

[Cite as *Israfil v. Ohio Dept. of Rehab. & Corr.*, 2017-Ohio-4458.]

MUMIN ISRAFIL

Plaintiff

v.

OHIO DEPARTMENT OF
REHABILITATION AND CORRECTION

Defendant

Case No. 2013-00720

Magistrate Robert Van Schoyck

DECISION OF THE MAGISTRATE

{¶1} Plaintiff, an inmate in the custody and control of defendant, brought this action alleging that on February 15, 2013, a corrections officer at the Franklin Medical Center (FMC) pushed plaintiff's wheelchair in a negligent manner and injured plaintiff. The issues of liability and damages were bifurcated, trial was held on the issue of liability, and the magistrate recommended judgment in favor of plaintiff. The court adopted the magistrate's decision and entered judgment accordingly. The case then proceeded to trial on the issue of damages.

{¶2} As was previously established during the liability phase of trial, when the corrections officer pushed plaintiff's wheelchair, plaintiff's left arm and hand struck a door and were pinched between the door and wheelchair, and plaintiff was also abruptly jerked about in the wheelchair. It was also established during the liability phase of trial that plaintiff was at FMC due to pre-existing medical issues, including back and neck problems.

{¶3} At the damages phase of trial, plaintiff explained that he had been experiencing chronic pain in his lower back, neck, and right side long before the incident at FMC. Plaintiff, who stated that he has been in defendant's custody since 1994, testified that some of those symptoms manifested after he was struck by a golf cart at the Warren Correctional Institution (WCI) in 2009. According to plaintiff, he started to

have some difficulty walking after that incident. Plaintiff recalled that at some point after the golf cart incident he was diagnosed with degenerative disc disease. Plaintiff stated that his physical condition worsened in 2010 as a result of injuries he sustained in an altercation with an employee at WCI. Plaintiff testified that he spent the next 16 months in “the hole” at WCI, during which time he suffered constant back and neck pain, numbness in his legs, severe headaches, and bed sores. Afterward, plaintiff stated, defendant transferred him to the Ross Correctional Institution (RCI).

{¶4} Plaintiff related that he received a medical evaluation when he arrived at RCI and was subsequently placed in the general population. Plaintiff stated that he was having back and neck pain at that time, though, and the back pain was spreading down his spine, and after he complained about having difficulty walking long distances he was placed in a segregation unit.

{¶5} Plaintiff explained that after about six months at RCI, he was transferred to the Toledo Correctional Institution (ToCI). At ToCI, plaintiff recounted, he received an evaluation by a Dr. Morris, who ordered an MRI and other tests, and also prescribed medication for management of his pain. Plaintiff testified that he was also issued a wheelchair, and that through the medication and use of the wheelchair he found some relief from his symptoms. Nevertheless, plaintiff stated, he still had pain and numbness in his right side, as well as neck pain and significant back pain. Plaintiff testified that a Dr. Pine at ToCI eventually arranged for him to be conveyed to FMC for further evaluation and to undergo physical therapy.

{¶6} Jeff Matthaes, R.N. testified that he is employed with defendant as the Health Care Administrator at FMC and that he has worked for defendant since 1997. Matthaes described his responsibilities at FMC, and he also explained different aspects of defendant’s medical record-keeping system. Matthaes stated that he never provided any nursing care to plaintiff and does not have first-hand knowledge about plaintiff, but he reviewed plaintiff’s medical records and offered explanatory testimony.

{¶7} Matthaes provided testimony about a General Evaluation form dated September 18, 2012, approximately five months before the incident at issue in this case, and among other things it indicated that plaintiff had longstanding lower back pain which, “with activity,” increased to a 10 on a scale of 1 to 10, and plaintiff also was noted at that time to have muscle atrophy with leg weakness. (Defendant’s Exhibit C.) Matthaes authenticated documentation showing that plaintiff was admitted to FMC on January 22, 2013, and that at the time of his admission it was noted that his medical history included diagnoses of degenerative disc disease and a herniated disc. (Defendant’s Exhibit D.) As Matthaes explained, certain baseline data may be collected when an inmate is admitted to FMC, and in the case of plaintiff this data included his back and neck pain levels, which were noted to be sharp and to intermittently reach 10 on a scale of 1 to 10 when walking, and 5 on a scale of 1 to 10 when sitting. (Defendant’s Exhibit D.)

{¶8} Plaintiff recounted that soon after arriving at FMC he started attending sessions with a physical therapist, Katie Coleman, who put him through a course of therapy that included range of motion tests, strength tests, traction, having him ambulate with a walker, and assessing his pain levels. Plaintiff stated that he cooperated and got into a routine with the physical therapy, but his back pain persisted. As plaintiff recalled, Coleman prepared documentation on February 8, 2013, to discharge him from the physical therapy and assess the level of assistance that he would require with mobility and other daily activities. (Plaintiff’s Exhibits 14 & 15.) Coleman indicated that the reason she discharged plaintiff was that he had reached the maximum functional benefit of the physical therapy. Coleman also indicated that plaintiff was to have a wheelchair for mobility at distances over 100 feet, as well as a wheeled walker, apparently for shorter distances. Plaintiff testified that he agreed with what Coleman wrote about his pain level at that time, rating the lower back pain as 4-5 on a scale of 1 to 10 and cervical pain as 1-2 on a scale of 1 to 10, but also noting that

when he ambulated short distances his lower back pain was 8 on a scale of 1 to 10; in addition, Coleman noted that it was recommended to plaintiff how he could improve his strength and range of motion, and that he was recommended to use ice or a hot pack as needed for pain relief.

{¶9} Plaintiff testified that his pain levels fluctuated while at FMC before the February 15, 2013 incident. Indeed, Matthaes authenticated numerous medical records, including many nursing assessment forms prepared every shift by the attending nurses, which demonstrate that plaintiff complained at times of back pain as high as 8 on a scale of 1 to 10, and with some frequency he rated it at least as a 4 or 5; additionally, he reported pain at times in other locations, including the legs, hip, and right shoulder. (Defendant's Exhibits E & F.)

{¶10} On the date of the incident, plaintiff recalled, he had pain in his back, neck, and legs, but he wanted to go out in the hallway and perform some exercise as he had been instructed to by the medical staff. Plaintiff testified that when he came out of his room in his wheelchair and was subsequently pushed back in the room by Corrections Officer Marvin Stanback, it scared him because he felt like he was going to fall out of the wheelchair. Plaintiff stated that he tried to brace himself in the wheelchair and had his left hand on the side of the wheelchair, but as Stanback pushed him back into the room the door closed against him, striking his left side and crushing his finger into the wheelchair. According to plaintiff, his finger hurt, but he also felt pain all throughout his body and he was in a state of shock. Plaintiff testified that Corrections Officer Candace Jordan proceeded to lock his door, and that after he pushed a call button and summoned a nurse, he could hear Jordan tell the nurse that he was fine. Plaintiff also testified that the nurse came back later to check on him, but that he could see a different corrections officer shaking his head as if to intimidate plaintiff into not mentioning anything to the nurse. Plaintiff stated that he eventually did speak with a nurse that evening and also the next morning, when the nurses made their regular

rounds to check on him and the other patients in the four-man room, but he was afraid to tell them what happened. As plaintiff explained, after seeing the corrections officer shake his head earlier to dissuade him from saying anything, he was scared and wanted to get out of FMC.

{¶11} Plaintiff testified that the morning after the incident he felt “busted up,” like he had been in a car crash. According to plaintiff, despite his pre-existing health issues, his physical condition after the incident was significantly worse than before. Plaintiff testified that a progress note written early in the morning on the day of the incident accurately reflects his condition at that time, documenting that he complained of back pain rated at 4 on a scale of 1 to 10, and right shoulder pain rated at 7 on a scale of 1 to 10, with the pain in both locations described as “achy.” (Plaintiff’s Exhibit 16.) Plaintiff testified that on February 17, 2013, he reported the incident to the institutional inspector at FMC by way of a Notification of Grievance, and therein he wrote that since the incident he was “bed-ridden every morning until the afternoon with severe neck & back pain and stiffness.” (Plaintiff’s Exhibit 1.) In testimony describing his condition after the incident, plaintiff stated that progress notes written on February 18, 2013, three days afterward, accurately reflect his condition at that time. (Plaintiff’s Exhibit 17.) According to those February 18, 2013 progress notes, plaintiff complained at 12:35 a.m. of pain throughout his “whole back,” at 5:35 a.m. he complained of back pain rated at 5 on a scale of 1 to 10, and at 10:00 a.m. he complained of back and neck pain rated at 7 on a scale of 1 to 10, with it also being noted that he was unable to sit up in bed. (Plaintiff’s Exhibit 17.) Plaintiff testified that he was forthright with the nurses when it came to relating his physical condition, but that he was afraid to share any information with them about the incident. Plaintiff also testified that the middle finger on his left hand, having been caught between the wheelchair and the door during the incident, hurt somewhat but was only a minor nuisance at the time and he did not seek out or receive any medical attention for it at FMC.

{¶12} Matthaes authenticated records showing that plaintiff was discharged from FMC on February 25, 2013, and conveyed back to ToCI. (Defendant's Exhibit D.) Plaintiff testified that when he arrived back at ToCI, he did not receive the same accommodations and pain management medication that were provided or recommended for him at FMC, where he recalled having been on Tylenol, ibuprofen, and Ultram. According to plaintiff, at ToCI his pain symptoms worsened to the point that his level of pain was 10 on a scale of 1 to 10 without any pain medication, but later he did receive such medication again and it reduced the level of pain to 7 on a scale of 1 to 10. Plaintiff testified that inmates can make a formal request for medical attention by submitting a Health Services Request (HSR) form, and he stated that he submitted several of these after he returned to ToCI. Plaintiff acknowledged submitting HSRs for issues such as back and neck pain, right-sided pain and tingling or numbness, or other issues on March 7, 2013, March 11, 2013, March 14, 2013, and March 23, 2013, although none of these HSRs relate his symptoms to the incident at FMC. (Defendant's Exhibit A.) Progress notes authenticated by Matthaes indicate that plaintiff was seen for a medical appointment on March 26, 2013, and that he complained of worsening back problems after being "abused" at FMC. (Defendant's Exhibit F, p. 281.)

{¶13} Although plaintiff admitted that he had not previously expressed any complaints about or otherwise sought care for the middle finger on his left hand, he testified that it had been bothering him all along and that there was no other injury or trauma to the finger during this span of time apart from the incident at FMC. Although he initially did not think it was a significant issue, over time it worsened and became more painful, plaintiff stated. According to plaintiff, the finger started to tingle, followed by throbbing or stinging pain, and ultimately it became swollen and filled with pus. Plaintiff testified that he squeezed the pus out of the finger himself at one point, but the finger continued to worsen and he decided to seek medical attention.

{¶14} Plaintiff recounted that after requesting medical attention for the finger he was seen by a nurse on April 10, 2013, as documented in both a progress note and a “Skin Complaints” nursing assessment form. (Plaintiff’s Exhibits 9, 18, & 21.) Plaintiff testified that he told the nurse the finger had been giving him problems for about a month and a half, as reflected in the Skin Complaints form, which also documented that plaintiff attributed the injury to getting the finger caught between a door and his wheelchair and that he had been aware the finger was infected for about 10 days. (Plaintiff’s Exhibits 9 & 21.) Plaintiff stated that after his appointment with the nurse, he was referred for an appointment with a doctor, which occurred on April 15, 2013, according to progress notes. (Plaintiff’s Exhibit 18.) Plaintiff recalled that the pus in the finger was swabbed and sent out for a lab culture, and that he was prescribed antibiotics. Additionally, Matthaes authenticated progress notes from April 16, 2013, showing that x-rays of the finger were taken on that date. (Defendant’s Exhibit F, p. 281.)

{¶15} Matthaes also testified that another document in plaintiff’s medical file shows that defendant transferred plaintiff from ToCI to the North Central Correctional Complex (NCCC) on April 17, 2013. (Defendant’s Exhibit F, p. 273.) Plaintiff testified that although the fingernail detached from his finger sometime after he started getting care for it, over time the swelling went away and the pain gradually diminished, with the finger being fully healed about a month or two after the transfer to NCCC. There are no longer any problems with the finger, plaintiff testified. As far as the back and neck pain is concerned, plaintiff testified that at the time of trial he was taking Neurontin, Ultram and Tylenol, which have provided him some pain relief and made it more tolerable, at least when he is resting. But, according to plaintiff, he feels that his physical condition remains worse than it was before the incident. Plaintiff stated that his level of pain at the time of trial was about 5 on a scale of 1 to 10. Plaintiff testified that since being transferred to NCCC, he has undergone MRIs and other treatment for his back and

neck problems, and it is his understanding that he has been diagnosed with chronic pain syndrome.

{¶16} “In order to sustain an action for negligence, a plaintiff must show the existence of a duty owing from the defendant to the plaintiff or injured party, a breach of that duty, and that the breach was the proximate cause of resulting damages.” *Sparre v. Ohio Dept. of Transp.*, 10th Dist. Franklin No. 12AP-381, 2013-Ohio-4153, ¶ 9. “As a general rule, the appropriate measure of damages in a tort action is the amount which will compensate and make the plaintiff whole.” *N. Coast Premier Soccer, LLC v. Ohio Dept. of Transp.*, 10th Dist. Franklin No. 12AP-589, 2013-Ohio-1677, ¶ 17. “[D]amages must be shown with reasonable certainty and may not be based upon mere speculation or conjecture * * *.” *Rakich v. Anthem Blue Cross & Blue Shield*, 172 Ohio App.3d 523, 2007-Ohio-3739, ¶ 20 (10th Dist.).

{¶17} Upon consideration of the evidence presented at trial, the magistrate finds as follows. As a result of being abruptly jerked about in the wheelchair when it was pushed by the corrections officer, plaintiff sustained a minor, temporary aggravation of his pre-existing back and neck pain. The medical records reflecting the pain levels that plaintiff reported to the nurses who made regular assessments of him while at FMC do not show that the changes in the degree of plaintiff’s pain after the accident were as significant as he described. In fact, just two days before the accident, plaintiff reported that his pain level was 8 on a scale of 1 to 10, but one day after the accident it was 6, two days later it was 5, and three days later it was 5. (Defendant’s Exhibit E, pp. 407, 268, 267, 266.) Plaintiff had a history of chronic back and neck pain, severe enough to impair his mobility, and indeed the very reason he was at FMC was for treatment of these issues. Looking at the documented history of plaintiff’s pain, which fluctuated regularly before and after the accident, there is little evidence of any significant change in the nature or severity of plaintiff’s pain after the accident, and his mobility impairment was basically unchanged as well during this time. Although plaintiff was in more pain

when he was transferred to ToCI and made several complaints to that effect, it is more probable than not that this was due to plaintiff not receiving the same accommodations and pain medications that he had been receiving at FMC. The documentary evidence of plaintiff's complaints at ToCI show that he was complaining of symptoms within the range of chronic complaints that he had been suffering before the accident.

{¶18} While plaintiff seemed to testify that he still suffers some negative physical effects of the incident, the evidence that he offered simply cannot support such a finding. Plaintiff did not present any expert testimony in support of his claims, nor was it established that he was ever diagnosed with any back or neck injury proximately caused by this incident. Plaintiff offered a large set of his medical records but presented little testimony or argument about their significance, and the records that were identified at trial in no way support the conclusion that plaintiff suffered any severe or long-term injury as a result of the incident. Weighing all the evidence, and comparing plaintiff's testimony with his documented complaints and other medical evidence, demonstrates that the aggravation of plaintiff's pre-existing symptoms was relatively minor and dissipated in the days that followed. Although plaintiff's pain increased when he was transferred to ToCI, plaintiff was no longer receiving the accommodations and pain management care that he had been receiving at FMC. Taking into account the worsening symptoms that plaintiff attributed to those factors and the general scarcity of evidence demonstrating harm from this incident, it cannot be concluded that such harm persisted to any appreciable degree after plaintiff's transfer to ToCI.

{¶19} On the subject of plaintiff's left hand, the greater weight of the evidence does show that plaintiff sustained an injury to the middle finger on that hand when it was caught between the wheelchair and the door as a result of the corrections officer pushing the wheelchair through the doorway. While it appears that plaintiff did not seek out any medical attention or make any documented complaints to medical personnel about the finger until early April 2013, even though he did complain about other harm

from the incident during that timeframe, plaintiff did complain in his Notification of Grievance that his left arm had been crushed in the incident, the injury to the finger did not initially appear to be significant, and between the far more serious chronic and debilitating ailments with which plaintiff is afflicted and the related difficulties he had when transferring back to ToCI, the fact that plaintiff waited as long as he did to seek medical attention for the finger does not disprove that it was injured in the incident, as defendant suggested. It was also argued by defendant that plaintiff told the nurse who looked at the finger on April 10, 2013, that it had only been bothering him for ten days, but what the Skin Complaints form prepared by the nurse shows is that plaintiff actually said the finger had only been infected for about ten days, which is consistent with plaintiff's testimony about the progression of the injury, explaining how the finger worsened over time and that it was not until it became infected that he thought it necessary to seek medical attention. The nurse also wrote that plaintiff told her the underlying injury to the finger occurred when it was caught between a door and his wheelchair a month and a half earlier, thus corresponding with plaintiff's testimony about the sequence of the finger injury.

{¶20} Plaintiff suffered some acute pain when the left arm and hand were crushed between the wheelchair and the door, and although the longer-term injury to the finger was a minor inconvenience to plaintiff at first, over time it became more swollen and painful, and eventually the fingernail detached from the finger. After seeking out medical attention for the finger, plaintiff had to attend a few appointments, keep the wound bandaged, take antibiotic medication, undergo x-rays, and have a sample taken from the infected area for lab testing. Based upon plaintiff's testimony, the symptoms improved once he began treatment and the finger healed within one to two months after his April 17, 2013 transfer to NCCC.

{¶21} Finally, it is noted that plaintiff's medical expenses were covered by the state of Ohio while he was in defendant's custody and he did not establish an

entitlement to recover for any other medical expenses, nor did he establish any entitlement to lost wages.

{¶22} Based upon the foregoing, for the past pain and suffering associated with the injuries caused to plaintiff as a result of defendant's negligence, plaintiff is entitled to damages in the amount of \$3,750. Accordingly, it is recommended that judgment be entered for plaintiff in that amount.

{¶23} *A party may file written objections to the magistrate's decision within 14 days of the filing of the decision, whether or not the court has adopted the decision during that 14-day period as permitted by Civ.R. 53(D)(4)(e)(i). If any party timely files objections, any other party may also file objections not later than ten days after the first objections are filed. A party shall not assign as error on appeal the court's adoption of any factual finding or legal conclusion, whether or not specifically designated as a finding of fact or conclusion of law under Civ.R. 53(D)(3)(a)(ii), unless the party timely and specifically objects to that factual finding or legal conclusion within 14 days of the filing of the decision, as required by Civ.R. 53(D)(3)(b).*

ROBERT VAN SCHOYCK
Magistrate

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