[Cite as *McKay v. Ohio State Univ. Med. Ctr.*, 2015-Ohio-5619.]

Court of Claims of Ohio
The Ohio Judicial Center
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DARLENE MCKAY, Admr.

Plaintiff

v.

THE OHIO STATE UNIVERSITY MEDICAL CENTER

Defendant

Case No. 2013-00120

Magistrate Anderson M. Renick

DECISION OF THE MAGISTRATE

{¶1} Plaintiff, Darlene McKay, administrator of the estate of her daughter, Jennifer Crispin, brought this action alleging claims of wrongful death and survivorship. The issues of liability and damages were bifurcated and the case proceeded to trial on the issue of liability.

{¶2} In July 2009, Crispin was a 23-year-old patient at defendant The Ohio State University Medical Center (OSUMC) where physicians performed mastoid surgery on her left ear subsequent to her history of frequent ear infections. On October 30, 2009, Crispin was admitted to OSUMC and placed on IV antibiotics, Zosyn and vancomycin, to treat an ear infection which was caused by methicillin-resistant staphylococcus aureus, known as MRSA. Crispin was also prescribed Percocet, an oral pain medication. On the evening of October 31, 2009, Stephanie Ferry, R.N. and a patient care associate (PCA) were assigned to the unit that included Crispin's room. During her interactions with Crispin, Ferry noted that Crispin was oriented and cooperative and she provided her with prescribed medication. Several times during her rounds that evening, Ferry observed and recorded in her progress notes that Crispin was "off unit." Soon after midnight on November 1, 2009, Ferry entered Crispin's room and found her sleeping with her IV disconnected and IV medication dripping on the floor. Ferry also

noticed a syringe that contained a cloudy substance in Crispin's purse, which lay open in the room. Ferry notified both the charge nurse and the on-call resident, Ahmed Malas, M.D. Later that morning, Ferry called Dr. Malas again after she learned that Crispin had an elevated heart rate and soon thereafter, at approximately 2:50 a.m., Crispin left the floor. At 4:42 a.m., Ferry noted Crispin looked pale and her oxygen saturation level was low, whereupon she applied supplemental oxygen to Crispin and she notified Dr. Malas. At 7:00 a.m., Nurse Susi relieved Ferry as the on-call nurse for Crispin, and Dr. Gaston replaced Dr. Malas as the on-call physician.

{¶3} Crispin was given supplemental oxygen and after she became drowsy with an elevated heart rate and low oxygen saturation level, Dr. Gaston ordered a toxicology screen, which was positive for Xanax and Oxycodone. Crispin was instructed to leave her oxygen mask on and remain in her room, but Susi noted that Crispin left the unit approximately 20 minutes later. Sometime after 1:00 p.m., Crispin called Susi, who found Crispin in distress in her bed with her IV pump disconnected and located in the bathroom. A "code" team responded and Crispin admitted that she had crushed a Percocet pill and injected the drug. Crispin was transferred to the ICU for emergency treatment; however, Crispin's condition continued to deteriorate and she died later that day.

{¶4} Plaintiff alleges that Crispin died as a result of self-injecting medication that was not prescribed to her and that defendant's medical staff negligently permitted Crispin to leave her hospital room, during which time she obtained controlled prescription medication from another patient, Daniel Madden. According to plaintiff, defendant's employees were negligent in both allowing Madden to provide prescription medication to Crispin and failing to properly monitor Crispin.

{¶5} "To maintain a wrongful death action on a theory of medical negligence, a plaintiff must show (1) the existence of a duty owing to plaintiff's decedent, (2) a breach of that duty, and (3) proximate causation between the breach of duty and the death."

Littleton v. Good Samaritan Hosp. & Health Ctr., 39 Ohio St.3d 86, 92 (1988), citing *Bennison v. Stillpass Transit Co.*, 5 Ohio St.2d 122 (1966), paragraph one of the syllabus.

{¶6} "In order to establish medical malpractice, it must be shown by a preponderance of evidence that the injury complained of was caused by the doing of some particular thing or things that a physician or surgeon of ordinary skill, care and diligence would not have done under like or similar conditions or circumstances, or by the failure or omission to do some particular thing or things that such a physician or surgeon would have done under like or similar conditions and circumstances, and that the injury complained of was the direct and proximate result of such doing or failing to do some one or more of such particular things." *Bruni v. Tatsumi*, 46 Ohio St.2d 127 (1976).

{¶7} The same standard applies equally to claims that a nurse negligently caused injury to a patient. *Ramage v. Central Ohio Emergency Serv., Inc.*, 64 Ohio St. 3d 97, (1992). "Because nurses are persons of superior knowledge and skill, nurses must employ that degree of care and skill that a nurse practitioner of ordinary care, skill and diligence should employ in like circumstances. Whether a nurse has satisfied or breached the duty of care owed to the patient is determined by the applicable standard of conduct, which is proved by expert testimony." *Berdyck v. Shinde*, 66 Ohio St. 3d 573, syllabus (1993).

{¶8} Nurse Ferry testified regarding her care and interaction with Crispin which she recorded in her nursing notes. Ferry began her shift on October 31, 2009, at 7:30 p.m. and she worked until 7:30 a.m. on November 1, 2009, which resulted in her working an extra hour due to the daylight savings time change. Ferry testified that the computer clock automatically changed to reflect the correct time. Ferry related that she interacted frequently with Crispin during her shift and she discussed the notes she recorded in Crispin's medical chart. According to the medical records, Crispin was in

her room between 7:15 p.m. and 7:30 p.m., but Ferry noted that Crispin was not in her room at both 8:15 p.m. and 9:00 p.m. Ferry testified that she met Crispin for the first time when she encountered her in the unit hallway at 9:40 p.m. Ferry performed an assessment at 10:00 p.m. during which she administered medication and found Crispin oriented and cooperative; however, within one hour later, she noticed that Crispin was again "off unit." During the eleven o'clock hour, Ferry checked on Crispin twice, noting that she remained oriented and cooperative. At 12:10 a.m., Ferry entered Crispin's room to prepare an IV antibiotic and she found Crispin sleeping, however, the IV was disconnected with fluid dripping on the floor. Ferry asked Crispin about the IV and a syringe containing a cloudy fluid that she observed in Crispin's purse, but Crispin denied knowledge of either the syringe or how the IV became disconnected. Ferry testified that she had never encountered such circumstances in over 14 years as a nurse and she notified the charge nurse, Dr. Malas and a hospital administrator. Ferry stated that Dr. Malas arrived on the floor soon thereafter and sent the syringe to the lab for analysis.

{¶9} During the next couple hours, Ferry observed Crispin sleeping and she assessed her condition each hour. At 2:45 a.m., Ferry noticed that Crispin's heart rate had increased, which Ferry described as a common reaction to the "eight out of ten" pain that Crispin had reported earlier. Ferry reported Crispin's change in vital signs to Dr. Malas and she noted that Crispin became upset when she learned that the incident involving the discovery of the syringe would be included in her medical records. According to Ferry, Dr. Malas was aware that the toxicology report was positive for Xanax and oxycodone. The nursing notes show that by 2:50 a.m. Crispin had left her room again. Ferry continued to check on Crispin each hour and at 4:42 a.m. Crispin called Ferry to tell her the IV machine was making a beeping sound because the antibiotic bag was empty. Ferry arrived and noted that Crispin was sleeping with her eyes half open, looked pale, and her oxygen saturation level was low. Ferry woke

Crispin, administered supplemental oxygen, and notified Dr. Malas, who ordered an EKG and chest x-ray. At 6:35 a.m., Ferry noted that Crispin was getting ready to go outside and her oxygen levels were decreasing. Ferry recalled that she told Crispin that it would be dangerous for her to leave the floor. At 7:00 a.m., Crispin tried to leave the floor and she asked for more pain medication.

{¶10} Ferry testified that during one of their conversations, Crispin told her that she was worried about another patient who was in a wheelchair and may have been overmedicated. Ferry stated that she checked on the patient and talked to the patient's nurse about Crispin's concern.

{¶11} Dr. Malas is board certified in internal medicine and testified by deposition that he does not have an independent recollection of treating Crispin. Dr. Malas reviewed Crispin's medical record and testified that it shows he explained to Ferry that Crispin's IV could not be disconnected because she needed to remain on IV antibiotics and IV access could be critical in the event that Crispin's condition deteriorated, requiring rapid administration of medicine or fluids. Dr. Malas testified that he discussed Crispin's respiratory suppression, which he described as a potential complication associated with pain medication. Dr. Malas noted that Crispin was easily aroused, denied chest pain, and responded well to supplemental oxygen and that he ordered an EKG and chest x-ray at 5:30 a.m. to evaluate any potential cardiac or pulmonary pathology. Dr. Malas ordered a toxicology screen at 6:30 a.m. but he did not receive the results before his shift ended at 7:00 a.m.

{¶12} Nurse Susi, who became Crispin's nurse when her shift began at 7:00 a.m., testified by way of deposition. Susi recalled that she had been informed that there was some "suspicious activity" on the previous shift. At 10:35 a.m., Susi informed Dr. Gaston that Crispin was drowsy, her oxygen level was low, and her heart rate was elevated. Crispin was given supplemental oxygen and Dr. Gaston ordered blood and urine toxicology screening, which was positive for Xanax and Oxycodone.

(Joint Exhibit 1, page 83.) Susi noted that Crispin left her room at 11:25 a.m. and at approximately 1:00 p.m. she evaluated and administered medication to Crispin. Soon after Susi left the room, Crispin used the call button and when Susi arrived she found Crispin in bed and in distress, and the disconnected IV pump was in the bathroom. A syringe was connected to the IV. Susi immediately called a "code" and Kristine Stepanovsky, R.N., the "stat nurse" arrived and asked Crispin what had happened. Susi testified that Crispin initially denied taking any drugs, but after Stepanovsky warned her of the grave danger, Crispin admitted that she had crushed a Percocet pill and injected the drug.

{¶13} Nurse Stepanovsky testified Crispin was coherent during their interaction and that she noticed a white substance in both the syringe and the IV "hep-well" to which the syringe was attached. Stepanovsky stated that she and another nurse gave Crispin fluids and administered Narcan, which typically reverses the effects of narcotic overdose, but the Narcan appeared to have no effect. Approximately minutes later, Crispin was intubated and Stepanovsky accompanied Crispin to the ICU.

{¶14} Hallie Prescott, M.D., was an internal medicine resident when she responded to the code. Dr. Prescott testified by deposition, at which time she was completing a fellowship with a focus on pulmonary and critical care medicine. Dr. Prescott testified that she learned Crispin had injected a crushed pill into her IV, but had not responded to Narcan and was subsequently intubated and transferred to the ICU. Dr. Prescott noted that blood gas readings showed oxygen was entering Crispin's bloodstream; however her tissues were not receiving sufficient oxygen, indicating that she was in shock. Dr. Prescott testified that a transthoracic echocardiogram was performed to visualize Crispin's heart in an effort to learn why Crispin was not responding to supplemental oxygen. According to Dr. Prescott, the echocardiogram showed that the right ventricle of Crispin's heart was completely dilated from struggling to pump blood through the lungs against overwhelming pressure. Dr. Prescott testified

that the echocardiogram supported her clinical suspicion that Crispin's condition was the result of right heart failure and obstructive shock as a consequence of pill fragment embolus. Dr. Prescott explained that pill fibers which become lodged and block blood vessels in the lungs can cause heart failure. Dr. Prescott testified that Crispin was given fluids and medicines in an effort to increase her blood pressure while cardiothoracic surgeons considered placing Crispin on a heart/lung bypass device. Despite the best efforts of the medical staff, Crispin suffered heart failure and died after approximately 30 minutes of CPR.

{¶15} LeRoy Essig, M.D., who is board certified in pulmonary medicine and critical care medicine, testified by deposition that he was the attending physician after the code was called. Dr. Essig recalled treating Crispin in the ICU and learning that Crispin had a history of IV drug use from the referring medical staff, the medical record, and Crispin's mother. Dr. Essig testified that he spoke to Darlene McKay after Crispin had passed away, at which time McKay admitted that Crispin had a drug problem, specifically with crushing pills and injecting them. According to Dr. Essig, McKay was distraught and stated that Crispin had gone missing for several days at a time and that she presumed Crispin was doing drugs during those periods.

{¶16} Dr. Essig testified that he had extensive experience treating IV drug users and that he has treated between 30 and 40 people who had injected crushed pills. Dr. Essig opined that, based upon his examination of Crispin, her medical history and test results, Crispin died from acute right heart failure as a consequence of pill emboli to the lungs. According to Dr. Essig, the coroner's findings which showed granulomas inflammation with birefringent polarizing material is typically found with pill emboli in the lungs and such findings are consistent with his opinion regarding the cause of Crispin's death. Dr. Essig testified that Crispin's death was not caused by the toxic effects of the four medications combined inasmuch as the primary side effect of the drugs in her system was respiratory depression, exhibited by difficulty breathing, which was no

longer an issue after she was intubated. Dr. Essig further testified that the medications in question do not cause the acute heart failure Crispin experienced in the ICU.

{¶17} Kenneth Gerston, M.D., worked for the Franklin County Coroner's Office and testified regarding Crispin's autopsy. Dr. Gerston explained both how he performed the autopsy and his findings. According to Dr. Gerston, toxicology tests showed therapeutic levels of Xanax and Tramadol and sub-therapeutic levels of Valium. Dr. Gerston testified that IV fluids may cause dilution such that toxicology test results reflect lower drug levels than would have been detected without the administration of IV fluids. Dr. Gerston stated that Percocet was not detected in Crispin's blood. Dr. Gerston acknowledged the finding of the coroner's office was that the immediate cause of Crispin's death was acute intoxication by the combined effects of four drugs; Xanax, Tramadol, Diphenhydramine (Benadryl), and Diazepam (Valium). (Joint Exhibit 2.) Dr. Gerston opined that, individually, the therapeutic levels of each drug would not cause harm, but that, in combination, the drugs acted to depress Crispin's respiratory system. Although Dr. Gerston related that the coroner's report listed the "manner of death" as "undetermined," he opined that an injection of Xanax ultimately caused Crispin's demise based upon the toxicology results.

{¶18} Dr. Gerston testified that his examination of Crispin's heart, including the right ventricle, did not reveal any abnormalities. Dr. Gerston stated that he did not agree with the opinion of defendant's expert, Dr. Baker, that Crispin's death was related to granulomas that had formed in her lungs. According to Dr. Gerston, it would take a large number of pills to affect lung function and the granulomas must have developed over an extended period of time, more than two weeks. Dr. Gerston agreed that Crispin's urine tested positive for the components of Percocet.

{¶19} Crispin's death was investigated by officers from OSU's medical and police department. Thomas Seeling, a security officer who worked at the medical center, spoke to Nurse Ferry, and although he had no independent recollection of that

conversation, Seeling states in his report that Ferry told him that she confiscated a syringe and sent it to a toxicology lab which determined it contained Oxycodone and Xanax. Seeling also reported that Ferry told him that Crispin was caught with three additional syringes later that same day. (Plaintiff's Exhibit 7.) According to Seeling, Ferry related that Crispin told her the syringe belonged to a friend who had visited her.

{¶20} Officer Dustin Mowery from the OSU police department testified that he investigated the incident and recalled speaking with Nurse Ferry. Officer Mowery reported that Ferry stated "Ms. Crispin had been caught four times injecting unknown substances into her IV." (Plaintiff's Exhibit 42.) Mowery testified that he understood that Ferry had found Crispin with one syringe and that Crispin's mother had related that Crispin had been found with a syringe on three other occasions, before she was treated at OSU. Elizabeth Corrigan, a records manager for the OSU police department, testified that she created a felony case summary that was based upon police reports, including Mowery's.

{¶21} Plaintiff, Darlene McKay, related that Crispin suffered from anxiety and PTSD which resulted from the aftermath of her father's suicide. McKay testified that she had custody of Crispin's son at the time of Crispin's death and that Crispin had a history of drug use. McKay stated that Crispin had previously overdosed on prescription drugs, but she did not believe her daughter had a severe drug problem and McKay denied any knowledge of Crispin crushing and injecting pills prior to the incidents at OSU. During cross-examination, McKay identified a complaint and supporting documents that she had filed in an action to obtain temporary custody of Crispin's son, wherein she stated that Crispin had "multiple mental health issues," had "walked away" from her son after being discharged from treatment for a drug overdose, and appeared under the influence when she broke into McKay's sister's home. (Defendant's Exhibit N.) McKay sought custody of Crispin's son until Crispin "proves she is drug free." *Id*. According to McKay, Billy Jenkins was a friend of both Crispin

and her cousin, Jared Crispin, and both men visited Crispin in the hospital. McKay testified that Jenkins dressed as a woman. McKay admitted that she had some knowledge that both Jenkins and Jared Crispin had used illegal drugs. McKay testified that she recalled talking to a physician at the hospital on the day Crispin died, but she denied telling the physician that Crispin had a problem with drugs, either generally or specifically with injecting crushed pills.

{¶22} Daniel Madden testified by deposition that he was a patient at OSU where he met Crispin while outside smoking. Madden testified that he met Crispin on October 30, 2009, and that he saw her approximately twice each day thereafter. Madden related that he never went to Crispin's room, but she visited his room on October 31, 2009 and told him that she had "snuck out of her room" a "couple times," which Madden understood to mean that she was not supposed to leave her room. (Defendant's Exhibit O, page 16.) Madden testified that he neither saw Crispin injecting herself with medication, nor did he see her with a syringe. Madden admitted that on October 30, 2009, he gave Crispin two Xanax pills and one Ultram, a non-narcotic pain reliever. According to Madden, he observed Crispin immediately swallow the two Xanax pills. Madden testified that on approximately half of the occasions that he met Crispin outside of the hospital, she was with a male acquaintance who dressed as a woman; however, Madden did not know that person's name.

{¶23} Shirley Daugherty, R.N., plaintiff's nursing expert, testified that Nurse Ferry violated the standard of care for nursing by inadequately documenting her interaction with Crispin, specifically, with regard to finding syringes in Crispin's room. Daugherty currently works as a consultant and prepares life care plans for disabled persons. Daugherty reviewed Crispin's medical records and the depositions of Crispin's treating nurses. Daugherty testified that Ferry acted appropriately by notifying the charge nurse and the on-duty physician after she found the syringe and Crispin's IV dripping.

According to Daugherty, the nursing standard of care required Ferry to contact security after the toxicology results showed the syringe contained Xanax. Daugherty testified that Ferry should have made a recommendation to Dr. Malas to order a psychiatric consultation. Daugherty acknowledged that the first syringe was sent for a toxicology screen and she was critical of the failure of OSU's nurses to document and save the other three syringes which plaintiff maintains were discovered and were referenced in police reports. However, Daugherty agreed that there was nothing in Crispin's medical records or in Ferry's police statement about finding more than one syringe before the code event.

{¶24} Plaintiff's medical expert, David Goldstein, M.D., is board certified in internal medicine and pulmonary diseases. Dr. Goldstein testified that he has experience treating patients who have suffered depression, attempted suicide, and overdosed on medication. Dr. Goldstein opined that Dr. Malas deviated from the standard of care in treating Crispin during the morning of November 1, 2009. According to Dr. Goldstein, Dr. Malas should have questioned Crispin about the syringe that was found in her room and explained the danger of injecting crushed pills. Dr. Goldstein testified that if Crispin continued to deny any knowledge of the syringe that Dr. Malas should have both required a "sitter" to watch her and ordered a psychiatric consultation. Dr. Goldstein opined that, if a sitter had been watching Crispin, she would not have had the opportunity to administer the final injection which preceded her demise. Dr. Goldstein testified that if Crispin had admitted that she had injected herself using the syringe but did not agree to comply with her physician's directions, Dr. Malas had a duty to remove the IV.

{¶25} Jenny Beerman, R.N., defendant's nursing expert, is a clinical assistant professor at the University of Kansas Hospital. Beerman has experience treating patients with MRSA and other conditions which require IV therapy. Beerman reviewed Crispin's medical records and relevant depositions and she opined that defendant's

nursing staff met or surpassed the duty of care owed to Crispin. Specifically, Beerman testified that Nurse Ferry met the standard of care after finding the syringe and Crispin's unhooked IV by assessing Crispin's condition and asking her what had happened and notifying both the charge nurse and Dr. Malas. According to Beerman, it was not appropriate for Ferry to notify security inasmuch as Crispin was not a risk to others, the charge nurse was involved, and Crispin had denied any knowledge of the incident. Beerman testified that Ferry continued to monitor Crispin and she kept the physician informed of significant changes in her vital signs and the results of the toxicology screen. Beerman stated that Ferry appropriately assessed Crispin after she was observed sleeping with her eyes half open and appearing pale, and Ferry administered supplemental oxygen and continued to notify Dr. Malas of Crispin's condition and oxygen saturation levels. Beerman testified that neither Ferry nor Susi were obligated to advocate for a sitter inasmuch as Crispin was not at risk of falling due to her condition and a sitter could not have forced Crispin to stay in her room.

{¶26} Bruce Farber, M.D., defendant's medical expert, is board certified in both internal medicine and infectious diseases, and he has experience treating patients with MRSA and inpatient IV drug abusers. Based upon his review of the medical records and depositions, Dr. Farber opined that defendant's physicians and nurses did not breach the standard of care regarding their treatment of Crispin. Dr. Farber testified that Crispin's behavior was typical of IV drug users and that there was no emergent need for a psychiatric evaluation inasmuch as Crispin had denied using drugs both upon admission and when Ferry found the syringe, showing that she did not want help for that problem. Dr. Farber explained that, generally, psychiatrists are not involved in treating IV drug users. According to Dr. Farber, there is no doubt Crispin understood there were risks associated with her behavior, but that drug users with serious addictions do not change their action based upon such knowledge. Dr. Farber testified that Crispin's behavior was certainly self-destructive, but not suicidal. Dr. Farber

related that a sitter was not required and that sitters typically aid mentally or physically impaired patients who need and want help, but that a sitter cannot restrain a patient, nor do they accompany patients into the bathroom unless they require assistance due to a physical limitation. Dr. Farber testified that Crispin could not be compelled to remain in her room, or the hospital, and her IV drug use was not a basis to place her in a psychiatric hospital.

{¶27} Dr. Farber testified that it would have been a gross mistake to remove Crispin's IV access because the line was needed to administer the antibiotics and other treatments for her serious infection. Dr. Farber explained that most hospital patients have IV access, which is useful in the event that a patient's condition deteriorates and emergency procedures, such as intubation are required. Dr. Farber opined that Nurse Ferry's conduct after finding the syringe met the standard of care inasmuch as she monitored Crispin's condition and reported any significant changes and the discovery of the syringe to Dr. Malas. According to Dr. Farber, Dr. Malas responded appropriately to Ferry's reports. Dr. Farber testified that Crispin was not in distress when the syringe was found and that when her vital signs changed on November 1, 2009, he ordered an x-ray and EKG to assess her heart and lungs, the most important organs related to oxygen saturation. Dr. Farber noted that Crispin's oxygen saturation levels returned to normal.

{¶28} Dr. Farber testified that the apparent self-injection which occurred at approximately 1:30 p.m. was not a suicide attempt. He explained that crushing Percocet pills for injection had become an epidemic and IV drug abusers engage in such dangerous activity to get high, not to commit suicide. Dr. Farber opined that the cause of Crispin's death was not acute intoxication from the drugs in her system and that the direct cause of her death was pulmonary hypertension and right ventricle dilation secondary to emboli that developed from crushed pills. During cross examination, Dr. Farber testified that based upon the autopsy findings he was "not

surprised" Crispin's medical records from a previous admission showed she had a history of abusing pain medications and "PICC line" (IV).

{¶29} Defendant's pathology expert, Andrew Baker, M.D., testified by deposition that he is a board-certified forensic pathologist and serves as chief medical examiner for three counties in Minnesota. Dr. Baker testified that he has performed postmortem examinations of individuals who had intravenously injected crushed pills. Dr. Baker explained that the records he had to review in this case were exceptional inasmuch as he had not only Crispin's autopsy information but also results from clinical tests performed in the ICU which showed heart and pulmonary function just prior to her death. According to Dr. Baker, Crispin's autopsy slides revealed granulomatous inflammation throughout her lungs, a reaction to foreign material (pill fragments) which occurred over a period of time. Dr. Baker testified that if he had been the medical examiner in Crispin's case, he would have certified her cause of death as "acute cardiopulmonary complications of intravenous foreign body injections and pulmonary granulomatosis due to acute and chronic intravenous drug and foreign body injections." (Defendant's Exhibit D, page 35.) Dr. Baker stated that the medical evidence supports his opinion regarding the cause of Crispin's death; specifically, the toxicology screen results show that she had drugs in her system that had not been prescribed, and clinical findings, including the EKG, show she suffered acute right heart failure hours before she died. Dr. Baker opined that the toxicology results do not support the conclusion that Crispin died of a drug overdose because blood tests showed a rather low, near therapeutic, level of Xanax that was "nowhere near a toxic level." Dr. Baker testified that if Crispin had actually overdosed on Xanax or Tramadol, she would have had a depressed level of consciousness and slower breathing, rather than being alert and complaining of chest pain.

{¶30} Upon review of the evidence presented at trial, the court finds that the treatment provided to Crispin by OSU medical staff complied with the relevant standard

of care at all times. As an initial matter, the court finds that plaintiff's assertion that defendant's employees discovered four syringes prior to the code event is not supported by the evidence. Although OSU police reports state that Ferry informed officers that Crispin had been caught with syringes on four different occasions, Ferry testified that the night she cared for Crispin was memorable and she adamantly denied making such a statement. Officer Mowery explained that he did not intend to convey that Ferry had found Crispin in possession of four syringes. Rather, Mowery understood that McKay had reported that she knew of three prior incidents involving Crispin being discovered with a syringe. Officer Seeling had no independent recollection of his interview with Ferry. Corrigan had no personal knowledge of the events at issue, she merely summarized written narratives from police reports. Most significantly, Crispin's medical records contain a detailed account of her interaction with defendant's medical staff and those records reflect that Crispin was found with only one syringe at OSUMC prior to the code incident from which she did not recover.

{¶31} Regarding the cause of Crispin's death, the court finds that the testimony of Drs. Baker and Essig was more credible than Dr. Gerston's testimony. Although Dr. Gerston testified that the autopsy did not reveal any abnormalities in Crispin's heart, he conceded that pulmonary hypertension is a clinical diagnosis and that he would defer to a board-certified pulmonologist regarding that diagnosis. Dr. Baker opined that physiologic tests performed by ICU specialists prior to Crispin's death were important in understanding the cause of her death and that those tests showed Crispin experienced acute right heart failure soon before she died. Furthermore, as Drs. Baker, Prescott, and Essig explained, Crispin's clinical history was not consistent with the acute combined toxic effects of the drugs referenced in the coroner's findings. However, the coroner's findings which showed inflammation from pill emboli in the lungs were consistent with Crispin's symptoms of decreased lung function and acute right heart failure. Drs. Baker and Essig also explained that both the Narcan and

respiratory intubation administered to Crispin would have been effective if Crispin's respiratory distress had been caused by the combined toxic effect of the drugs in her system; however, Crispin did not respond to either treatment. In short, the court is convinced that the cause of Crispin's death was not a drug overdose, but rather acute cardiopulmonary complications caused by lung damage from long term IV injections of crushed pills.

{¶32} With regard to the care provided to Crispin, after Nurse Ferry found the IV disconnected and discovered the syringe after midnight on November 1, 2009, the court finds that Ferry acted immediately and appropriately by informing Dr. Malas and the charge nurse. In assessing the conduct of defendant's medical staff, the court finds that the testimony of Nurse Beerman and Dr. Farber to be more relevant, accurate, and credible than the testimony of Nurse Daugherty and Dr. Goldstein. Both Beerman and Dr. Farber have significant experience treating MRSA patients and IV drug abusers and the court finds that their testimony concerning the response by defendant's medical staff was both credible and persuasive, showing that defendant's staff went beyond what was required to meet the standard of care. There is no question that Crispin needed an IV port to receive medication to treat her serious infection and that, even if a sitter had been assigned to monitor her, she would have remained able to seek privacy to use drugs, either in the bathroom or outside her hospital room. Furthermore, Dr. Farber testified that removing Crispin's IV access would not have prevented her from injecting crushed pills because IV drug users will inject themselves with or without such access, even knowing that their behavior is self-destructive.

{¶33} The court finds that Crispin understood it was dangerous and self-destructive to abuse drugs; she had been treated for a drug overdose and completed drug rehabilitation treatment prior to her admission at OSU. Dr. Goldstein admitted that during her admission to OSU, Crispin was not truthful regarding her drug abuse. Crispin's denial of drug abuse, even when confronted with evidence by Ferry

and Susi, indicates that she did not want help with her drug problem and that she intended to continue using drugs. Despite warnings that leaving her room would be dangerous, she continued to do so. Crispin injected crushed pills and lied to defendant's medical staff about her drug use, even after Nurse Susi found her in distress. The evidence shows that Crispin was not suicidal and that defendant's employees met the standard of care in treating her, including the decisions to neither assign a sitter nor order a psychiatric evaluation.

{¶34} Although plaintiff argues in her brief that Crispin should have been placed in emergency custody pursuant to R.C. 5122.01, such action requires that "[a]s a threshold matter, petitioner must establish [the patient] suffers from a substantial disorder of thought, mood, perception, orientation, or memory." *In re T.B.*, 10th Dist. Franklin No. 11AP-99, 2011-Ohio-1339, ¶ 10. Plaintiff did not address this argument at trial and the evidence showed that prior to the code event, Crispin was repeatedly assessed as being alert and oriented. Dr. Farber explained that IV drug abuse was not a reason to place Crispin in a psychiatric hospital and that there was no emergent need for her to receive a psychiatric evaluation at OSU.

{¶35} Although plaintiff argues that defendant should have known about Crispin's drug abuse from medical records for her previous admissions, Dr. Baker and Nurse Beerman explained that medical records from earlier visits were neither readily available nor customarily reviewed and that defendant's medical staff did not have a duty to review those records. Defendant's physicians, both treating and expert, explained that Crispin was appropriately treated with supplemental oxygen and monitored by diagnostic tests to determine whether the respiratory depression she experienced was caused by the pain medications she had been prescribed; a common complication associated with those medications.

{¶36} Based upon the foregoing, the court finds that plaintiff has failed to prove by a preponderance of the evidence that Crispin was injured by the negligence of

defendant's medical staff and that such negligence caused her death. Accordingly, judgment is recommended in favor of defendant.

{¶37} *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).*

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ANDERSON M. RENICK
Magistrate

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