[Cite as *Phelps v. Ohio Dept. of Rehab. & Corr.*, 2015-Ohio-5631.]

Court of Claims of Ohio
The Ohio Judicial Center
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OLISSEO J. PHELPS

Plaintiff

v.

OHIO DEPARTMENT OF REHABILITATION AND CORRECTION

Defendant

Case No. 2013-00587

Magistrate Robert Van Schoyck

DECISION OF THE MAGISTRATE

{¶1} Plaintiff, who at all times relevant was an inmate in the custody and control of defendant, brought this action for negligence arising out of an incident in which he fell and sustained injury inside the infirmary of the Chillicothe Correctional Institution (CCI) on January 9, 2013. The issues of liability and damages were bifurcated and the case proceeded to trial on the issue of liability.

{¶2} Plaintiff testified that during the early morning of January 8, 2013, he awoke in his cell in a profuse sweat while experiencing stomach pain. Plaintiff stated that he got the attention of a corrections officer who arranged for him to go to the infirmary. According to plaintiff, as he prepared to leave his cell and go to the infirmary, he felt weak, struggled to get dressed, and stumbled against the bars of the cell at one point, but with the assistance of corrections officers and a nurse he made it to a cart and was transported to the infirmary. Plaintiff, who stated that he was assigned to the disciplinary segregation unit of CCI during this time, as opposed to a general population unit, also stated that the officers placed him in restraints before he left the cell; plaintiff explained that the reason he was in the disciplinary segregation unit was that a urinalysis administered by prison officials found him to have “dirty urine.”

{¶3} Plaintiff related that he was initially taken to the "emergency room" area of the infirmary, and at some point was administered intravenous therapy. Plaintiff stated that while in the infirmary over the course of the day, he was able to get up and use the bathroom on several occasions without assistance. Plaintiff testified that he was eventually seen by Nurse Practitioner Gary Artrip, who informed him that he would be discharged to the segregation unit but would need to come back to the infirmary for lab work the next morning. Plaintiff recalled that he was discharged from the infirmary at around 3:00 or 4:00 p.m. on January 8, 2013.

{¶4} Plaintiff testified that at approximately 6:00 a.m. the following morning, on January 9, 2013, he was placed in restraints and escorted to the infirmary by a Corrections Officer Harold. Plaintiff recalled that he walked under his own power to the infirmary, a distance of about 200 feet in his estimation, although he had to stop for a moment along the way. Plaintiff stated that he was escorted to the phlebotomist, a Ms. Smallwood, who drew a blood sample. According to plaintiff, after the blood was drawn and he proceeded away from Smallwood's office into the hallway he felt very weak. Plaintiff testified that he then leaned against the wall and slid down until he was crouched on the floor. Plaintiff recalled that there were many inmates in the hallway waiting to have blood drawn, and one of them, inmate Antonio Bonner, as well as Corrections Officer Harold, helped him stand up. According to plaintiff, he was then taken to see Nurse David Conley, who initially told Harold that plaintiff was feigning illness and should be escorted back to his cell. Plaintiff testified, though, that he told Conley and Harold he did not have the strength to go anywhere, and after Conley conferred privately for a moment with a Corrections Officer Parnell, while Harold waited in the hallway with plaintiff, it was decided that plaintiff would be admitted to a patient room in the infirmary until the doctor arrived and could see him. Plaintiff stated that Smallwood subsequently handed him a cup for collecting the urine sample that had been ordered by Artrip.

{¶5} Plaintiff testified that while walking to the room, he briefly "passed out" and slumped down toward the floor at one point, but was ultimately able to make it there under his own power. Plaintiff stated that he had been instructed to produce a urine sample once he arrived at the room, which had its own bathroom, and he had to do so fairly soon because all the specimens collected that morning had to be ready for shipment to the lab by about 7:00 a.m. According to plaintiff, around the time that he went to the room he asked a corrections officer, possibly Corrections Officer Phil Williams, to remove his leg irons, but Nurse Conley said to keep them on because he thought plaintiff was faking. Plaintiff stated that once he got to the room he was left there by himself.

{¶6} Plaintiff testified that after a little while, he got up from the bed, walked over to the bathroom, and placed the urine sample cup on a windowsill above a radiator. As depicted in a photograph admitted at trial, as one stands facing the toilet in this bathroom, what appears to be a cast iron radiator is a couple of feet to the right. (Joint Exhibit 6.) Plaintiff testified that he felt as if he might faint, which he said was basically how he felt throughout that morning, and indeed he started to fall. Plaintiff explained that his legs got twisted up in the process and as he awkwardly went down, his right arm came down on top of a valve stem that protruded upward at one of the top ends of the radiator, puncturing and burning his arm. According to plaintiff, while the aforementioned photograph of the bathroom, taken subsequent to the accident, depicts a wheel handle atop the valve stem, there was no handle at the time of the accident. Plaintiff stated that he had been to the infirmary on prior occasions and had used this particular bathroom, but did not know if there had ever been a handle atop the valve stem in the past.

{¶7} Plaintiff testified that he was able to get up on his feet after the accident and press an emergency call button, and in response Smallwood, Conley, Harold, and Williams all came to the room. Plaintiff stated that Conley told Williams to remove

plaintiff's leg irons, and that a short time later he was transported to Ohio State University Medical Center (OSUMC). Plaintiff related that at OSUMC, he received care for his wound, and, with respect to his underlying medical issues it was determined that an ulcer had caused internal bleeding and low blood pressure, and that he needed a blood transfusion. Plaintiff stated that he had no prior history of ulcers or internal bleeding. As for the wound on plaintiff's upper right arm, it left a scar which plaintiff showed at trial.

{¶8} Antonio Bonner testified by way of videoconference from the Ross Correctional Institution, where he is now incarcerated. Bonner testified, though, that he was incarcerated at CCI from May 2008 to July 2013, and while he cannot be certain of the date he does remember seeing an incident involving plaintiff in the infirmary. According to Bonner, he had gone to the infirmary one morning to have lab work performed. Bonner testified that he and several other inmates were waiting in the hallway when plaintiff was escorted into the infirmary and brought to the front of the line. Bonner stated that plaintiff then leaned up against the wall and slid down to the ground, and plaintiff was sweating and obviously did not feel well. Bonner stated that when the phlebotomist called for the next in line, plaintiff asked him if he could help him up, and Bonner and a nurse then proceeded to give plaintiff a hand and help him get back on his feet.

{¶9} Bonner testified that after plaintiff's blood was drawn, he heard a nurse tell plaintiff to go to the patient room. Bonner recalled that plaintiff told the nurse he did not have the strength to walk there on his own, and according to Bonner plaintiff was still sweating and seemed weak, but plaintiff ultimately was escorted to the patient room and Bonner did not see him again that day.

{¶10} When shown the photograph of the bathroom where the accident occurred, Bonner testified that he recognized the bathroom, that he had been in there about one

year before the day in question, and that he remembered there was no handle on the valve stem at that time.

{¶11} Nurse Practitioner Gary Artrip testified that he has worked for defendant for 15 years, including the last five years at CCI, and that on January 8, 2013, he would have worked from approximately 7:30 a.m. to 3:30 p.m. Artrip testified that records from the infirmary show that at different times over the course of the day on January 8, 2013, he signed orders for plaintiff to get medication to relieve pain and nausea, and he ordered lab work that would require plaintiff to come to the infirmary the next morning for a blood draw and urine sample. (Defendant's Exhibit B.) Artrip explained that blood is usually drawn in the morning at CCI because some fasting is required beforehand, and samples are normally sent to defendant's Franklin Medical Center for lab work, which in the case of blood work takes about 24 hours to get the results. Artrip testified that progress notes also indicate that he conducted an examination of plaintiff near the end of his shift that day, at 3:10 p.m. (Plaintiff's Exhibit 5.) According to Artrip, based upon his observations that day he chiefly suspected that plaintiff might have kidney stones, and the lab work he ordered was intended to determine whether that was indeed the case. In particular, Artrip explained that the fact that plaintiff's complaints of flank pain had resolved after receiving fluids and the pain reliever Toradol was consistent with a working diagnosis of kidney stones.

{¶12} Artrip testified that progress notes indicate that he saw plaintiff again at 7:40 a.m. the following morning, January 9, 2013, after the accident in the bathroom had already occurred. (Plaintiff's Exhibit 6.) Artrip testified that based upon the continuation and severity of plaintiff's abdominal complaints, as well as abnormalities in his vital signs as measured after the accident, at 7:15 a.m. that morning, he issued an order for plaintiff to be transported by van to OSUMC. (Plaintiff's Exhibit 6; Defendant's Exhibit B.)

{¶13} With respect to the radiator, Artrip testified that he does not recall hearing any prior complaints about it and that he does not recall any work performed on it.

{¶14} Nurse David Conley, who is employed with defendant at CCI, testified that he works the first shift, arriving for work each day at 6:00 a.m. Conley recalled that early in his shift on January 9, 2013, sometime around 6:30 a.m., he was performing a daily count of medical equipment which he was required to perform at the beginning of his shift when he was approached by a corrections officer, probably Corrections Officer Harold, who told him that plaintiff did not feel well. Conley stated that the 6:00 a.m. to 7:00 a.m. hour is always a busy time in the infirmary, but that he was designated as the "ER" nurse that day and he immediately took a moment to speak with plaintiff and assess his condition for triage purposes. Conley stated that based upon his objective observations, he felt that plaintiff did not require immediate medical attention at that moment, or to be prioritized ahead of any other inmates who were already in the infirmary at that point to be seen. Conley stated that he did not have plaintiff's chart with him and did not take any notes down then, and that he could not remember exactly what plaintiff told him, but he recalled plaintiff telling him that he did not feel well and thought he might pass out. According to Conley, plaintiff seemed able to ambulate, and he was also argumentative, and Conley explained that if someone is able to argue like plaintiff did, that is an indication to him that the patient is not acutely ill. Conley stated that based upon his objective observations and the concerns raised by plaintiff and the corrections officer, he decided for the time being to put plaintiff under observation in the patient room set aside for segregation inmates. Conley denied saying at any time that plaintiff was "faking," and he added that if he had felt there was nothing wrong with plaintiff, he would have sent plaintiff back to segregation. As for the reason plaintiff was in the infirmary to begin with, Conley stated that he thought plaintiff was there for lab work, but that he had no specific knowledge about Artrip's order for plaintiff to have blood and urine samples taken for lab work.

{¶15} According to Conley, he was scheduled to see other patients that morning, but it was his intention to check up on plaintiff at some point, measure his vital signs, and further evaluate him once he had an opportunity to retrieve plaintiff's medical chart and review it. Conley testified that before he could do so, he was alerted that plaintiff needed assistance, at which time he went to the patient room, where he found plaintiff resting on the bed. As set forth in progress notes taken by Conley at 7:15 a.m., plaintiff complained of both abdominal pain and having fallen in the bathroom. (Plaintiff's Exhibit 6.) Conley testified that he looked at the wound on plaintiff's arm and measured plaintiff's vital signs, including taking plaintiff's blood pressure, which was low. Conley stated that he decided to recommend to the doctor or other advanced level provider who arrived for work first that morning to send plaintiff out to an emergency room, and that when Artrip arrived shortly thereafter he agreed and made the decision to send plaintiff to OSUMC.

{¶16} Regarding the restraints plaintiff wore that day, Conley testified that it is defendant's policy that inmates assigned to a segregation unit must wear leg irons whenever they leave their unit. While Conley had no specific recollection as to whether plaintiff had leg irons on, he stated that when segregation inmates are in the infirmary he only asks for corrections officers to remove their leg irons if he has to examine the lower legs or ankles or perform some other medical procedure that would necessitate their removal. Conley stated that based upon the medical attention he provided plaintiff that day, he would not have needed for the leg irons to be removed.

{¶17} Additionally, Conley testified that he does not remember any inmate ever complaining about the radiator in the bathroom of the segregation patient room before plaintiff's accident, nor could he recall any maintenance being performed or requested on the radiator.

{¶18} Phil Williams testified that he retired from employment with defendant in 2014 after serving more than 25 years as a corrections officer at CCI, and that for about

his last two years on the job he was stationed in the infirmary during the first shift, from 6:00 a.m. to 2:00 p.m. Williams testified that he vaguely recalls some of the events that occurred the morning of January 9, 2013, including seeing plaintiff escorted into the infirmary by Corrections Officer Harold, whom Williams explained was a first-shift escort officer. Williams stated that at some point he also saw Harold escort plaintiff into the emergency or triage room of the infirmary, where Conley was located, and also saw plaintiff and Harold leave that room later, at which time plaintiff appeared to be agitated. Williams testified that as plaintiff passed by his desk on the way to the segregation patient room, plaintiff asked him "Why is Mr. Conley like that?" without giving any indication why he was upset with Conley.

{¶19} Williams stated that he did not know the reason plaintiff was in the infirmary that morning, nor that plaintiff was supposed to produce a urine sample while in the patient room, and he further stated that he did not know about plaintiff falling onto the radiator. Williams also stated that he has no memory of plaintiff needing to be helped up off the floor of the infirmary at any time. With respect to the issuance of urine sample cups, Williams stated that this was most often done by a nurse, but that the phlebotomist did it at times too.

{¶20} Williams testified that all segregation inmates had to wear leg irons attached to a belly chain and have an escort whenever they left the segregation unit, and that plaintiff was wearing such restraints when he saw him on the morning in question. Williams explained that a corrections officer would remove the leg irons if it was so requested by a doctor or nurse, but that no one told him to remove plaintiff's leg irons that day and he made no attempt to do so. Williams also explained that the segregation patient room was the only patient room with its own bathroom, so that segregation inmates could be locked in and kept there without having to be let out to use the general population bathroom. Williams testified that he has no recollection of

any inmates ever complaining about or reporting any problems with the radiator in the bathroom of the segregation patient room prior to plaintiff's accident.

{¶21} As set forth in the complaint, plaintiff claims that defendant was "negligent in leaving his shackles on, in failing to assist him or prevent him from falling in his condition, and in not repairing the faulty heater." Complaint, ¶ 2. It is further alleged that defendant was "negligent in delaying medical treatment for Plaintiff's injuries." Complaint, ¶ 4.

{¶22} "To recover on a negligence claim, a plaintiff must prove by a preponderance of the evidence (1) that a defendant owed the plaintiff a duty, (2) that a defendant breached that duty, and (3) that the breach of the duty proximately caused a plaintiff's injury." *Ford v. Ohio Dept. of Rehab. & Corr.*, 10th Dist. Franklin No. 05AP-357, 2006-Ohio-2531, ¶ 10. "In the context of a custodial relationship between the state and its prisoners, the state owes a common-law duty of reasonable care and protection from unreasonable risks." *Woods v. Ohio Dept. of Rehab. & Corr.*, 130 Ohio App.3d 742, 744-745 (10th Dist.1998). "The state, however, is not an insurer of inmate safety and owes the duty of ordinary care only to inmates who are foreseeably at risk." *Franks v. Ohio Dept. of Rehab. & Corr.*, 10th Dist. Franklin No. 12AP-442, 2013-Ohio-1519, ¶ 17. "Reasonable care is that degree of caution and foresight an ordinarily prudent person would employ in similar circumstances, and includes the duty to exercise reasonable care to prevent an inmate from being injured by a dangerous condition about which the state knows or should know." *McElfresh v. Ohio Dept. of Rehab. & Corr.*, 10th Dist. Franklin No. 04AP-177, 2004-Ohio-5545, ¶ 16. "Prisoners, however, are also required to use reasonable care to ensure their own safety." *Nott v. Ohio Dept. of Rehab. & Corr.*, 10th Dist. Franklin No. 09AP-842, 2010-Ohio-1588, ¶ 8.

{¶23} Upon review of the evidence presented at trial, the magistrate finds that early on the morning of January 8, 2013, plaintiff alerted corrections officers in the segregation housing unit, where he was assigned at the time, that he was experiencing

stomach pain, and, as a result, he was promptly taken to the infirmary. Plaintiff was seen throughout the day by infirmary staff, including Nurse Practitioner Artrip, who developed a plan of care under which plaintiff was discharged from the infirmary and was supposed to return around 6:00 a.m. the next day to give blood and urine samples that would be sent to defendant's lab for diagnostic purposes. Plaintiff was indeed escorted back the next morning and had his blood drawn by the phlebotomist. Either just before or just after plaintiff was in the phlebotomist's office, he had a spell of lightheadedness that led him to lean against a wall and slide down to the ground. Corrections Officer Harold, who had escorted plaintiff to the infirmary from the segregation unit that morning, took plaintiff to the "emergency room" area of the infirmary, where he was seen by Nurse Conley, the designated triage nurse.

{¶24} Conley, who was in the middle of performing a mandatory tool count at the beginning of his shift and who had other scheduled patients waiting to be seen that morning, briefly assessed plaintiff and decided to admit him in the segregation patient room for the time being, with the intention of evaluating plaintiff further once Conley had an opportunity to see his other patients and to obtain and review plaintiff's medical chart. Harold then escorted plaintiff from the emergency room to the segregation patient room. Corrections Officer Williams, stationed at the officers' desk in the infirmary, observed plaintiff and Harold as they entered and exited the emergency room. A few minutes after plaintiff entered the segregation patient room, he got up and went to the attached bathroom to produce a urine sample with a cup that the phlebotomist had issued to him. Plaintiff put the cup on the windowsill above the radiator and got ready to urinate, but then he felt faint and started to fall down, his legs got twisted up in the leg irons, and he came down awkwardly such that his right arm swung down violently onto the valve stem of the radiator, cutting into and burning his skin. Plaintiff then exited the bathroom and pressed a call button, whereupon Conley and one or more corrections officers entered the patient room and attended to him.

Shortly thereafter, once Artrip arrived for work and assessed the situation, plaintiff was transported to OSUMC, where he was diagnosed with a bleeding ulcer, and he received treatment both for that ailment and the wound to his arm.

{¶25} Plaintiff's claim that defendant's employees were negligent in "failing to assist him or prevent him from falling in his condition" was pled as claim for ordinary negligence, as opposed to medical malpractice, and plaintiff advanced the ordinary negligence theory again at trial. As previously stated, the complaint also includes an allegation that defendant was "negligent in delaying medical treatment for Plaintiff's injuries."

{¶26} Insofar as either of these claims may challenge Artrip's professional judgment in developing a plan of care for plaintiff, whether it be failing to order that plaintiff have assistance either when producing the diagnostic urine sample or failing to expedite some aspect of plaintiff's medical diagnosis, care or treatment, or to the extent that these claims may challenge Conley's professional judgment in not expediting some aspect of plaintiff's care in conjunction with his initial triage assessment of plaintiff, the magistrate finds that such allegations would sound in medical malpractice and therefore require expert testimony to establish the standard of care and a breach of that standard—testimony that was not presented in this case. *See Gordon v. Ohio State Univ.*, 10th Dist. Franklin No. 10AP-1058, 2011-Ohio-5057, ¶ 67.

{¶27} Moreover, with respect to the alleged delays in plaintiff's medical care, the magistrate further finds that the evidence does not support a claim sounding in ordinary negligence concerning the actions of non-medical personnel, as corrections officers promptly arranged for plaintiff to go to the infirmary after being notified of his medical issues early on January 8, 2013, officers timely escorted him to the infirmary the following day for his appointment with the phlebotomist, and the evidence does not demonstrate any delay by non-medical staff.

{¶28} The magistrate also finds that the evidence does not weigh in plaintiff's favor as to the ordinary negligence claim based upon the failure to assist him or otherwise prevent him from falling. Plaintiff's essential argument is that Conley was grossly inattentive to plaintiff when Harold brought plaintiff to see Conley in the emergency room of the infirmary, failing to give serious consideration to plaintiff's concerns and physical condition. The magistrate finds, however, that Conley listened to plaintiff's concerns, performed a triage assessment of plaintiff, and exercised his professional judgment to devise a plan of care. Even if expert testimony is not necessary to support such a claim—either under an ordinary negligence standard or under the "common knowledge" exception applicable to malpractice claims—the magistrate finds that plaintiff did not carry his burden, for Conley's actions were reasonable when it is considered that Conley did not observe plaintiff faint that morning, Conley saw plaintiff ambulate and understood plaintiff had walked to the infirmary under his own power, Conley understood plaintiff had come to the infirmary for lab work rather than specifically for emergency care, Conley observed that plaintiff was well enough to argue with him about the acuteness of his complaints, plaintiff did not ask Conley to arrange for assistance with the urine sample, Conley did not know that plaintiff had not given his urine sample yet and would thus have to go to the bathroom soon, Conley remained in the emergency room when plaintiff was escorted away to the segregation patient room and was handed a urine sample cup by the phlebotomist, and the segregation patient room was equipped with a call button that plaintiff could use if he needed assistance.

{¶29} Furthermore, the magistrate finds that the actions of the corrections officers present in the infirmary that morning were reasonable, in that plaintiff was left in the segregation patient room in accordance with both Conley's directions and the policy of leaving segregation patients in there with the door locked, and plaintiff did not subsequently ask for help or otherwise indicate that he needed assistance.

Furthermore, Corrections Officer Williams knew little or nothing about the nature of plaintiff's medical issues that morning, and while Corrections Officer Harold had spent some time accompanying plaintiff that morning and knew he did not feel well, she acted reasonably in taking plaintiff to see Conley in the emergency room for evaluation and then placing plaintiff in the segregation patient room per Conley's directive. Additionally, the evidence does not demonstrate negligence on the part of the phlebotomist, who was not shown to know nor have reason to know of any unreasonable risk to plaintiff when she gave him the urine sample cup.

{¶30} To the extent plaintiff claims that corrections officers or other employees were negligent in leaving him shackled in leg irons while he was in the segregation patient room, the magistrate finds that defendant's employees acted pursuant to a departmental security policy requiring that any inmate assigned to a disciplinary segregation unit, such as plaintiff, wear leg irons at all times when the inmate was outside the segregation unit. The language in the Court of Claims Act at R.C. 2743.02 providing that "'the state' shall 'have its liability determined * * * in accordance with the same rules of law applicable to suits between private parties * * *' means that the state cannot be sued for its legislative or judicial functions or the exercise of an executive or planning function involving the making of a basic policy decision which is characterized by the exercise of a high degree of official judgment or discretion." *Reynolds v. State*, 14 Ohio St.3d 68, 70 (1984). Prison officials are afforded "wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security." *Bell v. Wolfish*, 441 U.S. 520, 547 (1979). Accordingly, while the fact that plaintiff wore leg irons that morning is a factor which the magistrate has taken into account when assessing whether any employee of defendant was negligent in failing to furnish assistance to plaintiff, the magistrate finds that defendant is entitled to discretionary

immunity on the separate theory of negligence set forth in the complaint predicated upon his being required to wear the leg irons.

{¶31} Finally, the magistrate finds that plaintiff is not entitled to recover under a theory of negligence based upon the condition of the radiator. The condition of the radiator was not unreasonably dangerous and it was not foreseeable that an injury was likely to result from there being no handle on the valve stem. There is no evidence that anyone had ever before been injured on the radiator. The valve stem is made of standard piping materials and was not shown to be unusually sharp, nor was it shown that the surface temperature of the valve stem was unusually high or any greater than that of the rest of the radiator, and the handle that plaintiff argues should have been affixed to the valve stem is a device for opening and closing the valve, as opposed to a safety shield or guard. Indeed, the proximate cause of plaintiff's injury was not the radiator, but the fall he suffered on account of feeling faint, through which he could have been injured on any number of conditions that were not unreasonably hazardous to ordinary users of the bathroom, such as falling onto the toilet or its exposed plumbing, onto the tile floor, into the window, or, as occurred here, onto the radiator.

{¶32} Moreover, the magistrate finds that the capacity of the radiator to burn those who would touch it was a condition that was open and obvious to the inmates using the bathroom, and the same is true for whatever insubstantial degree of danger was posed by the condition of the valve stem, and as such, under the open and obvious doctrine, defendant owed plaintiff no duty relative to those conditions. *Williams v. Ohio Dept. of Rehab. & Corr.*, 10th Dist. Franklin No. 04AP-1193, 2005-Ohio-2669, ¶ 8.

{¶33} Given that the condition of the radiator was not unreasonable and was open and obvious, the issue of whether defendant had notice that there was no handle on the valve stem is irrelevant. *Baldauf v. Kent State Univ.*, 49 Ohio App.3d 46, 50 (10th Dist.1988).

{¶34} Based upon the foregoing, the magistrate finds that plaintiff has failed to prove his claims by a preponderance of the evidence. Accordingly, judgment is recommended in favor of defendant.

{¶35} *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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ROBERT VAN SCHOYCK
Magistrate

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