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.

On Appeal from the State Court of Gwinnett County
Underlying Case No.: 21-C-01949-S5

BRIEF OF APPELLEES

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I. INTRODUCTION

This appeal arises out of the death of Janae Amos while under the care and supervision of Dolly's Personal Care Home. Appellant is the mother of Janae Amos and filed suit against Appellees in the State Court of Gwinnett County. Appellees prevailed on summary judgment. This Court should affirm the trial court's Order granting Appellee's Motion for Summary Judgment because there is no genuine issue of material fact whether Appellees breached their duty of care and whether that breach proximately caused Janae Amos' death. The evidence is clear that the alleged actions/failure to act of Appellees did not proximately cause Janae Amos' death.

Appellant claims that Appellees failed to properly review Janae's records that were maintained by Dolly's, failed to notice the use of Thick-it was not documented, failed to instruct Janae Amos' caregivers that use of Thick-it needed to be documented, and failed to notice that Thick-it was not consistently used in Janae's meals – specifically liquids. Appellant further alleges that Appellee Walcott failed to document her visits to Janae in an Outcome Measurement Review (OMR). However, it was not required for Appellee to provide an OMR after her monthly visit.

Appellant alleges these failures led to Janae's death. When Appellee Walcott visited Janae seven days after her admission to Dolly's, Walcott observed that Thick-it was present in the home and was advised by Dolly's staff that Thick-it was being used. Thus, Appellee Walcott had no reason to believe that Thick-it was not being used in Janae's liquids. Even if Appellee Walcott had advised Dolly's that they needed to document the use of Thick-it, such an instruction would not have changed the unfortunate outcome. Despite Dolly's training its staff how to care for Janae and such staff being aware of Janae's need for Thick-it, Dolly's staff were either not using the Thick-it consistently, or not using it at all. Thus, any instruction by Walcott to Dolly's that they needed to administer and document the use of Thick-it would have been an instruction of which Dolly's staff was already aware and would not have prevented Janae's death, because certain properly trained staff members failed to administer the Thick-it.

Appellant further claims that Janae required care and supervision of two caregivers, and that Appellees failed to detect and address that Dolly's was understaffed. Appellant's claims are inaccurate as Janae Amos' Individual Service Plan (ISP) did not dictate that her level of care required 24-hour supervision by two individuals. Rather, her ISP only required that two people were required to lift Janae when needed. Further, these staffing issue claims are irrelevant and did not lead to Janae's death.

II. STATEMENT OF THE CASE

a. Procedural History and Relevant Facts

This matter arises out of the death of Janae Amos while under the care and supervision of Dolly's Personal Care Home (hereinafter "Dolly's"). Janae passed away on November 21, 2018. (V2-13). Appellant filed a lawsuit against Dolly's on December 10, 2019, in the Superior Court of Walton County. (V2-9). Appellant later voluntarily dismissed that suit on March 12, 2021. (V2-9). On March 15, 2021, Appellant filed a renewal Complaint in the State Court of Gwinnett County and added Agnes Taylor, Cynthia Vincent, Creative Consulting Services, Inc. (hereinafter "CCS") and Yvette Walcott as defendants. (V2-9). On December 9, 2021, Dolly's, Agnes Taylor, and Cynthia Vincent were dismissed as defendants. (V2-162).

Appellee CCS provides support coordination and intensive support coordination services for individuals with developmental disabilities who receive services funded (in whole or part) and authorized by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). (V3-296). DBHDD provides the rules, regulations, framework and oversight for the care of the client in need. (V3-297). The support coordination services provide a snapshot in time regarding the individual's care. (V3-297).

When conducting monitoring visits of an individual, a CCS Support Coordinator can issue a coaching or referral if any issues or concerns are found. (V3-298). A coaching is an instruction given to a provider to correct an issue. (V3-298). A referral occurs when a provider has not complied with the coaching and the support coordinator informs DBHDD of the situation. (*Id*.). After issuing a referral to DBHDD, the issue is followed until resolved, however the Support Coordinator cannot force a service provider to comply. (*Id*.). DBHDD is the entity responsible for holding a service provider accountable. (*Id*.).

Appellee CCS provided care coordination for the client, Janae Amos, as chosen by Appellant. (V3-297). Appellant Chante Amos was Janae's mother. (V2-15). Appellant first sought support coordination services from CCS in 2006. (V3-318). Janae was a developmentally disabled individual in need of constant care and supervision, including the administration of her food and medications. (V3-315). At birth, Janae was diagnosed with cerebral palsy and later diagnosed with failure to thrive, epilepsy and scoliosis. (V3-315). Janae required a thickener called Thick-it to be added to her food and liquids to assist with swallowing. (V3-316). CCS was not responsible for administering Thick-it to Ms. Amos' liquids. (V3-298).

As a part of the coordination of care, a Support Coordinator employed by CCS visited Janae generally once per month to oversee the care that was provided to her. (V3-297). The role of a Support Coordinator includes oversight monitoring of direct

services that are given by a provider, like Dolly's. (V3-297). A CCS Support Coordinator, in conjunction with DBHDD, also developed and annually and periodically adjusted Janae's care plan as her needs changed over time. (V3-297). Janae was assigned various support coordinators while receiving support coordination services from Appellant CCS. (V3-318 and V3-523 – 618). At the time of her death, Janae's support coordinator was Yvette Walcott. (V3-297).

Before Janae received care from Dolly's, Appellant was enrolled in a service plan known as participant directed care. (V3-677 – 678). Through participant directed care, Appellant was responsible for caring for Janae and responsible for hiring staff to assist her. (V3-677 – 678). Under this service, Appellant still received support coordination services. During the time that Appellant received support coordination from CCS and over a period of five years, Appellant requested that her daughter be placed in a group home. (V3-524, V3-528-529, V3-568, V3-574).

Most pertinently, on April 2, 2018, Appellant requested that Janae be placed in a home. In response to this latest request, Appellee Walcott stated that Appellant's first step was to complete "a formal request," which would prompt the Region to evaluate what was needed. (V3-574). Appellee Walcott then located potential homes from the DBHDD database and contacted each home to determine whether there was space available for a young female. (V3-606, V3-666, and V3-717).

Support Coordinators do not choose which home to place individuals; instead, the family chooses where to place their loved ones and support coordinators merely provide suggestions. (V3-633). Appellant visited some of the potential homes suggested by Walcott. (V5-1127). Appellant was the ultimate decision-maker when it came to placing Ms. Amos in a home. (V3-639 and V5-1126). At no time did CCS or Defendant Walcott pressure Appellant to place Ms. Amos in a home. (V3-717, V5-1128 – 1129).

On April 13, 2018, Walcott visited Dolly's and sent photographs of the home to Appellant. (V3-605). On April 14, 2018, Appellant visited Dolly's and informed Walcott that she liked the staff's energy, thought Dolly's would be a great place for Janae, and wanted to move forward with placing Janae at Dolly's. (V3-605, V3-638 and V5-1129). On May 29, 2018, Appellant attended a meet and greet at Dolly's with Walcott. (V3-603). On September 12, 2018, the request to transfer Janae from her region (Region 3) to Region 2 (where Dolly's is located) was approved. Janae moved into Dolly's on October 7, 2018. (V3-598 – 599). When Dolly's came to pick up Ms. Amos from Appellant's home, at no time did Appellant advise she changed her mind about permanently placing Janae at Dolly's. (V3-717; V5-1138). In fact, Dolly's asked to pick up Janae on Saturday, October 6, 2018. (V3-599). October 6th happened to be Janae's birthday and Appellant wanted to spend that day with Janae

"in peace," so she asked that Janae go to Dolly's on Sunday, October 7, 2018. *Id*. That request was honored. *Id*.

While residing at Dolly's, Ms. Amos also attended a day program associated with Dolly's. (V3-718). Defendant Walcott conducted monitoring visits for Janae on October 15, 2018 (at Dolly's day program) and October 27, 2018 (at Dolly's community living arrangement). (V3-718). Janae had only been at Dolly's for 20 days, and Walcott reviewed records that reflected those 20 days. (V3-718). Walcott confirmed that Janae's ISP was present in hard copy at the home. (V3-598). On October 27, 2018, Walcott reviewed Janae's Medication Administration Record (MAR) and noted that the MAR was updated. (V3-598). Appellee Walcott was next scheduled to visit Janae in November but could not complete that visit because Janae passed away on November 21, 2018. (V3-718).

On November 20, 2018, Dolly's staff member Laura Morgan found Janae unconscious at 9:20pm and called 911 for emergency assistance. (V3-721, V3-736). Morgan last checked on Janae at 8:40pm. (V3-736). Janae's last meal consisted of macaroni and cheese, with juice between 6:30pm and 7:00pm; approximately three hours before she was found unresponsive. (V3-736). Upon EMS arrival, CPR was not being performed by Morgan. (V3-722). When questioned by EMS upon their arrival at Dolly's, Morgan could not advise EMS of Janae's medical conditions, nor could she explain Janae's general health, medications, or whether a Do Not

Resuscitate (DNR) existed. (V3-722). Instead, Morgan asked EMS whether they wanted to review Janae's patient binder. (V3-722). EMS advised Morgan that there was no time to go through Janae's patient binder while working a cardiac arrest. (V3-722). Janae was then transported to Piedmont Walton Hospital. (V3-722).

On November 20, 2018, Appellee Walcott was informed by Appellant that Janae had been transported to the hospital. (V3-718). On November 21, 2018, Appellee Walcott was notified by Appellant that Ms. Amos passed away. (V3-718). Janae's cause of death was myocardial arrest as a consequence of respiratory failure due to aspiration pneumonia. (V3-724).

DBHDD independently investigated Janae's death, as her death was unexpected, and prepared a report. (V3-726 - 742). In its Report, DBHDD noted that on October 31, 2018, which was four (4) days after Walcott's visit, Janae's primary care provider, Dr. David Fields, directed that Thick-it was to be administered with prescribed Robitussin. (V3-729). However, "Thick-it was not documented as being used." (V3-734). Notably, seven doses of Robitussin were administered to Janae between November 12, 2018, and November 19, 2018, without Thick-it. (V3-734). However, Appellee Walcott had not yet conducted her November visit and thus, was not aware that that there was no documentation that Thick-it was not administered with the Robitussin and Walcott was not aware that Janae was even prescribed Robitussin. (V3-718). Dolly's staff member, Laura

Morgan was interviewed by DBHDD and stated that she observed Thick-it in the home but "never used Thick-it in Janae's liquids or in giving her medications … [because] no one ever told her about it." *Id*. However, this information was contained in Janae's ISP, which was present in her patient binder and Morgan signed a document on November 1, 2018, attesting that she had been "trained, understand and will comply with the information written in the ISP." (V4-819). Morgan was hired on October 16, 2018 and trained by Syvlie Shiwiri on October 22, 2018. (V3-734).

Thick-it was also not used in Ms. Amos' liquids when she attended the day program. (V3-739). It was ultimately determined that Dolly's neglected Ms. Amos based upon staff failure to provide Thick-it in accordance with the ISP. (V3-740 – 742). It was further determined that those Dolly's staff members who did provide Thick-it, did not administer it correctly. (V3-740 – 742). DBHDD ultimately determined that the actions of Dolly's staff members constituted neglect. (V3-740 – 742). Notably, the DBHDD Investigative Report did not find any fault or neglect on the part of Appellees or otherwise state that Appellees failed to do something. (V3-740 – 742).

b. Inaccuracies contained in Appellant's Statement of the Case

The Material Facts Relevant to Appeal contained in Appellant's brief misstates facts critical to consideration of her enumerations of error. Therefore,

Appellees supplement that statement with the following relevant facts from the record:

Appellant contends that Appellees forced and encouraged Appellant to place Janae in a community living arrangement. Contrary to Appellant's claims, the evidence shows that Appellant repeatedly asked that Janae be placed elsewhere. On November 20, 2006, Plaintiff was experiencing hardship in caring for Janae and her other child, so she requested adoption placement for Janae. (V3-546 – 547). Approximately sixteen (16) months later, on March 14, 2008, Plaintiff informed her support coordinator Kareen Morris that if she did not receive more help caring for Janae, she would surrender Janae to DFCS. (V3-612 – 613). In response, Morris provided Appellant with information for her to apply for a Community Care Services Program (CCSP) waiver that would provide Appellant with support services. (*Id*.) Ultimately, Appellant chose not to apply for the waiver because she was already receiving a respite waiver and feared that the CCSP waiver would interfere with her respite waiver. (V3-611 – 612).

On August 13, 2013, Appellant contacted Appellee Walcott to inform her that she "identified a provider whom she knows and trusts and who has an available bed for Janae." (V3-568). For several months, while the potential provider awaited placement as a host home provider, Appellant continued to have in-home staff until February 19, 2014. (V3-565 – 568). On February 19, 2014, Appellee Walcott

performed a home visit and was informed that Appellant had no staff. (V3-565). At this visit, Appellant advised Appellee that she was still waiting for "the provider of … Ms. Amos' choice to be placed as a host home so that Janae can transition to CRA (pending an approval of an RFAS) with her." (V3-565). Appellant then continued to have various in-home staff, on and off. Appellant wanted to hire a particular in-home staff (Shila Joshi), but this plan did not come to fruition, so Appellant requested information from her support coordinator to place Janae in a host home. (V3-563). For several months, Appellant continued with in-home staff.

Appellant again requested placement for Janae on July 30, 2016, because "she would be moving to either Seattle or Maryland … [and] [was] unable to take Janae with her." (V3-529). Appellee Walcott advised she would do her best to make that happen and discuss the situation with Appellee's area coordinator. (*Id*.)

Appellant followed up on placement for Janae on October 26, 2016, because "she is a single mom and can no longer care for Janae properly." (V3-523). An assessment was completed in September 2016, but placement could not be completed because Janae's Health Risk Screening Tool (HRST) was not updated by Appellant. (*Id*.) Thus, the evidence in the record is clear that it was Appellant herself who repeatedly asked that Janae be placed in a home. The record does not show that Appellee Walcott ever suggested that Janae be placed in any home, and certainly did not encourage Appellant to place Walcott at Dolly's.

Appellant further alleges that Appellee Walcott picked Dolly's Personal Care Home for Appellant. As stated in the Statement of the Case above, Appellant visited Dolly's and informed Walcott that she liked the staff's energy, thought Dolly's would be a great place for Janae, and wanted to move forward with placing Janae at Dolly's. (V3-605, V3-638 and V5-1129). The referenced support notes contained in the record at V3-523 through V3-618 are absent any correspondence from Appellee Walcott that the idea to place Janae stemmed from Walcott and the notes are absent any correspondence from Appellant that she changed her mind and did not want Janae to permanently move to Dolly's, as Appellee claimed during her deposition. In fact, Appellee Walcott "reminded [Appellant] that they are a short car ride away and when she wanted Janae to visit, she would just have to make arrangements with the CRA provider since she herself has no transportation." (V3-598 – 599).

Appellant further claims that Janae required two staff present at all times, and that Appellees promised Appellant that Janae would have two staff present at Dolly's. First, Appellee Walcott made no such promises. Second, Janae's ISP did not require that she have two staff members. (V4-813). To the contrary, the ISP only dictated that two staff members were required to lift Janae, when ncessary. (V3-640 and V4-813). Appellant also argues that Dolly's was understaffed, and Appellees failed to address this issue. However, Janae's level of care did not require two staff members. (V3-640). Moreover, Appellees were not required to review internal staff

sign-in records. (V3-490 – 491). It is also not Appellees responsibility to determine the number of staff available in a group home; that is up to the Region nurse. (V3-490 – 491).

Further, contained in Appellant's Material Facts Relevant to Appeal, she claims that Appellee Walcott failed to complete OMRs for her two October visits. However, an OMR was not required to be completed for a monthly visit according to the DBHDD policies. *See* Support Coordination Contact Frequency Requirements, 02-433; Support Coordination Documentation, 02-434.

III. ARGUMENT AND CITATION OF AUTHORITY

a. The Trial Court Properly Granted Appellees' Motion For Summary Judgment Because No Fact Issues Remain Whether Appellees' Proximately Caused Janae Amos' Death.

"A legally attributable causal connection between the allegedly-negligent conduct and the resulting injury — i.e., proximate cause — is an essential element of any negligence claim. In the tort context, proximate causation includes all of the natural and probable consequences of the tortfeasor's negligence, unless there is a sufficient and independent intervening cause." (internal citations omitted.) *Miller v. Turner Broad. Sys.*, 339 Ga. App. 638, 642 (2016). Proximate cause means "that which, in the natural and continuous sequence, unbroken by other causes, produces

an event, and without which the event would not have occurred." *Guida v. Lesser*, 264 Ga. App. 293, 297 (2003). "Negligence is the proximate cause of an injury only when the injury is the natural and probable consequence of the negligence, such a consequence as under the surrounding circumstances of the case might and ought to have been foreseen by the wrongdoer as likely to flow from his act." *Duncan v. Klein*, 313 Ga. App. 15, 22 (3)(2011) (internal citations omitted). Georgia jurisprudence consistently requires foreseeability in negligence claims and the occurrence of an unfortunate event is insufficient to authorize an inference of negligence without foreseeability. *Hill v. Hospital Authority of Clarke County*, 137 Ga. App. 633, 640 (1976). The result of an act must be reasonably anticipated or expected. *Haves v. Brown*, 108 Ga. App. 360, 363 (1963).

Here, a determination of proximate cause requires a finding that Janae's death after suffering a heart attack was the natural and probable consequence of Appellee Walcott's alleged failure to properly coach Dolly's Personal Care Home that the use of Thick-it needed to be documented, and should have been foreseen by Appellees as likely to flow from Walcott's alleged failure to issue such a coaching. Appellee Walcott visited Janae on October 15, 2018, and October 27, 2018. (V3-718). At her October 27, 2018, visit, Walcott was informed that Thick-it was in the home and given to Janae. (V3-718). Walcott did not tell Dolly's that the administration of Thick-it needed to be documented. However, Walcott's actions of not telling Dolly's

the use of Thick-it needed to be documented did not proximately cause Janae's death, rather, the failure to administer Thick-it proximately caused her death. In other words, it was not foreseeable that Janae's death would flow from Walcott's alleged failure.

Moreover, "under the well-established doctrine of intervening causes, a defendant's breach of a duty does not constitute a proximate cause of a plaintiff's injury when there has intervened between the act of the defendant and the injury to the plaintiff, an independent act or omission of someone other than the defendant, which was not foreseeable by the defendant, was not triggered by the defendant's act, and which was sufficient of itself to cause the injury." *Maynard v. Snapchat*, Inc., 366 Ga. App. 507, 509 (2023). In *Maynard*, Snapchat created a feature in its application, known as a speed filter, that allowed users to capture their real-time speed while driving. *Id*. at 510. Users would drive in excess of 100 mph to record excessive speeds and share on social media. *Id*. This Court held that "a finder of fact could infer that Snap's Speed Filter was a proximate cause of the collision." *Id*. This Court further held that the intervening cause doctrine did not shield appellee from liability because the nature of the intervening act (driving in excess of the speed limit while utilizing the speed filter) was of such a nature that it was probable injury would result from invention of the speed filter. *Id*. at 511.

Here, in between Walcott's alleged failure to issue a coaching regarding documentation of Thick-it and Janae's death, Dolly's staff members failed to either consistently provide the same amount of Thick-it or failed to provide it altogether. (V3-726-742). The negligent actions of Dolly's staff were an intervening cause independent of Walcott's alleged failure to act. Furthermore, Dolly's negligent actions were not foreseeable to Walcott because Walcott was shown that Thick-it was present in the home, and informed that it was being administered to Janae. Thus, Walcott had no reason to believe Thick-it was not being administered, and no reason to believe that Janae would later pass away because of Dolly's failure to administer the Thick-it. The alleged failure to issue a coaching does not amount to the actions of Snapchat in *Maynard* in creating a speed filter, and thus, was not a proximate cause of Janae's death.

In her brief, Appellant cites to *Mercy Housing Georgia III, L.P. v. Kaapa* Housing (A23A0462, May 30, 2023). In Mercy Housing, appellant's father had a stroke, and was not discovered for several days. *Id*. at 5. Mercy Housing was mandated to provide tenants like appellant's father with an emergency call button, and Mercy Housing failed to do so. *Id*. at 2. The Court determined that "there is evidence in the record that had the mandatory emergency call system been provided to Mr. Kaapa, it is likely that "[he] would have been rescued sooner, thereby avoiding or lessening the extent of his injuries." *Id*. at 10. However, in the present

case, there is no evidence in the record that had Thick-it been documented, Janae would not have had a heart attack and died. Again, Janae died because of the failure to administer the Thick-it. Consequently, there is no genuine issue for a jury to determine as to whether Appellee Walcott's actions or failure to identify the lack of documentation proximately caused Janae's heart attack and later death.

"If subsequently to an original wrongful or negligent act a new cause has intervened of itself sufficient to stand as the sole cause of the misfortune, the original act must be considered as too remote. If the cause is too remote, it was not the proximate cause." *Pearson v. Tippmann Pneumatics, Inc*., 281 Ga. 740, 741-742 (2007). Walcott visited Janae at Dolly's personal care home on October 27, 2018, and observed two staff present. (V3-598; V3-644). It was on this date that Appellant alleges Walcott failed to detect that Thick-it was not documented when administered and Walcott failed to issue a coaching. However, Walcott was informed that Thick-it was present in the home and being provided to Janae. (V3-718). Some of Dolly's staff administered Thick-it, but there were some staff who did not because they did not familiarize themselves with Janae's ISP. (V3-726 – 742). Laura Morgan was not administering Thick-it to Janae's liquids. (V3-735 – 736). Walcott's allegedly negligent failure to issue a coaching was too far remote from Janae's death, which was caused by a heart attack due to respiratory failure and aspiration pneumonia.

(V3-724). Therefore, the trial court did not err in finding there was no proximate cause.

b. <u>There is no expert evidence in the record proving that Appellee's alleged failures proximately caused Janae's death.</u>

Janae's untimely death was not a foreseeable result of Appellee's actions, and Appellant has failed to come forth with expert testimony to prove same. Appellee's claims raise a very specific medical question that requires expert testimony to establish causation under Georgia law.

Usually, expert testimony is unnecessary to establish causation in simple negligence cases. *Cowart v. Widener*, 287 Ga. 622, 622 (2010). "However, expert evidence is required where a medical question involving truly specialized medical knowledge (rather than the sort of medical knowledge that is within common understanding and experience) is needed to establish a causal link between the defendant's conduct and the plaintiff's injury." *Id.* (internal citations omitted). For example, expert evidence is needed to determine whether exposure to mold caused the plaintiff's respiratory illness. *See Allstate Ins. Co. v. Sutton*, 290 Ga. App. 154, 160 (2008).

In *Cowart*, the Decedent suffered from numerous health problems, including severe erosive esophagitis. *Id*. at 624. While on a road trip from Augusta to Ohio,

the Decedent complained to Widener that his throat was closing in on him and that he had been coughing up blood. *Id*. at 625. The Decedent advised Widener that he was feeling fine and wished to lay down without being disturbed. *Id*. Around three hours later, Widener noticed a foul odor and pulled over to check on the Decedent. *Id*. The Decedent had died. *Id*. The coroner concluded that the Decedent died from natural causes. *Id.* at 626. A wrongful death suit was filed against Widener, his employer and insurance company, alleging that he negligently or intentionally withheld medical care which caused the Decedent's death. *Id*. The defendants moved for summary judgment which was granted by the trial court upon its conclusion "that the plaintiffs could not establish that Widener proximately caused Cowart's death without producing expert evidence, which they had failed to do." *Id*. at 622. This Court affirmed. *Id*.; *see also Cowart v. Widener*, 296 GA. App. 712 (2009).

On writ of certiorari, the Supreme Court affirmed and explained plaintiffs were required to show Widener caused the Decedent's death by failing to render or seek assistance, and they failed to point to any expert evidence from which a jury could conclude that Widener's conduct proximately caused the Decedent's death. *Id*. at 631.The Court further stated a jury could not rely on its common sense and experience to answer the causation questions and held that summary judgment was properly affirmed by the Court of Appeals. *Id*. at 633, 791.

The case at bar is not a simple negligence case that does not require an expert's specialized knowledge. Appellant has raised a very specific medical question: did Appellee's alleged negligent conduct cause Janae to have a heart attack, one month after the last monitoring visit? A jury cannot rely on its own common sense and experience to answer this question and determine whether the alleged failure to review and detect deficiencies in documentation, and issue a coaching caused Janae to have a heart attack. Georgia law is clear that a jury needs an expert with specialized knowledge and experience to establish a causal link between the actions of Appellees and the death of Janae. Such expert testimony is absent from the record. Thus, Appellant cannot prove proximate cause and the trial court's grant of summary judgment granted to Appellees finding that there was no evidence of proximate cause was proper.

c. Appellees did not breach any duty owed to Janae Amos.

Appellant claims that Appellees breached their duty of care by failing to properly monitor and oversee the care that Janae received from Dolly's. However, there have been no actions on the part of Appellees that rise to a breach of duty.

In order to prevail in a negligence action, a plaintiff must satisfy the elements of the alleged tort; specifically, the plaintiff must show the existence of a duty on the part of the defendant, a breach of that duty, causation of the alleged injury, and

damages resulting from the alleged breach of the duty. *John Crane, Inc. v. Jones*, 278 Ga. 747, 751 (2004). The threshold issue in any negligence case is whether the defendant owes a duty to the plaintiff. The existence of a legal duty is a question of law for the court. *Ghali v. Miles*, 355 Ga. App. 266, 267 (2020), citing *Rasnick v. Krishna Hospitality*, 289 Ga. 565, 566 (2011). The duty can arise either from a valid legislative enactment, that is, by statute, or be imposed by a common law principle recognized in the caselaw. *Murray v. Ga. Dept. of Transp*., 284 Ga. App. 263, 272 (4) (2007).

Appellees owed Janae Amos a duty to oversee and monitor the care provided to Janae. Since 2006, Appellees monitored the care provided to Janae by Appellant and continued to monitor her care when Janae transitioned from participant-directed care to a community living arrangement at Dolly's on October 7, 2018. (V3-523 – 618).

Appellant argues that Walcott breached her duty to Janae because she failed to complete Outcome Measure Reviews when she visited Janae in October 2018. The OMRs for 2018 were not produced to Appellant because those records were not available online to be downloaded from the State's online system that had been updated. (V3-487 – 488). Because these documents were not produced, it cannot be inferred that Walcott failed to complete the OMR. Moreover, as discussed below in part d, an OMR for October 2018 was not required according to DBHDD policies.

Appellant further argues there was a breach of duty because Walcott failed to review documents from Dolly's. However, Walcott did review documents in Dolly's possession pertaining to Janae. (V3-718). Appellant further argues in her brief that Walcott "admitted that had she looked at the records and seen there was no documentation of Thick-it and Ensure, it would have concerned her." However, Walcott did not admit that she never reviewed the documents. (V3-673).

d. Appellees are not negligent per se.

In arguing that Appellees are negligent per se, Appellant asserts that Appellees are required to abide by and failed to abide by the DBHDD rules and regulations. However, the "Provider Manual for Community Behavioral Health Providers" found on V6-1305 does not apply to support coordination agencies. Additionally, only the first page of this manual, not the entire manual itself, is located in the record. Further, as stated in the manual's title, the rules apply only to providers and support coordination agencies are not providers. (V6-1305).

The policy that applies to support coordination is the "Operating Principles for Support Coordination & Intensive Support Coordination Providers" issued by DBHDD, which includes the "Recognize, Refer and Act Model." Per this policy, face-to-face visits occur quarterly, but are mandated to occur monthly when an individual resides at a community residential alternative (such as Dolly's). *See*

Support Coordination Contact Frequency Requirements, 02-433. These visits are documented in the Support Notes instead of the OMR, because they occur monthly. *See* Support Coordination Contact Frequency Requirements, 02-433; Support Coordination Documentation, 02-434.

> B.2.b. In addition, the following circumstances require a SC or ISC face-to-face visit on a monthly basis whereby a **comprehensive Support Note is entered to document the visit**, per Support Coordination Documentation, 02-434:
>
> i. **For SC individuals receiving CRA services, a face-to-face visit to the residence is required monthly**.

(emphasis added). Per this policy, Walcott was required to visit Janae monthly when she transitioned from the care of her mother to Dolly's. Walcott visited Janae twice in one month, exceeding the visit requirement as set forth in 02-433. (V3-598). After each of these visits, Walcott memorialized her visits in the Support Notes as required by 02-434. (V3-598). Walcott was not required to complete the OMR for her completed monthly visit per 02-433. Therefore, Appellees are not negligent per se as Walcott abided by the DBHDD policies regarding support coordination.

IV. CONCLUSION

Based upon the foregoing arguments, Appellees respectfully request that this Court find the trial court did not err in granting Appellees' Motion for Summary Judgment and affirm the trial court's ruling.

Respectfully submitted this 12th day of July, 2023.

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CERTIFICATE OF COMPLIANCE

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I have this day served a copy of the within and foregoing Brief of Appellees upon the following undersigned counsel for Appellant by depositing a copy of same within the United States Mail with sufficient postage affixed:

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This 12th day of July, 2023.

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