
IN THE COURT OF APPEALS
STATE OF GEORGIA

APPEAL NO. A23A1609

CHANTE AMOS, individually; and as Temporary Administrator of the Estate of JANAE MICHELLE AMOS, Deceased,

Appellant,

v.

CREATIVE CONSULTING SERVICES, INC., and YVETTE WALCOTT,

Appellees.

BRIEF OF APPELLANT

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Kull v. Six Flags Over Georgia II, L.P., 264 Ga. App. 715, 716 (2003).

Hubbard v. Department of Transp., 256 Ga. App. 342, 350 (2002).

Chante Amos, Appellant herein, respectfully files and serves this Brief of Appellant.

I. INTRODUCTION

This is a wrongful death and personal injury action relating to the death and pre-death pain and suffering of Jane Michelle Amos, deceased ("Janae"). Appellant Chante Amos brought this action in her individual capacity as Janae's surviving mother and in her representative capacity as the temporary administrator of Janae's estate. Janae died at the age of 23 years while living at a residential facility operated by Dolly's Personal Care Home, Inc. ("Dolly's").[1] Janae had developmental disabilities and was placed at the Dolly's facility to receive full-time care and assistance with all her daily dietary and personal living activities.

Janae's Individual Service Plan ("ISP"), a document that sets out the requirements of her care, noted that Janae used a wheelchair and required full physical assistance of two persons with lifting and transferring. The ISP also required that Thick-It, a thickener, be added to Janae's liquids to bring them to nectar consistency for swallowing to prevent her from choking.

One night after Janae had been fed dinner of Mac & Cheese and juice, the sole caregiver on duty at the facility put Janae to bed. That caregiver, like other

[1] Dolly's Personal Care Home, Inc. is not a party to this appeal.

caregivers at Dolly's, did not add Thick-It to Janae's liquid foods or drinks as required by the ISP. On that night, Janae choked and vomited while lying in bed with no ability or assistance to reposition herself or to get up. By the time the caregiver returned to the bedroom to check on her, Janae Amos was unresponsive and covered in vomit. Janae was taken by ambulance to a hospital, where she was admitted to the intensive care unit, placed on a ventilator, and treated for aspiration pneumonia. Due to her injuries, she died the next day.

Appellee Creative Consulting Services, Inc. ("Appellee CCS") contracts with the State of Georgia to provide support coordination for individuals with developmental disabilities who receive services authorized by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). Appellee CCS was the support coordination agency that provided such services for Janae. Appellee Yvette Walcott ("Appellee Walcott") was employed by Appellee CCS as a support coordinator, and she was responsible for coordinating and monitoring the services and care provided to Janae.

Appellant Amos contends that Appellees were negligent in monitoring Janae's care by failing to properly review Janae's records at Dolly's and in failing to detect and address the fact that Dolly's was understaffed and that its caregivers were not administering Thick-It in Janae's diet as was required by the ISP for her safety and wellbeing. Appellees' conduct violated the DBHDD rules and regulations

regarding support coordination monitoring, and material questions of fact remain on whether it proximately caused Janae's physical and emotion pain and suffering and to her death.

II. JURISDICTIONAL STATEMENT

The Georgia Court of Appeals has appellate jurisdiction in this case because this is an appeal from an order granting summary judgment, which is a final judgment that is directly appealable. See O.C.G.A §§ 5-6-34. The Georgia Court of Appeals and not the Supreme Court has jurisdiction over this appeal because it is an appeal from a final judgment and the issues do not involve any of the special matters over which the Supreme Court has original appellate jurisdiction. See O.C.G.A §15-3-3.1; Ga. Const. art. VI, § 6, ¶ III.

The trial court entered its Order Granting Summary Judgment on March 29, 2023. Appellant filed her Notice of Appeal on April 27, 2023. The hearing transcript was filed on May 8, 2023. Appellant filed her Amended Notice of Appeal on May 17, 2023. This appeal was docketed in the Georgia Court of Appeals on June 2, 2023.

III. ENUMERATION OF ERRORS

1. The trial court committed reversible error by granting summary judgment in favor of Appellees, erroneously holding that there is no genuine issue of material

fact as to whether Appellees' actions or omissions proximately caused the death of Janae Amos.

2. To the extent that the trial court's order can be construed to grant summary judgment in favor of Appellees on grounds other than an alleged lack of proximate cause, then the trial court committed reversible error by granting summary judgment in favor of Appellees on the erroneous holding that there is no genuine issue of material fact to be tried.

IV. STATEMENT OF THE CASE

A. Material Facts Relevant to the Appeal

i. Janae's Background

Janae was a twenty-three-year-old young woman with a beautiful smile and a happy disposition. V3-718; V4-835. She also was nonverbal, non-mobile, and incontinent due to developmental disabilities, for which she needed full-time care and assistance. V3-352. Janae was diagnosed with cerebral palsy, epilepsy, failure to thrive, and scoliosis. V3-315. Despite her disabilities, Janae persevered and even graduated from high school. V3-333, 724. Due to her medical condition, Janae received support services through the Georgia DBHDD. Appellee CCS was the support coordination Agency that provided support coordination services for Janae. V3-297. Appellee Walcott was employed by CCS as a support coordinator and was responsible for monitoring Janae's care. Id.

ii. DBHDD's Rules Applicable to Appellees

The role of a support coordinator is to "provide oversight monitoring of direct services that a provider gives" to the client (V3-433–34) to "enhance the health, safety, and general well-being" of the individual served. See [https://dbhdd.georgia.gov/be-dbhdd/be-compassionate/support-coordination]. Support coordination agencies contracting with the State of Georgia must comply with the rules and regulations of the Georgia DBHDD. V3-297; V6-1305. One such rule or regulation is the DBHDD's Outcome Evaluation: "Recognize, Refer, and Act" Model, 02-435. V6-1307. The whole purpose of the DBHDD Model 02-435 is to serve as a pathway to effectively identify any issues regarding the care and "ultimately achieve the best outcomes" for the individual served. Id. This model explicitly lists the tasks of a support coordinator. For example, under Procedure B(2), the model requires that:

> "For each focus area question, the [Support Coordinator] completes the following:
>
> a. Communicate with and observe the waiver individual as it relates to the elements of the item to be reviewed;
>
> b. Observe the setting for evidence pertaining to the item reviewed;
>
> c. **Review any pertinent documentation relating to the item reviewed;**
>
> d. Engage in discussion with staff members and natural supports who may have information on the item reviewed."

V6-1308 (Emphasis added.).

The DBHDD also requires support coordinators to utilize The Individual Outcome Measure Review ("IOMR"), a document consisting of more than 50 questions that evaluate the health and safety, among other things, of the individual. V3-435. The IOMR in effect in 2018 during the time Janae was at Dolly's specifically asks the following questions:

> (20) Are all staff knowledgeable about all information contained within the individual's ISP?
>
> (23) Are all staff knowledgeable about all of the individual's healthcare plans?
>
> (24) Are indicated healthcare plans being implemented?
>
> (28) Are all physician/clinical recommendations being followed?
>
> (29) Are all prescribed medications being administered, as ordered, and documented accurately?
>
> (30) Are all required assessments/evaluations completed?
>
> (35) Are supports and services being delivered to the individual, as identified in the current ISP?

V6-1325-27.

The support coordinator must issue a "coaching" or "referral" if there are any issues or concerns with the care described above. V6-1308.

iii. Appellee CCS's Expectation of its Employees

Support coordinators are required to attend monthly "area meetings" where they are provided copies of the state regulations. V3-429–31. It is CCS policy that support coordinators must follow state policy. V3-438–39. When conducting monitoring visits of an individual, the support coordinator must complete an outcome measure review. V3-435. Appellee CCS expects its support coordinators to look at all the documents being kept by the provider each time that an outcome measure review is conducted, specifically "all notes related to the person [they] work for." V3-439–40.

Initially when a concern is found, a coaching is issued; however, if there is a lack of documentation for care that is required in the ISP, then a referral is issued. V3-656. If the support coordinator issues a referral, then the provider (Dolly's, in this case) would have "to respond as to what happened and they would have to give a reason why it happened and how going forward it would not happen again." V3-657. It is part of the support coordinator's function to investigate a concern to see if the care was carried out properly. V3-445. It is also part of the support coordinator's function to look at the staffing in the home when visiting a client and to document in the outcome measure review if the staffing of the home is not correct, as well as issue a coaching or a referral. V3-447–48.

iv. Janae's Placement at Dolly's

Before she was placed at Dolly's, Janae lived with her mother and siblings at Appellant Amos' home. Once Janae became an adult and graduated from high school, Appellant Amos became more open to placing Janae in a group home setting. V3-333. Appellee Walcott encouraged Appellant Amos to consider placing Janae in a community home. V3-332–33. As Janae's mother, Appellant Amos was always worried about Janae's safety and wellbeing. V3-335–39. Appellee Walcott presented Dolly's to Appellant and stated that it would be a great place for Janae. V3-339. Appellee Walcott assured Appellant Amos that Janae would always have two staff members present at Dolly's to care for her. V3-336–37. This assurance was important given Appellant Amos's concern that the other resident at the facility might require individual attention from the caregivers, as well. After visiting Dolly's, Appellant Amos agreed to Janae's placement at Dolly's. Id.

Janae was taken to Dolly's for full-time care and assistance on October 8, 2018. V3-298; V3-358.

v. Janae's Individual Service Plan

An Idividual Service Plan ("ISP") is a document that sets out the requirements for the services and care that are to be provided to an individual served. Appellees played a direct role in creating and updating Janae's ISP. V3-322, 674. The ISP would be updated yearly, roughly two months prior to Janae's birthday. V3-634.

Janae's ISP noted that Janae required full-time assistance for her dietary and personal needs. V4-812. In approximately 2006, it was determined that Janae required a thickener to be added to all foods and liquids (including water) to reach a nectar consistency. V3-316. The ISP even required protective measures such as Choking/Aspiration Protocol and the use of Thick-It in Janae's liquids and foods, noting Janae's risk for choking and aspiration. V4-810, 813. The ISP required Janae to have 24/7, on site supervision. V4-812.

vi. Appellee Walcott's Knowledge of Janae's Need for Thick-It

Appellee Walcott personally worked with Janae for about five years prior to Janae's death. V3-332. During that time, Appellee Walcott personally reported that Janae had an incident of aspiration pneumonia prior to coming into Dolly's care. V3-674. Appellee Walcott knew that that Janae's care required the use of a thickener and understood the importance of a thicker for Janae's safety. V3-316–17. Appellee Walcott used this personal experience with Janae's previous incident in developing the ISP. V3-674.

vii. Appellee Walcott's Visits with Janae at Dolly's

Appellee Walcott would visit Janae once a month. V3-435. In October 2018, Appellee Walcott visited Janae twice. V3-718. She visited Janae at the day program hosted by Dolly's on October 15, 2018, eight days after Janae moved into Dolly's. Id. Appellee Walcott's support notes for the visit contain the conclusory statement

that "all supports and services are being delivered to Janae according to the ISP," but the 50 monitoring questions required by the Model 02-435 are not addressed. V3-598. The notes do not even mention Thick-It or the use of a thickener for Janae's safety.

Appellee Walcott visited Janae again on October 27, 2018 at the group home, 19 days after Janae moved into Dolly's. V3-718. Appellee Walcott's support notes for that visit mention an emergency room visit that was not documented in Janae's HRST records, prompting Appellee Walcott to email a Dolly's administrator about the issue. The support notes also state that the staff ratios are 2:2, and that there "are no issues with the ISP documentation at this time." The note concludes with: "No coachings or referrals were given as a result of this monitoring visit." V3-598. Again, the 50 monitoring questions required by the Model 02-435 were not addressed, and there is no mention of Thick-It. During her deposition, when asked about documentation regarding Thick-It administration, Appellee Walcott simply stated: "Thick-It was present in the home and being used **as far as the staff told me**." V3-649.

viii. <u>The Night of November 20, 2018</u>

Tragically, on the night of November 20, 2018, Janae Amos choked on her own vomit, alone in her bed. V2-13. The sole caregiver present at Dolly's had put Janae to bed around 8:00 p.m., after which she never saw her awake again. When

the caregiver checked on Janae at about 9:20 p.m., Janae was covered in vomit and was unresponsive. Janae was lying on her back and the "vomit was in her nose, mouth, and on the pillow." V3-736. Janae was taken by ambulance to a hospital, where she was admitted to the intensive care unit, placed on a ventilator, and treated for aspiration pneumonia. Due to her injuries, she died the next day. V3-724, 731, 735.

ix. DBHDD's Clinical Mortality Investigative Report

DBHDD conducted a clinical mortality investigation on December 21, 2018, due to Janae's unexpected death. V3-726. The DBHDD's Clinical Mortality Investigative Report ("State Report") shows that records from Dolly's regarding Janae's care were reviewed during the investigation. V3-731−32. There were discrepancies in at least the following: Goal Tracking notes, Medication Administration Records ("MARS"), and her Bed Time Supervision & Bed Checks progress notes.

Significantly, the State Report found there was **no** documentation relating to the use or administration of Thick-It in the file for October or November. V3-741. The State Report concluded that: "Neglect is substantiated as the staff of Dolly's Personal Care Home failed to use Thick IT as recommended by Physician and ISP." V3-741. Interviews with the staff at Dolly's showed that the caregiver present on the night of Janae's choking "did not mix Thick IT in the water or juice" before giving

Janae something to drink. V3-741. Four other staff members failed to administer the Thick-IT properly, ignoring the ISP and directions on the Thick-It container. V3-741.

Regarding the Bed Time Supervision & Bed Check progress notes, there was no documentation for each of the 30-minute interval checks that were supposed to be made. The State Report noted as follows:

> "There were Progress Notes that were documented with a general summary that individual was monitored, however, each 30 min interval finding was not documented and there was testimonial evidence provided stating that Amos was monitored by staff from 30- minute intervals, hour intervals, every other hour. A few of the staff did not follow their own policy."

V3-734.

B. Relevant Proceedings Below

Appellant brought action on December 10, 2019 in Superior Court of Walton County and voluntarily dismissed that suit on March 12, 2021. On March 15, 2021 Appellant filed her renewal Complaint in the State Court of Gwinnett County. On November 17, 2022 Appellees filed a Motion for Summary Judgment. On November 20, 2022, Appellant filed a timely Response to Appellees' Motion for Summary Judgment. On March 29, 2023, the State Court of Gwinnett County

granted summary judgment in favor of the Appellees on the issue of lack of proximate cause. On April 27, 2023, Appellant filed her Notice of Appeal. The hearing transcript was filed on May 8, 2023. On May 17, 2023, Appellant filed her Amended Notice of Appeal.

The Notice of Appeal was filed timely to preserve each enumerated error listed above. See O.C.G.A § 5-6-38.

V. ARGUMENT AND CITATION TO AUTHORITY

A. Standard of Review on Appeal

A de novo standard of review applies to an appeal from a grant of summary judgment, and the Court views the evidence, and all reasonable conclusions and inferences drawn from it, in the light most favorable to the nonmovant. Barge v. Melvin Carmichael Enterprises, Inc., 252 Ga. App. 725, 726, 556 S.E.2d 906, 907 (2001).

Summary judgment is appropriate only when the record demonstrates "that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." O.C.G.A. §9-11-56. To prevail at summary judgment, the moving party must demonstrate that there is no genuine issue of material fact and that the undisputed facts, viewed in the light most favorable to the

nonmoving party, warrant judgment as a matter of law. See Callaway Gardens Resort, Inc. v. Grant, 365 Ga. App. 222, 878 S.E.2d 65 (2022).

B. The trial court erred in granting summary judgment regarding proximate causation because fact questions remain on whether Appellees' failure to correct the discrepancies in Janae's files proximately caused Janae's death.

Proximate cause is "that which, in the natural and continuous sequence, unbroken by other causes, produces an event, and without which the event would not have occurred." Reed v. Carolina Cas. Ins. Co., 327 Ga. App. 130, 132 (2014). There may be more than one proximate cause of an injury. The proximate cause of an injury may be two separate and distinct acts of negligence of different persons acting concurrently. Milton Bradley Co. of Ga. v. Cooper, 79 Ga. App. 302, 306, 53 S.E.2d 761, 764 (1949). In Georgia "the general rule is that if, subsequently to an original wrongful act, a new cause has intervened, of itself sufficient to stand as the cause of the misfortune, the former must be considered as too remote, still if the character of the intervening act ... was such that its probable or natural consequences could reasonably have been ... foreseen by the original wrong-doer, the causal connection is not broken." (Citation omitted.) Granger v. MST Transp., LLC, 329 Ga. App. 268, 270, 764 S.E.2d 872, 874 (2014). Furthermore, "[t]he mere fact that the plaintiff's injuries would not have been sustained had only one of the acts of negligence occurred will not of itself operate to limit the other act as constituting the proximate cause." Id.

Questions of cause and proximate cause and whose negligence constituted the proximate cause of the plaintiff's injuries are, except in plain, palpable and indisputable cases, solely for the jury. Granger v. MST Transp., LLC, 329 Ga. App. 268, 272, 764 S.E.2d 872, 875 (2014); See also Mercy Housing Georgia III, L.P., (A23A0462, May 30, 2023) (where court found that a jury question remained on whether apartment complex's failure to provide a vulnerable tenant with the adequate system to seek emergency assistance proximately caused the tenant's death after suffering a stroke).

In the present case, it is undisputed that Janae's injuries and death occurred because Janae's caregivers failed to administer Thick-It correctly into Janae's food and liquids, then left her in bed where she choked, vomited, and aspirated. See DBHDD's Clinical Mortality Investigative Report, V3-726-42. The evidence also shows that Dolly's was understaffed with only one caregiver present on the night of the incident, and that the caregiver on that night failed to check on Janae every 30 minutes as Dolly's policy required. Id.; EMS Report, V3-721. What is at issue in this appeal is whether Appellees' failure to monitor Dolly's records and to detect and address Dolly's care shortcomings is also a proximate cause of Janae's injuries, suffering, and death.

The State Report revealed that there were various deficiencies in Janae's file at Dolly's, including discrepancies within the MARS, Bed Time Supervisions & Bed

Check, and her Goal Tracking sheets, among others. Specifically, there was vital documentation missing regarding the use and administration of Thick-It in Janae's file during her entire time at Dolly's. Most importantly here, the DBHDD report concluded that Dolly's staff failed to administer the Thick-It correctly (and in many cases failed to administer it at all) and failed to follow Dolly's own policy of checking on residents every 30 minutes during the night. V3-741, 734.

By failing to properly monitor and review documentation in Janae's file, Appellee Walcott failed to detect these problems and to protect Janae from harm. Appellee Walcott admits that the use of Thick-It must be documented in a client's care records and that she should look for such documentation when conducting a monitoring visit. V3-672. Yet, she simply took the word of the staff member present at the time of her visit that Thick-It was being used properly. Id. The same is true for the issues of Dolly's understaffing and failure to check residents regularly at night. Appellee Walcott admits that she thought Dolly's had two staff members present whenever Janae was in the home, including at night. V3-640. Yet, she did not even check the staffing records at Dolly's to verify her assumption.

Appellee Walcott failed to notice that there was no documentation regarding Thick-It at all, or that bed time checks were not done regularly, along with the other documentation deficiencies found by the State Report. If Appellee Walcott had checked the records and issued a referral, as required by DBHDD and CCS policy,

then Dolly's would have had "to respond as to what happened and they would have to give a reason why it happened and how going forward it would not happen again." V3-657. At the time that Appellee Walcott last visited Janae, Janae had been at Dolly's for nineteen days. Even if the file there was relatively small, it was still a record in existence that needed to be looked at thoroughly. Janae received full-time care, and there should have been multiple entries regarding her medications, the use and administration of Thick-It, and progress notes throughout the nights. Material questions of fact remain on whether Appellees' failure to review the records and detect these deficiencies led to and proximately caused Janae's injuries, suffering, and wrongful death.

C. To the extent the trial court's order can be construed to grant summary judgment on grounds other than an alleged lack of proximate cause, then the order should be reversed because questions of fact remain on the other elements of negligence.

The trial court granted summary judgment in favor of the Appellees based on its finding that "the record fails to show that the actions or omissions of Defendants proximately caused the death of Janae Amos." V2-7. As shown above, however, material questions of fact do remain regarding proximate cause, and the summary judgment order should be reversed. To the extent the trial court's order can be construed to have granted summary judgment in favor of Appellees on grounds other than an alleged lack of proximate cause, then the trial court's order should still be

reversed because Appellees are not entitled to judgment on any other grounds as a matter of law.

To state a cause of action for negligence, a plaintiff must establish the following essential elements: (1) a legal duty; (2) a breach of this duty; (3) an injury; and (4) a causal connection between the breach and the injury. R&R Insulation Svcs. V. Royal Indem. Co., 307 Ga. App. 419, 426 (2010). An employer is responsible for the negligent or intentional torts of their employee, provided they are committed by the employee in furtherance and within the scope of the employer's business. Lucas v. Beckman Coulter, Inc., 348 Ga. App. 505, 508 (2019); see also O.C.G.A. § 51-2-2.

i. Appellees owed a duty of care to Janae

Within the context of a tort action generally, duty is defined as "[a] legal relationship arising from a standard of care, the violation of which subjects the actor to liability." Southwestern Emergency Physicians, P.C. v. Quinney, 347 Ga. App. 410, 423, 819 S.E.2d 696, 706 (2018), citing Black's Law Dictionary 523 (7th ed. 1999). And the threshold issue in any cause of action for negligence is whether, and to what extent, "the defendant owes the plaintiff a duty of care." Id. Ordinary care is that degree of care which is exercised by ordinarily prudent persons under the same or similar circumstances. See O.C.G.A. § 51-1-2. "Exactly what constitutes 'ordinary care' varies with the circumstances and the magnitude of the danger to be

guarded against. Since it is impossible to prescribe definite rules in advance for every combination of circumstances which may arise, the details of the standard must be filled in each particular case. But, to be negligent, the conduct must be unreasonable in light of the recognizable risk of harm." (Citations omitted.) Jackson v. Post Properties, Inc., 236 Ga. App. 701, 702, 513 S.E.2d 259, 262 (1999).

Here, Appellee CCS, as the organization providing the support coordinators and Appellee Walcott, as the support coordinator, owed their client, Janae Amos, the duty of care of an ordinarily prudent person to monitor and oversee that the care being received by Janae was proper. Appellees provided support coordination for Janae that was funded through a Comp Waiver with the Georgia Department of Behavioral Health & Developmental Disabilities ("DBHDD"). The DBHDD has established rules and policies under the authority of O.C.G.A. §§ 37-1-4 and 37-1-20, and Appellees were required to follow the policies and procedure of the DBHDD in coordinating the services for Janae. Regardless of whether Appellees were providing direct care to Janae, Appellees had an independent duty to exercise ordinary care in monitoring the treatment and care Janae was receiving at Dolly's to determine whether is met the requirements of Janae's ISP.

Appellees also had a duty to properly monitor and review documentation regarding Janae's meals, specifically the requirement of Thick-It, because they had prior knowledge of Janae's high risk of choking and aspiration as shown in the ISP

that they created. The ISP even required protective measures and protocols to be placed for that very reason. Appellees also had a duty to properly monitor and thoroughly review all documentation regarding staffing. The ISP stated that Janae needed 24-hour, full-time supervision and assistance, and Appellee Walcott had explicitly stated to Appellant Amos that Janae would have two staff members caring for her at all times.

ii. Appellees breached their duty of care to Janae

a. General Negligence Claim

"[M]erely acting in a way that no prudent person would is negligence . . .." Arbor Mgmt. Servs., LLC v. Hendrix, 364 Ga. App. 758, 768, 875 S.E.2d 392, 400 (2022), reconsideration denied (July 8, 2022). "Whether a party has failed to exercise ordinary care may be decided by the court only in cases in which undisputable, plain and palpable facts exist on which reasonable minds could not differ as to the conclusion to be reached." Jackson, 236 Ga. App. 701, 702.

Here, fact questions remain on whether Appellees breached their duty of care to Janae by not properly monitoring and overseeing the care that Janae was receiving at Dolly's. Appellees were independently responsible for the monitoring of Janae's care. Appellees concede that their role is to provide oversight monitoring of direct services that a provider, such as Dolly's, gives to the client. Appellee Walcott played a direct role in creating Janae's ISP, and she knew Janae had a risk of choking and

aspirating if Thick-It was not administered to her liquids and foods. Appellee Walcott also knew that Janae required two staff members present for her care; she even assured Appellee Amos that would be the case.

When conducting monitoring visits of an individual, the support coordinator is supposed to complete an "outcome measure review," a document that has over 50 questions in it that cover health and safety, among other things. V3-435. CCS expects their support coordinators to look at the documents being kept by the provider each time that an outcome measure review is conducted, specifically "all notes related to the person [they] work for." V3-439–40. During her time with Janae, Appellee Walcott visited Janae once per month to oversee her care, as part of the coordination of care. V3-297. Appellee Walcott was authorized to look at records kept by the facility on the client for whom she was providing support coordination. V3-672. Appellee had the authority to demand Dolly's caregivers to produce all of Janae's records. V3-673. Appellee Walcott only asked Dolly's caregivers to confirm tasks and did not ask to see documentation, stating, "when I visit, unless I see it, if they say we're putting it in there, that is what I go by." V3-672. Further, Appellee Walcott even admitted that had she looked at the records and seen that there was no documentation of Thick-It and Ensure, it would have been a concern for her. V3-672.

b. Negligence Per Se Claim

"Generally, negligence per se arises when a statute or ordinance is violated. Kull v. Six Flags Over Georgia II, L.P., 264 Ga. App. 715, 716 (2003). The violation of certain mandatory regulations may also amount to negligence per se if the regulations impose a legal duty." Id. "When the law requires a person to perform an act for the benefit of another or to refrain from doing an act which may injure another, the injured party may recover for the breach of legal duty if he suffered damage thereby." Hubbard v. Department of Transp., 256 Ga. App. 342, 350 (2002). "Before negligence per se can be determined, a trial court must consider (1) whether the injured person falls within the class of persons it was intended to protect and (2) whether the harm complained of was the harm the statute was intended to guard against." Id. The plaintiffs have the burden of demonstrating a causal connection between the negligence per se and the injury. Id. Mercy Housing Georgia III, L.P., (A23A0462, May 30, 2023) (where court found that apartment complex was negligent per se when defendant failed to comply with regulations by providing a vulnerable individual with the adequate system to seek emergency assistance).

The DBHDD has established rules and policies under the authority of O.C.G.A. §§ 37-1-4 and 37-1-20, and Appellees were required to follow the policies and procedure of the DBHDD in coordinating the services for Janae. One such rule is the DBHDD's Outcome Evaluation: "Recognize, Refer, and Act" Model, which

requires support coordinators to follow the guidelines to identify any issues regarding the care of Janae. Under this Model, Appellee Walcott was required to look at pertinent documents relating to the care of Janae and to properly fill out answers to the 50 questions that make up the IOMR. Under this Model, Appellee Walcott was also required to issue coaching or a referral if any discrepancy is found. However, as the State Report revealed, there were various discrepancies within Janae's file regarding her care, even before the two visits that Appellee Walcott had with Janae in October of 2018. Thus, Appellee Walcott failed to follow the Model by not properly reviewing the pertinent documents relating to the items being reviewed. Even if Appellee Walcott did review the pertinent documents, she still failed to abide by the Model because she did not issue coaching or a referral to address the concern.

In the State Report, it was documented that Janae's file had **no** documentation regarding the use or administration of Thick-It -- no documentation from the first day that she arrived through her last day in the home. The State Report also revealed that regular night-time checks were not recorded as required. These discrepancies alone create material questions of fact regarding whether Appellees were negligent per se.

VI. CONCLUSION

Janae suffered pain and died tragically because of serious deficiencies in the care she was given at Dolly's. Material questions of fact remain on whether Appellees' improper monitoring and oversight of her care failed to detect and address the deficiencies and thus proximately caused Janae's injuries, pain, and wrongful death. For this reason, the trial court's Order Granting Summary Judgment in this case should be reversed. And the case should be remanded to the trial court for a trial by jury.

This submission does not exceed the word count limit imposed by Rule 24.

This 22nd day of June, 2023.

Respectfully Submitted,

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IN THE COURT OF APPEALS
STATE OF GEORGIA

CHANTE AMOS, individually; And as Temporary Administrator of the Estate of JANAE MICHELLE AMOS, Deceased, Appellant, v. CREATIVE CONSULTING SERVICES, INC. and YVETTE WALCOTT, Appellee.	)	CASE NO. A23A1609 ON APPEAL FROM GWINNETT STATE COURT

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I have this day served a copy of the within and foregoing Brief of Appellant upon all other parties in this action by depositing a copy of the same in the U.S. Mail with sufficient postage affixed to ensure first class delivery upon:

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This 22nd day of June, 2023.

/s/ David R. Hughes
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