would continue to work with community resources and make sure that there was going to be appropriate follow-up, if we were concerned that the follow-up wasn't going to happen. [NEWMARK 115:4]

Comments: One of the duties of the hospital social worker is to follow-up regarding the status of the collaborative referrals that are made in the community. The record does not indicate that any such follow-up was made by the social worker with DSS, the family, or any other agency. There was a follow-up skeletal survey scheduled outside of the hospital, but no social work follow-up is documented that considered the results of that second survey.

- "Yeah. It's like this one really fell through the cracks because nobody—PMC (Piedmont Medical Center) didn't call law enforcement on that one, and Levine's never called law enforcement. It's like, 'Holy crap.'" [AUDIO TRANSCRIPT, CHRISTA DSS PART 1 & 2, 12/17/09]

  Comments: The option to refer a case to law enforcement is not the exclusive responsibility of DSS alone. Anyone can make such a referral. Given the nature of the risk profile, there was nothing to preclude the hospital social workers from contacting law enforcement in the interest of erring on the side of caution. Such a referral was never made.

INTERVENTION

Failure to develop an appropriate differential discharge plan that adequately utilized the numerous alternatives, options, and community-based resources available to ensure the child's safety

Comments: Because the social worker did not comprehend the inherent risk in a discharge to the home setting under the parents' supervision while DSS conducted its investigation over a period of weeks, the available alternatives for implementing a safe discharge plan were not considered. Some possible considerations include:

Temporary foster care
Court order for ex parte removal of child
Live-in care
Initiate/coordinate law enforcement investigation
Appoint a Guardian Ad Litem
Delay discharge; keep in hospital until safety plan is established
Relative placement (assuming they have been evaluated and cleared)
Clear all visitation with DSS
Mother and father supervised at all times
Obtain a restraining order

Examples of other appropriate discharge plans that could have been considered (based on the Jan, 2010, second hospital encounter):

- [On 01/11/10, as the DSS investigation began at the time of the second hospitalization, the following safety plan was written]: "Safety Plan: ...Kayla and Michael will have no unsupervised contact with Owen [redacted] Owen [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 [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 [redacted] Owen [redacted] will not go home with Kayla and Michael." [DSS00147]

DOCUMENTATION

Failure to document effectively the nature of the assessment, communication, and interventions related to the high-risk for child abuse

- [The Suspected Chile Abuse and Neglect form (SCAN) "wasn't completely filled...out because...that's a form that's used on admission. So all the information that is required to be put in that form had already been gathered before." [COURTLAND 55:7-13]

  Comments: *But the information to be gathered by the nurse [Lynn Meyers, RN] was not documented anywhere while the information that was documented by the hospital social worker was inadequate as well. The fact that the injury was not determined until after admission does not preclude each practitioner from conducting their own independent assessment before discharge. Each staff member has a responsibility to complete their own independent assessment during the hospitalization and to not "rubberstamp" the assessments of others.*

IV. Conclusion

Although the defense contends that: "[t]he decision regarding the discharge of a child into the custody of his parents or to some other person or entity is a decision that must be made by the Department of Social Services (DSS), by law enforcement, or by the courts, and is not a decision which can be made by a hospital or physician [MOTION FOR SUMMARY JUDGMENT]", this is not the case.

As outlined in the hospital's (CMC) Child Abuse and Neglect Algorithm [NEWMARK Exhibit 2], in cases of suspected child abuse or neglect, discharge decisions are the joint responsibility of the hospital and DSS who work together to determine the appropriate disposition for the child. Specifically, the algorithm states: "When medically cleared, do not discharge child until disposition has been determined by medical social worker and DSS [NEWMARK Exhibit 2]."

DSS and law enforcement each depend upon the hospital's assessment of risk, which is based on a combination of both medical and psychosocial data. Within the context of the multi-disciplinary team model, the medical data is the responsibility of the hospital physicians, nurses, child maltreatment specialist, and other ancillary staff while the psychosocial data is the responsibility of the hospital social workers. The hospital discharge plan is the culmination of this two-pronged assessment of medical and psychosocial risk.

In December, 2009, although purportedly designed to offset the risk of the possibility of non-accidental trauma, both the hospital's discharge plan and DSS's safety plan clearly were based on the assumption that the child's injuries were more likely than not, accidental. This is evidenced by the fact that, while the parents were still under suspicion of having possibly abused the child, the child was placed back into their very care with instructions that they were to "...supervise 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 breeching this duty, a causal chain of misunderstood and miscommunicated risk of potential harm ultimately led each organization involved in the continuum of care to not take the appropriate steps to put into place adequate safety measures necessary to protect the child, thereby resulting in the child's re-injury in January, 2010.

GEORGE W. SAVARESE, PhD, LCSW

Sworn to and signed before me
this 6 day of April, 2013

Notary Public

"OFFICIAL SEAL"
Marina L Stevens
Notary Public, State of Illinois
My Commission Expires 10/26/2016

My Commission expires: 10/26/2016

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EDUCATION

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

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

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

ADMINISTRATIVE EXPERIENCE

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

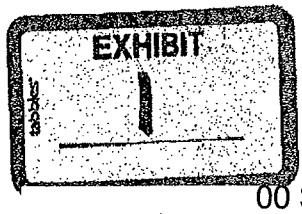
Executive Clinical Director. Founded and direct a private psychosocial services consultation organization which provides psychosocial risk and resource management services in a variety of clinical, medical, and forensic markets; Direct the strategic planning, organizational and program development, research,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

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

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

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

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



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

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

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

ACADEMIC EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TRAINING EXPERIENCE

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

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

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

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

CLINICAL EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RESEARCH EXPERIENCE

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

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

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

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

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

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

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

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

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

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

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

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

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

OTHER EXPERIENCE

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

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

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

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

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

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

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

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

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

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

VOLUNTARY ACTIVITIES

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

PUBLICATIONS

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

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

MEMBERSHIPS/CERTIFICATIONS/LICENSES

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

Exhibit 13

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abuse, it is safe to discharge him?
A Yeah, I guess, yes.
Q It's the converse of what you said?
A Yes, yes.
Q You said "equivocally." If you said there was a child abuse, you could say it may not be safe to send him home?
A Yes.
Q But if you take the exact converse, if you can say unequivocally there was no child abuse, you can safely send him home; right?
A Yes.
Q Now, but Owen [redacted] fell in between those two things?
A Yes. There was some elements of the workup that stated that there was concern for non-accidental trauma, but other elements of the workup of the evaluation which did not meet the criteria because they were negative and therefore, it could not be determined whether or whether not he had been the victim of child abuse.
Q Okay. And I think one of the things you said was the skeleton survey?
A Skeletal survey.
Q "Skeletal survey."

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A Right.
Q And the skeletal survey would have been where they do radiograph of both arms, both legs, and your core.
A Yes.
Q And your head?
A Yes, "and your head."
Q And they determine whether there's been any previous fractures or evidence of any kind of breaks or something that would indicate any kind of trauma; right?
A Yes.
Q Now, when you have abusive head trauma, would you agree with me that many times you do not see any other signs of symptomology on a skeletal exam?
MR. TODD: Objection.
THE WITNESS: It depends on the specifics of the case.
BY MR. HOOD:
Q It depends on the actual case itself?
A Yes.
Q And when you have someone who has an isolated incident of abusive head trauma, you may not see anything on a skeletal survey; right?

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A You may or may not.
Q Okay. And so in this particular case, because of the abusive head trauma -- excuse me.
In this case, because of the subdural hematomas, the skeletal survey may or may not help?
A May or -- it may or may not help, depending. You may also repeat it in two weeks to see if there were any injuries that were young and were fresh if you didn't see them on the first skeletal survey.
Q And -- and in doing that I know there's a huge, huge controversy over shaken-baby syndrome that is now called abusive head trauma.
A Yes.
Q And I know that -- there is a classic triad. I know there's a -- a -- you know, there are mimics that are written about in the literature. I know that they don't even use that nomenclature anymore --
A Sure.
Q -- in the medical field?
A Right.
Q It's now AHT --
A Right.
Q -- as opposed to SBS?

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A Right.
Q And when you have a situation and you've ruled everything out except for either accidental or non-accidental trauma, how do you ensure a baby is safe if you don't know that it's not non-accidental trauma?
A You put in place a safety plan and you report them to the Department of Social Services and you get law enforcement to involve -- to investigate if they can further get information to see if there is anything that corroborates for there to be accidental or non-accidental trauma.
Q Okay. And so when you get it to a point where you've ruled in or out everything except for accidental versus non-accidental trauma, then you work with DSS and law enforcement to determine whether it's one of the two; right?
A Or a combination of both or -- what -- or whatever.
Q Or a combination of the both --
A Yeah, whatever.
Q -- because you can have accidental trauma and non-accidental trauma?
A Yes, yes.
Q Okay. And -- and so in that case, you would be

Exhibit 14

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to key the report in.
Q You're passing the physical report to intake to put in the system?
A Yes. And you can't put your dictation in until that physical report is entered into CAPPS.
Q Let me ask you this, then: So if there's no actual file open in the CAPPS system for the on-call worker or the on-call supervisor, are you-all taking notes -- handwritten notes?
A Casework continues on -- whether that report's in CAPPS that casework continues on. And then, yeah, the worker would have -- they can write in Microsoft Word. You can key in your dictation in Microsoft Word --
Q Uh-huh.
A -- once the report's in there, you can cut and paste and put the dictation in there.
Q Move it over.
A But notes are being taken. That case is active. Nobody's waiting for a file to be passed to them. It's active.
Q And do those notes -- if they're taking notes, are those notes always transferred to CAPPS, or -- like, I'm -- I'm thinking if you didn't have a computer, you were doing it in Microsoft Word, are

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some of these caseworkers -- do you know if they're hand writing notes?
A Initially, when they're out on call Sunday night, the notes would've all been hand-written.
Q Okay.
A Any evening night -- excuse me. 24 hours a day, workers do not have computers to type up notes when they're initiating reports.
Q Did I interrupt you?
A No.
Q Okay. And if they're hand writing notes, do those notes then go into the case file?
A No.
Q Okay. Do you know whether or not they're kept?
A They're not as -- that will depend on the worker.
Q Okay. Okay. Does your office conduct audits of any kind? Chart audits -- well, chart audits is not a right phrase. Like, client file audits, or anything like that? Do you do audits of your files?
A Yes.
Q Okay. How often do you do that?
A The state does a child welfare review. That varies.
Q Do you remember when the last one was?

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A No. Yeah. There was -- well, that was the federal review when the family died. Then we got 24 workers.
Q Federal review. When was that done?
A That was 2004. August 2004. August or October. The family died in August, and then we got 24 workers out of that. The feds came in. We were very short staffed.
Q And that was in 2004?
A Yes. Oh. Oh, no. I'm sorry. I'm -- I would need -- I know when the family died -- maybe it was 2005 because the feds came in and reviewed the files, and we got some workers that we needed.
Q And then do you know any -- any time they came after that, whether it's federal or state?
A I know the state comes every two or three years. Or -- or it would be considered the federal review. We have -- I -- I really don't remember. But I know they've been in a couple of times. We always get reviews. It's standard procedure with DSS. And DSS will be up for one this year. York County.
Q And then are there -- is there any documents created that you are aware of related to these reviews?
A We're informed of them.

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Q Okay. But you -- are you not -- are you given any, like, summaries of what they found?
A It's discussed with us. We're not given a hard-written --
Q You're not given a hard copy?
A Not given a hard copy.
Q You discuss it amongst -- I mean, is there --
A Our --
Q -- like a meeting?
A Our program manager discussed it with us.
Q Okay. Okay. Do you, as a supervisor or even -- well, as a supervisor, do you-all routinely involve law enforcement in your cases?
A How do you mean by "routinely"?
Q Are they involved in every case?
A No.
Q Are they involved in certain cases?
A Yes.
Q What kind of cases?
A Physical abuse, sexual abuse, some physical neglect. Contributing delinquency of a minor.
Q And, in those cases that don't come directly from law enforcement, do you always notify them in those cases?
A No.

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Q Okay. How do you decide what cases to refer to law enforcement and what cases not to refer to law enforcement?
A The policy.
Q What does the policy say related to that?
A I don't know it word for word. I would need to review it, but --
Q Turn to the front of that notebook. Tabs 1 and 2 are the policies that have been produced related to South Carolina Department of Social Services.
A Oh, this is the new stuff.
Q And, if you look at Tab 2, which is Exhibit 2,
A Okay. 1/14/2010.
Q Yes.
A All right. I mean, if a home is deplorable and conditions are such that it's unsafe for the child --
Q What page are you on?
A I'm not reading that, but I'm just remembering one of them. -- then that's a reason to make a referral. That would be considered physical neglect, and that's something that law enforcement can look at was some deplorable homes.
Q In some deplorable homes or all deplorable homes?
A Oh, see -- adjectives.

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Q See, that's what I'm -- I'm trying to figure out is there a rule or a policy that says, "We notify" -- I see, to be fair, "We notify law enforcement in all sexual abuse cases."
A That's the one.
Q So how do you decide, on any other case, to notify law enforcement? How is that decision made? To notify or not notify?
A The decision would be based on the safety of the child in that home.
Q Okay.
A Or for physical abuse -- if it's excessive physical discipline, and there are marks or open cuts, lasting permanent damage on a child, that is a -- that is definitely a law enforcement referral.
Q Okay.
A A -- a small bruise on the arm is not a law enforcement referral.
Q What about a subdural hematoma?
A That -- those would be considered law enforcement referrals if there's information that relates that there's been an -- that it may have been on -- the child may have been injured purposefully by a caregiver.
Q Okay. So if there's a subdural hematoma with no

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information that the child was purposefully injured by a caretaker, you do not have -- you don't -- is it fair to say you would not automatically refer that to law enforcement?
A No. Those would be referred to law enforcement, period. We're not the ones to decide.
Q Who's -- who decides?
A It's a group. We gather -- the information is gathered from the assessment.
Q Okay.
A The -- all the information is gathered from the -- from the 45-day period of the assessment.
Q Okay.
A That -- that would -- and it's a group staffing. So the assigned caseworker and the supervisor and the legal department make the decision on those -- on those cases. The -- I -- I would think there's an exception -- no. But --
Q Now, let me ask you this: When you -- when there is a decision made to make a referral to law enforcement, how long do you have to make the referral?
A Twenty-four hours.
Q And, as a supervisor, if you tell one of your workers to send a referral to law enforcement, I

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would assume you expect that to be done in 24 hours; is that fair?
A Yes.
Q And what would you expect them to send?
A I usually do it. I have a referral -- there's a referral form, and what they -- what is sent is the name of the victim, then the alleged perpetrator's name, the physical address of the victim, the physical address of the perpetrator, a phone number for both victim and perpetrator, date of birth for the victim. Then there's a summary that you can give law enforcement. For example, child states that daddy beat him with a wooden paddle on his back. And the jurisdiction has to be noted, because York County Sheriff's Department does not cover all of York County. They don't cover the city of Rock Hill. They don't cover Clover or Pee Dee, so forth. So we have to make sure we know what jurisdiction we're dealing with, with the physical, where the incident happened. Parents may have a county address, but the incident may've happened at grandma's who lives in the city. Well, that report goes to the city --
Q City.
A -- and not the county. So there's a form that we

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have that can be completed by workers or supervisors that has the identifying information -- who your perp and who your victim is, and the summary of what the report's about -- and different procedures in place with notifying each law enforcement agency, regarding this law enforcement referral that is sent to them with an attached intake report, minus the fed's food stamp information and prior unfounded or indicated information on the report. They're given the reporter's page. They're given the first five pages that is supposed to go with that intake -- with that law enforcement referral.

Q So that's a lot of information that you give them upon referral; is that fair?

A They -- they get the information that was on the report at the time the report was given. So, like, when a --

Q Go ahead.

A With Chandra they wouldn't have had all other information initially with her and I that night because with our report -- they get what we were given.

Q Right.

A They -- because all that other information she

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found out was separate from our report. We can't add to our report. The intake is what it is when it comes in. You can't add to it after you go out and interview people.

Q Would you then send whatever dictation that you have as well?

A That could be sent to law enforcement, yes.

Q Okay. And what does law enforcement do that DSS does not do related to investigations?

A I have -- don't -- I don't know what law enforcement really does. I mean, I know they go -- I can say they go interview the people, but I -- I can't speak on what their job is exactly. Theirs is -- theirs is a little different than us. They also have criminal court; we have family court. We don't charge people; they can charge people. They can arrest people; we can't arrest people.

Q Can they place children into protective custody?

A Yes.

Q Okay. And can they -- can they do that without asking the Court's permission?

A EPC's, yes.

Q Let's talk a little bit about the hospital. When you have a case -- when the hospital has a child to come in, do they typically -- and they suspect

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abuse or neglect or whatever, do they typically call DSS or do they call law enforcement? Do you know?

A I do not know.

Q Okay. And what role does the hospital play in your investigations?

A The hospital notifies DSS. The hospital will share medical records with DSS. The hospital will speak with DSS regarding the patient's condition, release date. The hospital shares information about parents' behavior while they're there visiting the child. The hospital asks the department for guidance in what the department is going to do regarding their patient.

Q Uh-huh. And do you, as -- as a supervisor, do you rely on them to help you make case decisions?

A No. No. We -- we -- not all the time. No. We have our investigation that -- we have less evidence than criminal have to get, and -- we -- the hospital, it doesn't make the case decision.

Q Do you rely on their medical expertise to decide whether or not a child has been abused?

A Yes.

Q Okay. Do you know how long, generally, it takes to get medical records from Levine's Children

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Hospital? Children's Hospital.

A Most times, when you're on scene, they'll give us the initial report that they have -- the initial record that they have.

Q Okay.

A And then we would have to get a release signed. And I could not tell you the time period for that, for any follow-up records that they have.

Q But is it fair to say, then, that you get some records on scene most of the time?

A You can -- like a -- we have gotten some records on scene.

Q Is it -- well, let me ask you this: Do you -- did you, at this time, carry your own cases or were you solely a supervisor?

A Supervisor at that time.

Q Do the supervisors ever carry their own caseload, in addition to being supervisors?

MR. FRAWLRY: (To Ms. Harill) You mean as caseworkers and not just supervisors?

MS. HARILL: Yes.

MR. FRAWLEY: All right.

A Will you repeat the question?

Q Do -- did you, as a supervisor, ever carry your own caseload in addition to being a supervisor?

Exhibit 15

LOLA: York County DSS. This is Lola. How may I help you?
LIEUTENANT MILLER: Where have you been hiding?
LOLA: 18 West Liberty Street, down the hall.
LIEUTENANT MILLER: You have?
LOLA: Yeah. How are you doing, W.J.?
LIEUTENANT MILLER: I'm doing good right this second.
LOLA: That's good.
LIEUTENANT MILLER: But is Devondra Hill still Christa Hemmett's?
LOLA: Yes, she is. And they are both not in the office.
LIEUTENANT MILLER: Oh, no shit.
LOLA: Yeah. They ran away.
LIEUTENANT MILLER: I -- sometimes I -- you know, I try not to get upset, and I --
LOLA: I know.
LIEUTENANT MILLER: -- I probably shouldn't.
LOLA: Uh-huh. You're safe.
LIEUTENANT MILLER: But why would I get a DSS report of a one-year-old child who has two subdural hematomas and a flax [sic] subdural hematoma today when it was -- the child was taken to Piedmont on December the 2nd and then transferred to Charlotte? Why would I get that today?

LOLA: I don't know.
LIEUTENANT MILLER: And I -- and I'm not asking you to answer any questions. You're my sounding board.
LOLA: Yes, I know. I know. And --
LIEUTENANT MILLER: And -- but that just infuriates the living hell out of me, because in the statement that says that the child has a -- none of the -- the parents don't know anything about any falls.
LOLA: Yeah. That's one from on-call that Shondra Tyler went out on the 6th. Me and her sent that out, and we staffed it with them on Monday.
LIEUTENANT MILLER: And I do not --
LOLA: So you haven't --
LIEUTENANT MILLER: I don't have -- there's not a report on it where law enforcement was called --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- or nothing.
LOLA: Uh-huh. Yeah. They had that for the 7th to follow up on.
LIEUTENANT MILLER: Why --
LOLA: Yeah. So you got it today?
LIEUTENANT MILLER: Yeah. I just got it when I walked in the door.
LOLA: I don't know.
LIEUTENANT MILLER: It was sent on the 16th --

LOLA: -- which was last --
LIEUTENANT MILLER: -- which would've been last night. Well, it came in at six -- almost seven o'clock last night.
LOLA: Yeah.
LIEUTENANT MILLER: You know, I just -- I try my best.
LOLA: Uh-huh.
LIEUTENANT MILLER: Now, if anything's going to stroke me out, this -- this will.
LOLA: Yeah. The (inaudible) --
LIEUTENANT MILLER: Things like this will, but the other stuff that I know about, we can deal with. But I just -- I don't understand -- they'll send me something over here about a child having sex with somebody.
LOLA: Uh-huh. Oh, that's right away, right? But not the other one.
LIEUTENANT MILLER: Yeah. But they won't send me where a one-year-old child's got damn bruising on its brain.
LOLA: Uh-huh. Yeah. That -- and that was staffed on the 7th because I passed that on to them, and it was discussed, and it's law enforcement referral. So, yeah, I can't explain what happened.
LIEUTENANT MILLER: I guess my main thing is: Did --

was DSS called out?

LOLA: Yeah, it was. Because I sent Shondra Tyler out. That was --

LIEUTENANT MILLER: That day or that night -- whatever that -- whenever it was?

LOLA: Yeah. That night I sent her out to the hospital, and then we brought the report in the next day and sent -- and staffed it and passed the report on to the assigned caseworker. And we staffed that case, and they had all the information, and they were going to make their law enforcement referral.

LIEUTENANT MILLER: Well, let me ask you this question: Why were we not called that night?

LOLA: Because the child was in the hospital, and the parents appeared to be appropriate. And they didn't think that it was -- oh, because the information was -- they thought that we were coming up there to release the babysitter. After the worker went up there and followed up with the report, no doctor had said that the child had a non-accidental injury. Staff thought that DSS was there to release the sitter so they could -- so the sitter could go home, and there was no concerns for the child, that it was accidental.

So I didn't send law enforcement up there with

her on that report. Child was in a safe place. She was -- went up there. She wasn't saying that it was not -- non-accidental, the social worker that had called. There's an injury -- she -- they had that report on -- that baby was there on Saturday.

That baby has been to four different doctors. That family picked that -- that child was -- November 30th went to the doctor, December 2nd went to Riverview. The 4th -- there was one appointment at Sunshine, and then Friday, the 4th, the baby went to PMC. And then PMC sent the baby to Charlotte on Saturday, and then Sunday the hospital called us.

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

LIEUTENANT MILLER: Uh-huh.

LOLA: And we brought the case in the next day and staffed it.

LIEUTENANT MILLER: Okay. What -- well, I guess -- I guess my question is -- and I'm just -- all I'm doing is throwing stuff at you because I'm trying to figure out what's going on.

LOLA: Uh-huh.

LIEUTENANT MILLER: Is they're saying -- the parents are saying that -- at least in the DSS report -- that this child hasn't fallen, hasn't hit his head on anything, or none of that stuff.

LOLA: Yes. Yes.

LIEUTENANT MILLER: And --

LOLA: And that's what they told the on-call worker too, that they're not aware. And then it was like they said the same thing. And I'm -- the medical records, I don't know what's happened with those, what -- what the end results were with those. So nobody has an answer as to why or how that child was injured. There was a question of an uncle, though.

LIEUTENANT MILLER: Yeah. The --

LOLA: Dad and --

LIEUTENANT MILLER: The babysitter or the -- or the mother went and picked them up from the daddy and the uncle, or what was -- there was something in there about that.

LOLA: No. What I remember is: The uncle was with the dad.

LIEUTENANT MILLER: Right.

LOLA: They were the two that were left alone with the child on one occasion, and that was per the grandma who told the social worker or the nurse at the hospital. So, yeah.

LIEUTENANT MILLER: Would that --

LOLA: We have 24 hours to make our referral too, and I mean, that's no excuse or whatever, but it's like, "You know what? We'll go out there and we'll initiate our contact, make sure that child -- they don't leave against medical advice." They were cooperative. And then -- then next day, assign it to the caseworker. It's like, "You're the one that needs to get out there and find out what's going on, follow up with that," because we don't need ten caseworkers at court.

LIEUTENANT MILLER: Uh-huh.

LOLA: I don't know. Devondra's back in the office. I heard her voice. You want to ask her why they waited? I mean, I -- I don't know, W.J.

LIEUTENANT MILLER: Okay. Yeah. I definitely want to talk to her. But I just -- you know -- you know I'm going to call you first.

LOLA: Yeah.
LIEUTENANT MILLER: Because I know there's always more to a story than what I'm actually reading here. But I just --
LOLA: Yeah.
LIEUTENANT MILLER: I -- I can't understand how I -- how I get this, you know, seven or eight days later.
LOLA: Yeah. And --
LIEUTENANT MILLER: And -- and -- but I get this other crap immediately.
LOLA: Yeah. The hospital staff, per Shondra after the -- after she had gone out there and when she was ready to leave, a nurse and another staff person came up to her and said, "So are you releasing the sitter now so they can go home?" And they were surprised that we were even there otherwise, pointing the finger at the parents. Shondra Tyler. And then that was upsetting to me because, like, why -- you thought we would just go up there and release your sitter. We thought you were calling because you thought there was physical abuse, but no doctor had stated that. And Christa's also followed up and called the doctor the next day, or somebody on staff there -- Bridgette, I think.
LIEUTENANT MILLER: Okay.

LOLA: So they would have a bit more information, too, than what would be on that report, but -- you know, I -- it still should've -- we had 24 hours; it still should've gone out on the Monday by the latest.

LIEUTENANT MILLER: Yeah. I just don't -- I don't know.

LOLA: Yeah. Because you have Shondra Tyler who interviewed the people, and then whoever -- Devondra Hill, if she interviewed anybody, would have whatever she has also. So -- but I made the call not to call law enforcement that night.

LIEUTENANT MILLER: Okay.

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

LIEUTENANT MILLER: Okay. What's -- who was the uncle? because I don't see anything on here about his name

or anything other than "uncle."

LOLA: Oh, okay. Hang on. I'm going to move my phone, and if I lose connection --

LIEUTENANT MILLER: Well, I'll tell you what: No. There's no need in you having to deal with this. I left a -- a message for Christa -- Christa Hemmett to call me back.

LOLA: Uh-huh. And she's gone on home visits, but she should be back this afternoon.

LIEUTENANT MILLER: Right. I've left a message. She can call me on my cell phone or home phone as long as this child seems to be in decent custody right now.

LOLA: Yeah. Because it's -- or the child, I think, is at home, right? Is that what your report says?

LIEUTENANT MILLER: It doesn't say.

LOLA: It doesn't? What -- what's her name?

LIEUTENANT MILLER: Her name is -- or his name is Owen [redacted]

LOLA: C-a -- oh, right. Yeah. Yeah. Oh, [redacted]

LIEUTENANT MILLER: [redacted]

LOLA: Okay. All right. I'm -- I -- I'll just pull it up right here, and let's see if her dictation shows who that uncle was that she had spoke to, because she was supposed to say. Let's see. It's Owen --

Jennifer's the -- Brian [redacted] is the uncle. He's the paternal uncle, Brian [redacted] "In the beginning, Owen's -- change in Owen's behavior that they first noticed was on 11/28, sleeping, screamed a lot nonstop." They took him to Riverview Clinic on 11/28. Doctor said nothing was wrong. Then --

LIEUTENANT MILLER: Do you have the address and telephone number for the uncle?

LOLA: No. But I think he lives there with them. My understanding --

LIEUTENANT MILLER: At the same house?

LOLA: Yeah. My understanding is he's living at that home.

LIEUTENANT MILLER: Okay. Golden Park Road?

LOLA: Yes. Yeah.

LIEUTENANT MILLER: And -- wait. Are you finding anything else in there?

LOLA: Oh, okay. So 11/28 he went to Riverview Clinic. Then on 12/2 he went to Sunshine Peds. Doctor said he had a sore throat -- had a throat infection and a minor cold. 12/4 the baby was limp; they rushed him over to Piedmont. Then he was transferred to Levine. That was 12/5 like around two o'clock in the morning, I guess. I remember there -- something said about that. And then -- so that's

three appointments that he went to where people -- because the baby was going limp. And I don't know what the medical records are.

My -- she checked out the play packs or whatever the child sleeps in. A small, flat, brownish bruise on the left side of his head was noticed in November, which was probably the 28th. No idea where it came from. "Owen head turns and jerks around sometimes during tummy time on the floor." Oh, uncle has been in their home with either parent.

LIEUTENANT MILLER: He's what?

LOLA: Uncle might not live there. Uncle said that he never watched the children alone, but he has been in the home with either parent and watched when they did things around the house. So that's probably -- that's probably not the uncle's address. But Devondra or Christa should have that address for the uncle. She doesn't have that in her dictation here. Let's see.

Well, and then, too, Levine's stuff -- oh, no. Owen -- our -- we stopped our case so I guess they stopped the case, and the child was allowed to go home. Second T -- second CT scan was stable. That was on 12/7. Owen -- yeah. So he was discharged.

Okay. I'm not seeing another address for the uncle, but Devondra may have that. What day is that? I mean, that day -- it was done on a Monday. No. She didn't put the address of the uncle in here.

LIEUTENANT MILLER: Okay.

LOLA: Yeah. Christa will probably follow up with you because she had called and talked to a doctor, and 12/7 the hospital could not determine where -- whether the injuries are accidental or non-accidental. Bones, eye exam, skeleton survey were negative. His head still appeared swollen, though, on the 7th. Family has no clear history of trauma. The hospital -- however, the hospital cannot rule out any trauma. So their concern was lack of supervision.

LIEUTENANT MILLER: Well, see, yeah, that's -- that's my whole thing is: How did this child's head get bruised up like this?

LOLA: Uh-huh.

LIEUTENANT MILLER: And nobody knows. You know, he wasn't crying sometime?

LOLA: He was. He was. See, and that -- all -- he was showing signs and symptoms, and that's why the family started reacting. 12/7, Laura 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. Yes, there was.

LIEUTENANT MILLER: What I'm saying --

LOLA: (Inaudible.)

LIEUTENANT MILLER: But what I'm saying is --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- that sometime, if he would've had these bruises come up on his head, he would've started crying at that time.

LOLA: Yeah. See, now, they noticed the change in his behavior. He was sleeping a lot, screamed a lot nonstop. That was 11/28. Then he was taken to Riverview. Riverview doctor said nothing wrong with him. "Owen continued the abnormal behavior through the week on 12/1 and went all day and night without urinating."

So then they took -- they scheduled an appointment with the pediatrician for the 2nd, and they took the child there. That doctor said a sore throat and a minor cold, no medicine.

Then on 12/4, pulling in the driveway, Michael came outside -- Michael, the dad, came outside and said that Owen just went limp. He was still breathing. They rushed him to the hospital. "At

the hospital, Owen let out a loud scream and took a huge breath." And that's what she put.

And then -- so they've noticed these behaviors, and they were following up with the doctor on these behaviors. But nobody -- the doctors were saying everything was fine until Friday the 9th. Mr. [redacted] said Owen was sleeping a lot, he wasn't eating. He'd wake -- woke him up to feed him. He'd let out a loud scream, stretch out, was turning red and went limp. So that was the 4th.

But they were noticing -- the parents were noticing the child's behavior wasn't -- did not appear right, and they would take the child to the doctor. And there's only that one time where that bruise on his head -- the little brownish -- small, flat, brownish bruise. So that would've -- that was in November. That would've been the 28th.

LIEUTENANT MILLER: Uh-huh.

LOLA: A small, flat, brownish bruise on the left side of his head; they noticed that. And they did not know where it came from. Again, back to "Owen's head jerks -- turns and jerks around during tummy time on the floor." So it may -- I mean, if it is lack of supervision, you can hit something with it,

and -- and they weren't in the room, had something there that shouldn't have been. But again, too, he's only a small baby.

LIEUTENANT MILLER: Right. I can -- you know, I've got a grandson that's almost one year old, and I know he can bounce, you know --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- and crack his head, do whatever. But --

LOLA: Yes.

LIEUTENANT MILLER: -- my thing is -- is, unless you leave him alone --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- you know, for hours at a time, if a child falls and hits their head hard enough --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- that there's an internal brain bruise --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- which my understanding of the --

LOLA: Hematomas?

LIEUTENANT MILLER: -- falx -- well, the falx subdural hematoma --

LOLA: Uh-huh.

LIEUTENANT MILLER: You know, other than bruising, you

know, they'll cry for a little while and then they'll quit or either go to sleep or something like that. But that one that went behind the -- I guess it's behind the skull --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- you know, that's not something they usually get by just falling.

LOLA: Right.

LIEUTENANT MILLER: And that's why -- that's -- I guess that's my main concern is that -- had it just been, you know, a couple of bruises where it could've been, you know, the playpen or the crib or something where he climbed up and slipped and fell and hit his head, that's a different story.

LOLA: Right.

LIEUTENANT MILLER: But when you got a child going limp and, you know, not acting right and doing all that kind of stuff, and then you get in there and you got a bruise behind the skull --

LOLA: Right.

LIEUTENANT MILLER: -- there's something.

LOLA: Yeah. Something happened.

LIEUTENANT MILLER: Yeah.

LOLA: Something happened. Yeah.

LIEUTENANT MILLER: So that's -- I guess that's my

biggest thing, and then I -- I -- my whole thing was just to call up and bitch.

LOLA: Uh-huh.

LIEUTENANT MILLER: Because I figured I'd get to the end of it sooner or later, but I just don't like little children -- you know, one minute --

LOLA: Right.

LIEUTENANT MILLER: One minute -- there's no consistency, I guess, is what I'm saying.

LOLA: Yeah. There isn't, W.J. Wholeheartedly, there is not.

LIEUTENANT MILLER: And I guess that's what gets me. Because I can get something, you know --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- like these kids with the dogfighting and stuff, you know.

LOLA: Oh, yeah, that was a good one.

LIEUTENANT MILLER: You know, we get those and then we got the ones whose Mama and Daddy's smoking pot, you know, and that kind of stuff, you know, immediately --

LOLA: -- and these ones you're not?

LIEUTENANT MILLER: -- so -- huh?

LOLA: And this one you're not?

LIEUTENANT MILLER: And this one we get, you know -- on

the 6th it was evidently staffed, from what I see --

LOLA: The 7th because -- oh, sorry. I keep saying the -- no. The 7th because we -- I was on call with Shondra, and Shondra and I received that report. At 5:01 she got the phone call from the hospital that night.

LIEUTENANT MILLER: Uh-huh.

LOLA: And she called me and told me about it, and I sent her out to just go interview the family. And then we staffed that case on Monday morning and gave them the information and transferred it to Christa and Devondra because it was their assigned case.

LIEUTENANT MILLER: I guess -- and that's ten days ago is what I'm saying.

LOLA: Yes. Yes. Uh-huh.

LIEUTENANT MILLER: But anyway, I miss talking to you. I don't -- I don't see you enough.

LOLA: Yeah. It has been quite a while. It's like, shoot, I put -- put my phone on, but darn it, you would've called me today because I didn't, but I'm reaching for it right now to turn it on.

LIEUTENANT MILLER: Yeah. Well, I've called your cell phone, and you've told me that it wasn't working

that good.

LOLA: Oh, it is now. They -- they -- she -- it's been fixed because they had gave -- given us new phones, and they had trouble with switching the phone line over or whatever -- however that works when you transfer to a new phone --

LIEUTENANT MILLER: Right.

LOLA: -- phone company. But it works now, unless my message still says it's not working. I didn't change it. I don't know. But it's working. I've been carrying it and turning it on.

LIEUTENANT MILLER: Well, that's good.

LOLA: Yeah.

LIEUTENANT MILLER: I'll have to start aggravating you some more now.

LOLA: I know. It's like, okay. All right. So --

LIEUTENANT MILLER: Well, anyway, like I say, I left a message for Christa to give me a call because we're just going to need to meet about this one so that we can figure out --

LOLA: Okay.

LIEUTENANT MILLER: -- you know, if there's anything else that needs to be done. We definitely need to find out what the uncle's deal is, who he is, you know, all that good stuff.

LOLA: Yeah, because the uncle -- because Grandma is the one that pulled the nurse aside, I guess Friday -- Friday night -- well, 2 a.m. Saturday morning or whatever on Saturday Grandma told the nurse or the social worker that the uncle had been with the child too. It was the uncle and the dad.

LIEUTENANT MILLER: Uh-huh.

LOLA: So Grandma had some concerns about the uncle. And Shondra was saying to me, "How do I address that? Because he's saying" -- after she talked to him and then she came out and said, "Okay, Lola. He's saying he never had the child alone." And I gave her a different approach, and he did admit that -- then he did say, well, he was alone when the parents -- with the parents. But, yeah, he -- he -- later he changed his story. But Grandma had suspicions of the uncle.

LIEUTENANT MILLER: Uh-huh.

LOLA: So -- and we shared all our information with them -- with Christa and Devondra. We shared our information on Monday morning with what we had. And we told them, so we -- they knew about the uncle and everything and the information that the hospital had said so, yeah.

LIEUTENANT MILLER: Okay.

LOLA: They -- they -- they should have it, and she should be interviewing him or talking to him. But, yeah, my understanding was they were (inaudible) could go ahead and do a law enforcement referral that day.

LIEUTENANT MILLER: Well, yeah, and I don't -- I'm easy as hell to get along with.

LOLA: Yeah.

LIEUTENANT MILLER: You know, and I -- if there's a problem or something, I'll -- and most of them call me. Y'all call me --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- you know, immediately and say -- but I haven't heard from Devondra on this one yet.

LOLA: Oh, wow.

LIEUTENANT MILLER: Everybody usually calls me and says, "Hey, I'm going to, you know, send this referral over." And by the time I can get to the fax machine, that's where it's at.

LOLA: It's there. Yeah.

LIEUTENANT MILLER: You know, but everybody usually gives me a heads up that it's coming, which they really don't need to do, but, you know, they can call me later and say, "Did you get it?" --

LOLA: Right.

LIEUTENANT MILLER: -- because sometimes I don't get them, and they have to resend them.
LOLA: True. True.
LIEUTENANT MILLER: But -- and -- and if one's -- and if one's late, just give me a call and say, "Hey" --
LOLA: Yep.
LIEUTENANT MILLER: -- "you know, I'm going to get it to" --
LOLA: Yep.
LIEUTENANT MILLER: -- "I'm -- I'm going to let you know right now this is the names and stuff, but it's going to be a day or two before you actually get all the paperwork because I'm" --
LOLA: Uh-huh.
LIEUTENANT MILLER: -- "trying to put something together." And I know y'all are busy. That's all they got to do is call me and tell me that instead of letting me find out ten days later that we had this with no phone calls.
LOLA: Yeah.
LIEUTENANT MILLER: Because I swear I don't want to get in -- you know, I ain't going to get nobody in trouble if I can damn help it.
LOLA: Right.
LIEUTENANT MILLER: But I may ask the wrong person about

something one day and, you know --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- the next thing you --

LOLA: Uh-huh.

LIEUTENANT MILLER: -- know your butt's on the chopping block.

LOLA: Yep. And consistency again. Not everybody on call is following up, making that referral to law enforcement. It's going to the caseworker the next day. "Here's what you're going to need to do: You're going to need to follow up with law enforcement and make your referral," because, if it does go to court, we don't need ten workers and, if one goes out there on call, puts the situation in place, makes sure things are safe and they're at the hospital, that's fine; they're safe. Next day the next person assigned the case needs to follow up, get with law enforcement, and they run with it.

LIEUTENANT MILLER: Yeah.

LOLA: So -- and then -- so that can go back and forth, back and forth on how that goes. But, heck, I'll be checking every darn report. For the county, we'll just go ahead and send you guys out there right off the bat so I don't have to have this conversation about why I didn't send her. Yep.

LIEUTENANT MILLER: You know, and -- and --
LOLA: And then I don't want one like we had with Shaquita Gladden where they took the babies away from Daddy and you were out there on that case.
LIEUTENANT MILLER: Yeah. And I -- you know, and I understood, and I tried to explain to him what it was. I understood that to a -- you know, to a point. That wasn't -- I don't think that was a big deal. But my big deal was going to be -- is drawing that thing out after we'd done decided, you know, we wasn't going to keep that kid for no 45 days.
LOLA: Yeah.
LIEUTENANT MILLER: After about three days, we'd done figured out there wasn't nothing going to happen.
LOLA: Right.
LIEUTENANT MILLER: You know, that was bull.
LOLA: Yes. Yeah.
LIEUTENANT MILLER: But, yeah, no. I -- I -- I don't have a problem with taking or not taking -- well, I don't have a problem with taking children if we need to at that time --
LOLA: Right.
LIEUTENANT MILLER: -- just for safety's sake.
LOLA: Uh-huh.

STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK)
)
)
Elizabeth Hope Rainey, as the Appointed Guardian Ad Litem to Owen C., a minor,)
Plaintiff,)
vs.)
)
South Carolina Department of Social Services,)
Defendant.)

IN THE COURT OF COMMON PLEAS
SIXTEENTH JUDICIAL CIRCUIT

CASE NO.: 2011-CP-46-4508

MOTION AND ORDER INFORMATION

FORM AND COVERSHEET

FILED RECEIVED
2017 APR -4 AM 11:10
DAVID HAMILTON
CC.C.P.&S.S.
YORK COUNTY, SC

Plaintiff's Attorney:	Defendant's Attorney:
Whitney B. Harrison, Bar No. _____ Address: 1517 Hampton Street, Columbia, SC 29201 Phone: 803-779-0100Fax 803-787-0750 E-mail: wharrison@mcgowanhood.comOther:	Patrick J. Frawley, Bar No. _____ Address: PO Box 489, Lexington, SC 29071 Phone: 803-359-2512 Fax803-359-7478 E-mail: Pat@oldcourthouse.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: Plaintiff's Motion to Alter or Amend and for Reconsideration
Estimated Time Needed: _____ Court Reporter Needed: ☐ YES/☐ NO

SECTION II: Motion/Order Type

☒ Written motion attached
☐ Form Motion/Order
I hereby move for relief or action by the court as set forth in the attached proposed order.

Signature of Attorney for ☒ Plaintiff /☐ Defendant — 4/4/2017 Date submitted

SECTION III: Motion Fee

☒ PAID – AMOUNT: $ 25.00
☐ EXEMPT: (check reason)
☐ 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

Collected by: _____ Date Filed: _____
☐ MOTION FEE COLLECTED: $ _____

☐ CONTESTED – AMOUNT DUE: $ _____

SCCA 233 (11/2003)

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF YORK	)	SIXTEENTH JUDICIAL CIRCUIT
Elizabeth Hope Rainey, as the Appointed Guardian ad Litem to Owen C., a minor	)	Civil Action No.: 2011-CP-46-4508
Plaintiff,	)	**MOTION TO ALTER OR AMEND AND FOR RECONSIDERATION**
V.	)	
South Carolina Department of Social Services	)	
Defendant,	)	

FILED RECEIVED
2017 APR -4 AM 11: 10
DAVID HAMILTON
YORK COUNTY, SC

TO: SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES AND PAT FRAWLEY

This motion is made pursuant to Rules 52 and 59 of the South Carolina Rules of Civil Procedure. *See also Elam v. S.C. Dep't of Transp.*, 361 S.C. 9, 21–22, 602 S.E.2d 772, 778–79 (2004) ("it is proper to view a Rule 59(e) motion not only as a vehicle to request the trial court 'alter or amend judgment,' but also as a vehicle to seek 'reconsideration' of issues and arguments."). Plaintiff Elizabeth Hope Rainey received electronic notice of the Court's order granting Defendant South Carolina Department of Social Services' ("DSS") Motion for Summary Judgment on March 29, 2017.

Plaintiff respectfully submits the Court may have overlooked or misapprehended the following points in reaching its decision:

I. **The Order Fails to Recognize that DSS has a Duty to Exercise Slight Care in Each Undertaking and that an Exercise of Slight Care in One Portion of the Investigation Does Not Absolve DSS from Exercising Slight Care during the Ongoing Investigation.**

The Court's Order misconstrues the gross negligence standard at summary judgment and DSS's duty to exercise slight care in each undertaking. The fact that DSS exercised slight care during one portion of the investigation does not absolve DSS from its duty to exercise slight care during the ongoing investigation. The Court's holding oversimplifies the gross negligence standard and DSS's duty to *thoroughly* investigate in direct contradiction to the South Carolina Supreme Court's holding in *Bass v. South Carolina Department of Social Services*, 414 S.C. 558, 570–71, 780 S.E.2d 252, 258 (2015).

The Supreme Court in *Bass*, rejected a similar argument by DSS now relied on by this Court that any evidence in the record of DSS acting with slight care satisfies the agency's duty to exercise slight care for the duration of the investigation. *See* Order p. 7 ("the issue before the Court is whether the actions DSS did undertake meet the standard of 'slight care'"); *Id.* ("In this case, the summary-judgment-standard requires that DSS demonstrate the absence of a factual issue concerning the exercise of "slight care . . . . DSS need only show from the entire record that it met the standard of slight care in this case."). In *Bass*, the Court reviewed whether there was evidence in the record to support the denial of DSS's JNOV motion as to gross negligence. *Id.* DSS asserted that it properly investigated and acted to remove children in emergency circumstances, analogous to the twenty-four-hour requirement in this matter, and as such demonstrated slight care. *Id.* The Court agreed that DSS demonstrated slight care as to the initial decision. *Id.* However, it found that *whether DSS acted with slight care in thoroughly investigating after the initial action was a question for the jury*. *Id.* This distinction is significant because the Supreme Court acknowledged that the duty to demonstrate slight care exists for each decision/action by DSS. As *Bass* firmly states, DSS may not rely on its purportedly reasonable conduct during one portion of its investigation to justify failings in other portions of its investigation. As it stands, this Court's

Order ignores genuine issues and evidence of DSS's failure to exercise slight care by taking a holistic approach to DSS's action instead of examining the specific duties DSS has been charged to execute pursuant to statutory provisions, along with its own policies and procedures.

In support of its holding, the Court relies on *Clyburn v. Sumter County School District No. 17*, which is distinguishable from this case. In *Clyburn*, the plaintiff, a high school senior was threatened by a non-student assailant (a middle school student related to another high school student) on a school bus and that incident was reported to the school principal. The school principal attempted to contact the parents of both high school students, met with the high school students and explained the potential criminal violations, and reached out to the principal of the non-student assailant to address the matter. Additionally, the bus driver kept an eye out for the non-student assailant. Unfortunately, a second incident occurred in which the plaintiff was injured. The plaintiff argued the school district failed to exercise slight care because the police were not contacted. The trial court granted summary judgment in favor of the school district because it found slight care was exercised. The Supreme Court affirmed. In upholding the trial court, the Supreme Court detailed the actions taken by the school district to mitigate a future issue.

Significantly, in its analysis the Court distinguished *Clyburn* from *Hollins v. Richland County School District*, 310 S.C. 486, 427 S.E.2d 654 (1993), in which the Court held the issue of whether slight care was exercised when sending a note home, as a means of notifying a parent of a bus suspension, with an eleven-year-old was a question for the jury. In *Hollins*, while walking home, the eleven-year-old was struck by an automobile while attempting to cross the highway. The Court explained the school created the risk by failing to give adequate notice to the parent about the child's bus suspension and distinguished the efforts taken to control the situation in *Clyburn*. Moreover, a review of both opinions demonstrates the Court's influence and concern

over the child's age in *Hollins* as a determinative factor in assessing gross negligence, i.e. the necessary level of care required to satisfy slight care based on the child's age.

The age of the child continues to be an important factor in our Supreme Court's assessment and serves as a key distinction in evaluating gross negligence as it relates to matters with minors. In fact, in *Etheredge v. Richland School District One*, 341 S.C. 307, 534 S.E.2d 275 (2000), the Supreme Court once again echoed the clear distinction of slight care that is needed with an eleven-year-old child compared to high school students for gross negligence. If a six to seven-year age difference (the age between the eleven-year-old child and high school students) played such a significant factor in the Court's assessment of slight care in *Etheredge*, the disparity between a three-month-old child and a high school senior only amplifies the necessary level of care that is required and the need for a jury to determine whether DSS was grossly negligent.

As it stands, the Court's Order overlooks the significant differences between *Clyburn*, *Etheredge*, and *Hollins* compared to this matter. Practically, DSS was the only entity in control and able to protect Owen C. from potential abuse. This is particularly important given Owen C.'s inability to advocate or articulate for himself given his age.[1] This further suggests this inquiry is best left to the jury.

Notwithstanding the Supreme Court's key distinction of a child's age in addressing gross negligence, DSS has a unique level of responsibility to exercise slight care compared to schools, their employees, and school districts in *Clyburn*, *Hollins*, and *Etheredge* based on Legislative enactments. The Legislature enacted child protection statutes for the essential and expressed

[1] The South Carolina Court of Appeals in *Rainey v. Charlotte-Mecklenburg Hospital Authority.*, No. 2015-UP-209, 2015 WL 1880212, at *3 (S.C. Ct. App. Apr. 22, 2015), held the duty to investigate and ensure Owen C.'s safety belonged solely to DSS.

purpose of protecting children like Owen C. from the risk of parental abuse and/or neglect.[2] By statute DSS is the state agency responsible for investigating and intervening in cases of suspected child abuse and neglect. As such, DSS had a statutory duty to protect Owen C. from harm and to safeguard his well-being—a duty that encompassed protecting him from his own parents, if necessary.[3] Further, DSS has promulgated its own policies and procedures, which outline the standard of care that must be followed by DSS "[i]n all instances." S.C. Code Ann. § 63-7-900 (emphasis added); *accord* S.C. Code Ann. § 63-7-960.[4] In sum, these mandates impose a direct duty for DSS to execute a myriad of actions, each of which must be completed with slight care, pursuant to *Bass*.

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[2] S.C. Code Ann. § 63-7-10 (A)(3) ("State and community agencies have a responsibility to implement prevention programs aimed at identifying high risk families and to provide supportive intervention to reduce occurrence of maltreatment."); S.C. Code Ann. § 63-7-10(B) ("It is the purpose of this chapter to establish an effective system of services throughout the State to safeguard the well-being and development of endangered children" and to "establish an effective system of protection of children from injury and harm while living in public and private residential agencies and institutions meant to serve them.").

[3] *See, e.g.*, S.C. Code Ann. § 63-7-20(4), (6), (10), (13)[3] (discussing DSS obligations to children); S.C. Code Ann. § 63-7-960 (same); *see also Jensen v. S.C. Dep't of Soc. Servs.*, 297 S.C. 323, 331–32, 377 S.E.2d 102, 106–07 (Ct.App.1988) (holding the sections mandating DSS investigate and intervene to remove an endangered child from the home create a special duty); *Jensen*, 304 S.C. at 202-03, 403 S.E.2d at 619 (DSS has a duty to intervene with parents in cases of reported abuse).

[4] *See also* Exhibit 9, Portions of DSS Human Services Policy and Procedure Manual, Chapter 7: Child Protective and Preventive Services (outlining the responsibilities of DSS personnel with respect to investigation and assessment); *accord Madison ex. rel. Bryant v. Babcock Ctr., Inc.*, 371 S.C. 123, 140, 638 S.E.2d 650, 659 (2006) (stating a defendant's standard of care in a negligence action "may be established and defined by . . . a defendant's own policies and guidelines); *Id.* (explaining in a negligence claim, a party breaches its duty by deviating from the applicable standard of care which "may be established and defined by the common law, statutes, administrative regulations, industry standards, or a defendant's own policies and guidelines."); *see also* Exhibit 10, NASW Code of Ethics 2008 & NASW Clinical Social Work in Social Work Practice 2005. DSS's overarching policy states, "The safety of children is the paramount concern that must guide child protection efforts." Exhibit 9, at p. 3–4; *see also Id.* ("The child is our primary client in child protection cases . . . .").

While the Court acknowledges the "slight-care standard requires consideration of these policies and procedures, since they necessarily affect the actions of DSS staff in specific cases," the Court's Order appears to ignore the articulated statutes and policies as separate and distinct requirements to act and investigate with slight care. (Order p. 7). The Court's Order explains "the issue before the Court is whether the actions DSS did undertake meet the standard of slight care." (Order p. 7). Further, the Court held:

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

(Order p. 7).

This explanation of the legal issue, the Court's inquiry, and the requisite evidence misstates the law. The Court at summary judgment is required to evaluate both DSS's action *and inaction* based on the statutes, along with the policies and procedures. It is insufficient to assert any action satisfies slight care, pursuant to *Bass*. As explained in Plaintiff's Memorandum in Opposition and at the hearing, Plaintiff identified distinct violations of DSS's policies and procedures. For example, law enforcement was not contacted by DSS within twenty-four hours as required. Additionally, Owen C.'s father did not sign the safety plan during DSS's initial meeting nor prior to Owen C.'s release back to his parents. *See* Safety Plans submitted by DSS (SCDSS 0464 and SCDSS 0427). Moreover, Plaintiff asserted genuine issues of material fact, discussed herein, that are supported by a mere scintilla of evidence. Accordingly, DSS's motion for summary should have been denied.

II. Genuine Issues of Material Fact Exist and Plaintiff Offered more than a Mere Scintilla to Survive Summary Judgment

The Court's Order states "the summary-judgment-standard requires that DSS demonstrate the absence of a factual issue concerning the exercise of 'slight care.'" Contrary to this Court's ruling, multiple issues of material fact exist and should be presented to a jury.[5] The Court's Order summarily holds there were no genuine issues of fact and that DSS carried its burden of slight care. (Order p. 7). That holding is unsupported by issues raised by Plaintiff and the evidence submitted to the Court.

There are at least three genuine issues of material fact related to whether DSS thoroughly investigated with slight care prior to Owen C.'s release to his parents on December 7th. These include (1) whether DSS had the requisite facts to make a determination regarding maltreatment, i.e. risk of harm to Owen C. at the time of his release; (2) whether DSS allowed a medical discharge to abrogate its own duty to protect Owen C. and rely solely on Levine; and (3) whether Ms. Hinnant fundamentally appreciated the information shared by Levine and exercised slight care in forming her assessment/opinion/recommendation.

At a minimum, there are at least three genuine issues of material fact related to whether DSS thoroughly investigated with slight care following Owen C.'s release from Levine. These include: (1) whether Ms. Hill exercised slight care when she had no contact with the family for ten days and no contact with Owen C. for fourteen days; (2) whether Ms. Hill exercised slight care when there is no evidence to suggest she attempted to request medical records or contact collateral sources to further the investigation with no contact with Owen C. or his family; and (3) whether

[5] Plaintiff incorporates by reference the full arguments asserted in her Memorandum in Opposition to Summary Judgment and arguments made at the hearing. Any reference to an exhibit relates to the exhibits filed in the Memorandum in Opposition.

Ms. Hinnant exercised slight care as a supervisor of this case when she knew Ms. Hill had no contact with Owen C.

At a minimum, there are at least two genuine issues of material fact related to whether DSS exercised slight care in fulfilling its duty to thoroughly investigate Owen C.'s case when law enforcement was not contacted within twenty-four hours as required by law. These include (1) whether Ms. Hill exercised slight care as a social worker when she took ten days to contact law enforcement; and (2) whether Ms. Hinnant exercised slight care as a supervisor when she instructed Ms. Hill to contact law enforcement and later became aware that law enforcement had not been contacted.

Each of these issues contain a material/factual issue that is unresolved by the evidence submitted by DSS. Each of these inquires is a mixed question of law and fact that should be addressed by a jury. *Faile v. S.C. Dep't of Juvenile Justice,* 350 S.C. 315, 332, 566 S.E.2d 536, 545 (2002) (explaining that because gross negligence claims implicate mixed questions of law and fact, their determination typically rests with the jury). Moreover, as discussed *supra*, DSS cannot prevail on summary judgment unless it demonstrates that slight care was exercised for each of these issues. Plaintiff has asserted more than mere scintilla as to each issue of material fact, and thus it was an error of law to grant summary judgment.

III. The Order's Finding as to Law Enforcement Misapplies the Summary Judgment Standard and Incorrectly Addresses Proximate Cause.

As discussed *supra*, Plaintiff contends DSS failed to exercise slight care in fulfilling its duty to thoroughly investigate Owen C.'s case when law enforcement was not contacted within twenty-four hours as required by law. Plaintiff has continually argued that pursuant to Section 63-7-980(B)(1) of the South Carolina Code of Laws, DSS was required to contact law enforcement within twenty-four hours when there are accusations of abuse or neglect that "also appear to

indicate a violation of criminal law." S.C. Code Ann. §63-7-980(B)(1); *see also* Exhibit 9, DSS Policy and Procedure 710(15) at p. 17. Thus, DSS was required to report Owen C.'s injuries by December 7th. However, DSS did not contact law enforcement until late in the evening on December 16th, effectively December 17th. Evidence in the record demonstrates that DSS failed to exercise slight care in reporting to law enforcement.[6]

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[6] Ms. Hill stated at her deposition that DSS automatically refers cases with injuries or abuse to law enforcement, and that her responsibilities included reaching out to law enforcement when those issues arose. Exhibit 5, Hill Deposition, at p. 27-28; *see also* Exhibit 3, Hinnant Deposition, at p. 24 (stating "its absolutely our responsibility" to contact law enforcement). This position was supported by the deposition of Ms. Southerland, who stated that a child with a subdural hematoma would require a law enforcement referral within twenty-four hours. Exhibit 14, Deposition of Lola Southerland, p. 33. She further explained that in those types of injuries "we're not the ones to decide." *Id.* at p. 35. However, Ms. Hill did not notify law enforcement as required within the first twenty-four hours of the allegations. Instead, she waited ten days before contacting law enforcement. *See also*, Exhibit 5, Hill Deposition, at p. 29. (acknowledging referral was ten days late).

This failure to act with slight care is further supported by the transcript of the call between Lieutenant Miller and Ms. Hinnant. *See* Exhibit 6. In response to receiving a DSS notification of abuse, Lieutenant Miller called Ms. Hinnant. He first explained the information that was provided was inadequate and he needed more to go by to understand the circumstances of this case. During this call, Lieutenant Miller expressed his frustration with the lack of notice by DSS stating, "I guess the thing that bugs me the most is getting it ten days after." *Id.* at p. 7; *see also Id.* at p. 9, (explaining his immediate reaction to receiving DSS's paper worked included "What the hell?" regarding the delay, and an automatic concern that "*we've got some body that's done hurt this child*") (emphasis added); *see also* Exhibit 15, Transcript of Telephone Call between Lt. Miller and Lola Southerland (reacting to the ten delay Lieutenant Miller states "just infuriates the living hell out of me, because in the statement that says that the child has a none of the—the parents don't know anything about the falls."); *Id.* ("Now, if anything's going to stroke me out, this –this will."). In response, Hinnant explained that she had asked Ms. Sutherland to make contact and "fussed at her" about the delay. *Id.* at 7. Moreover, she stated, "[Ms. Sutherland] should've made it as soon as she got the report when we staffed it from on-call," on December 7th. *Id.* Hinnant admitted to Lieutenant Miller that she knew the call had not been made within the twenty-four-hour period, as required by their policy (as well as statute), but had not realized there was such a significant delay. *Id.* In fact, Hinnant stated this inaction was "unacceptable" because an injury like Owen C.'s requires reporting per DSS's policy, and characterized this failure as a "big problem." *Id.* at p. 8, 10, 14.

The Court's Order in Footnote 2, failed misapprehends Plaintiff's argument and the evidence submitted under the summary judgment standard, as required at this stage of litigation. Instead, the Court incorrectly weighed the evidence and addressed proximate cause. Specifically, the Court's Order states:

> One concrete example Plaintiff cites as a violation of the applicable standard of care[7] is the fact that DSS did not notify law enforcement of DSS's involvement in the case, and the investigation of the report made by the hospital within twenty-four hours of notification to DSS. *While DSS failed to carry out this mandate, law enforcement was notified and had an opportunity to investigate the case.* Law enforcement took no action on the case prior to the sever injury of Owen by his father. *Thus, while DSS did not act within the prescribed time to notify law enforcement, that failure was not the proximate cause of the tragic injury to Owen [C.].*

(Order p. 7, fn.2) (emphasis added). The Court improperly weighed the evidence and decided that this failure had no effect on Owen C.'s injury. *See S.C. Prop. & Cas. Guar. Ass'n v. Yensen*, 345 S.C. 512, 518, 548 S.E.2d 880, 883 (Ct. App. 2001); *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986) (explaining the trial court is not to weigh the evidence but rather to determine if there is a genuine issue for trial). This finding is improper because the issue of proximate cause was not raised by either party. Moreover, this is not a ground to grant summary judgment.

At the hearing and in the Memorandum in Opposition, Plaintiff's counsel repeatedly argued that the failure to contact law enforcement demonstrates DSS's failure to exercise slight care in multiple ways. First, the complete failure of DSS to discharge a statutory duty to contact law enforcement is more than a mere scintilla of evidence that DSS failed to exercise slight care. Second, it shows that DSS failed to exercise slight care in evaluating Owen C.'s risk of abuse and whether it was safe to discharge him. DSS's policies and procedures state, "child maltreatment

[7] Plaintiff notes the Order incorrectly characterizes this as an example of the violation of the standard of care. DSS's failure to contact law enforcement is a direct violation of its statutory requirement.

results from a combination of factors: psychological, social, situational, and societal." *See* Exhibit 9, at p. 3–4. In assessing those factors, DSS outlines that the following "[f]actors . . . may contributed to an *increased risk for child abuse and neglect include*, for example family structure, poverty, substance abuse, poor housing conditions, teenage pregnancy, *domestic* and *community violence*, mental illness, and lack of support from extended families and community members."[8] Exhibit 9, at p. 3–4 (emphasis added). Because law enforcement was not contacted prior to Owen C's release, DSS was unaware if there was any domestic or community violence in his home. DSS's failure to seek out this information creates a genuine issue of material fact as to whether DSS exercised slight care in evaluating the safety of Owen C. at the time of his release.[9] Third, Plaintiff presented evidence that Ms. Hinnant, the DSS supervisor, was aware that Ms. Hill had not contacted law enforcement as required, which raises a genuine issue of material fact as to whether she exercised slight care in her supervision.

In addition to weighing the evidence, the Court's Order improperly determined that the failure to contact law enforcement could not be the proximate cause of Owen C.'s injuries. First, the question of proximate cause is one n that should be left to the jury. *See McKnight v. S.C. Dep't of Corr.*, 385 S.C. 380, 387, 684 S.E.2d 566, 569 (Ct. App. 2009) (recognizing that ordinarily, proximate cause is a question for the jury). Second, the Court's causation holding ignores the multiple ways the failure to contact law enforcement connect to DSS's investigation. Third, the Court's Order applies an unfair inference by concluding "law enforcement took no action on the

[8] Significantly, the factors identified by DSS's own policies and procedures are mirrored by national standards. *see also* Exhibit 9, NASW Code of Ethics 2008 & NASW Clinical Social Work in Social Work Practice 2005.

[9] Exhibit 5, DSS Letter Requesting Law Enforcement Involvement; Exhibit 11, Deposition of Charlotte Williams, p. 12-13 & Sherriff Records, p. 59 (discussing grandmother's prior criminal record and domestic violence charge); *Id.* p. 27-28 (Michael telling police he was charged with possession of stolen goods sixteen).

case prior to the sever injury of Owen [C.] by his father" that the known failure by DSS was of no consequence. (Order p.7). That assumption incorrectly disregards DSS's distinct obligation to not only notify law enforcement, but to also evaluate the safety of the child—which requires knowing background information garnered from law enforcement records. Without that information, DSS blindly released Owen C. to his parents. That is a failure to exercise slight care or at least at minimum creates a genuine issue and a jury question. DSS repeatedly argued that in addressing these types of cases the plaintiff is not entitled to hindsight, but rather is required to evaluate slight care based on the information at time. The Court's assumption as to proximate cause is incorrectly based on hindsight instead of the legal requirement that DSS must exercise slight care as it executes each duty.

Overall, the Court's reasoning regarding DSS's failure to contact law enforcement is an error of law. Summary judgment should have been denied based on DSS's failure to contact law enforcement. Plaintiff submitted sufficient evidence, including deposition testimony, transcripts of calls between DSS and law enforcement, and expert affidavits to demonstrate genuine issues of material fact.

IV. The Order Misstates or Overlooks Important Facts Related to DSS's Failure to Exercise Slight Care.

The Court's Order misstates or overlooks pertinent facts that support Plaintiff's assertion that DSS failed to exercise slight care. Moreover, these facts illustrate genuine issues of material fact exist and a determination of gross negligence should be addressed by a jury. Specifically, the following facts should be reconsidered:

- Owen C. was "lethargic, not responsive and [it was believed] he was dead" when he arrived at the hospital and as a result he was sent to Levine, the leading children's hospital, because of an "apparent life threatening event." *See* Exhibit 1, York County DSS 00143; Exhibit 2, at CMC0059-0062. However, Owen C. was released back to his parent's by DSS with

no medical or social explanation of the circumstances that led to Owen C.'s near death status.

- Owen C.'s father, never signed the first safety plan on December 6th during DSS's initial meeting with the parents, nor did he sign the second safety plan on December 7th at the time DSS released Owen C. back to his parents. The Court's Order incorrectly states that Owen C.'s parents signed the safety plan. *See* Safety Plans submitted by DSS (SCDSS 0464 and SCDSS 0427). Moreover, each of these omissions by DSS demonstrate a failure to exercise slight care.

- Levine, a leading children's hospital, could not determine whether Owen C. had been the victim of a child abuse, and in fact would not rule it out. Exhibit 13, Deposition of Dr. Cheryl Courtlandt, at p. 45. Further, it is undisputed that Levine and its employees informed DSS numerous times[10] that it was uncertain of the cause of Owen C.'s injuries.[11]

- Evidence suggests at the time of Owen C.'s release DSS was unaware of Owen C.'s housing conditions, his family structure, any potential community or domestic violence, and the level of support of his extended family. DSS had not been to the home and was unaware of the conditions. Ms. Hill stated at her deposition that she did not know the family structure at the time of Owen C.'s release. Specifically, she admitted she was unware that grandmother did not reside with Owen C. until December 21st. *See* Exhibit 5, Hill, at p. 19. In sum, DSS failed to exercise slight care in assessing Owen C.'s case prior to his release to his parents.

- DSS social worker Ms. Hinnant informed law enforcement that the hospital did not have "any suspicions" of abuse. *See* Exhibit 7, Transcript of Telephone Call between Lt. Miller and Ms. Hinnant, at p. 13. This statement was factually inaccurate and a misrepresentation. This raises a genuine issue if she improperly influenced Lieutenant Miller's independent assessment and investigation of the case specific circumstances. Moreover, it raises a genuine issue of material fact as to whether Ms. Hinnant exercised slight care in supervising Owen C.'s case and the case worker (it is undisputed she knew the caseworker had not contacted law enforcement), along with her ability to appreciate the risk of harm.

- DSS had no contact with Owen C.'s family for ten days. Further DSS did not see or have any contact Owen C. for fourteen days. *See* Exhibit 4, Dictation, at p. 248, 252-253; Exhibit 5, Hill Deposition, p. 19.

- There is no evidence in the record that Ms. Hill made any other efforts to further the investigation and assessment of the alleged abuse when she had no contact with the family. There is no evidence that Ms. Hill requested medical records or contacted collateral sources

[10] Notably, no multidisciplinary meeting took place with law enforcement, hospital, and DSS prior to Owen C.'s medical discharge or release to his parents.

[11] This reliance on Levine is especially troubling given the "minimal information" gathered by the hospital's social workers, which independently violated the national standard of care and the hospital's own policies and procedures. Exhibit 12, Savarese Aff. Exhibit 2, at CMC 0092-0098.

like doctors, neighbors, family friends, etc. to investigate the alleged abuse. *See* Exhibit 5, Hill Deposition, p. 19, 39.

- Plaintiff submitted the Affidavit of George Savarese, Ph.D., LCSW, in which he opines DSS failed "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.]." He further stated "it is my opinion to a reasonable degree of professional certainty that the actions or inactions of the employees and/or agents of [DSS] . . . contributed to the injuries and damages of Owen [C.]."

CONCLUSION

Based on the arguments stated above, Plaintiff respectfully requests this Court reconsider its ruling and find DSS is not entitled to summary judgment.

Signature Page to Follow

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April 4, 2017
Rock Hill, South Carolina

CERTIFICATE OF SERVICE

I, Jessica L. Cooksey, an employee of the law firm McGowan, Hood & Felder, LLC do hereby certify that I served copies of the above ***Plaintiff's Motion to Alter or Amend and for Reconsideration*** on the Defendants in the above-captioned matter by email and by depositing the same in the United States Postal Service, with proper postage affixed thereto, on this 4th day of April, 2017, addressed to the attorney(s) listed below:

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