[Cite as *Hairston v. Ohio Dept. of Rehab. & Corr.*, 2015-Ohio-5632.]

Court of Claims of Ohio
The Ohio Judicial Center
65 South Front Street, Third Floor
Columbus, OH 43215
614.387.9800 or 1.800.824.8263
www.cco.state.oh.us

PAUL R. HAIRSTON, JR.

Plaintiff

v.

OHIO DEPARTMENT OF REHABILITATION AND CORRECTION

Defendant

Case No. 2013-00631

Magistrate Anderson M. Renick

DECISION OF THE MAGISTRATE

{¶1} Plaintiff filed this action alleging medical negligence and negligent hiring, retention, and supervision of defendant's, Ohio Department of Rehabilitation and Correction (DRC), employees based upon treatment provided to him. The issues of liability and damages were bifurcated and the case proceeded to trial on the issue of liability.

{¶2} At all times relevant, plaintiff was an inmate in the custody of defendant at the Pickaway Correctional Institution (PCI). Plaintiff was 49 years old at the time of his incarceration in 2011, and soon thereafter, he received a physical examination which included his medical history. Plaintiff testified that he had occasionally tested his blood pressure at a pharmacy prior to his incarceration and that the results were always within the normal range. According to plaintiff, prior to his incarceration, he had not been examined by a physician since he was a youth.

{¶3} Although plaintiff's initial blood pressure reading at the Corrections Reception Center (CRC) was within normal range (117/79), he was subsequently diagnosed with both high blood pressure and diabetes and provided with prescription medication to treat those conditions. Plaintiff related that his father had both high blood pressure and diabetes and suffered a stroke in 1995. Plaintiff testified that after

his diagnosis, he had talked to his father who discussed the potential consequences of not taking the medication, and plaintiff acknowledged that he understood the importance of taking his medication. Plaintiff testified that he did not recall receiving a handbook of institution policies and procedures at either CRC or PCI; however, plaintiff signed documents which indicate he received the handbook and he did recall defendant's staff explaining how to access medical services at both institutions. Specifically, plaintiff understood that he needed to complete a health services request form (HSR) to receive medical care and medicine.

{¶4} At PCI, plaintiff was prescribed Lisinopril and Glyburide to treat his newly diagnosed hypertension and diabetes. Plaintiff was advised that he should take his medication and have his blood sugar level checked daily. Plaintiff explained that he had a daily routine which included taking his medication each morning before breakfast. Plaintiff testified that the pills were provided in a "blister pack," onto which an information strip was attached. Plaintiff stated that he was instructed to obtain prescription refills by removing the strip and attaching it to an HSR form which he then completed and placed in a secure drop box in the chow hall. Plaintiff testified that on August 22, 2012, he completed an HSR form to obtain a refill of his prescription medications. (Plaintiff's Exhibit 4A-000055.) According to plaintiff, on several different occasions over a period of approximately two months, he notified corrections officers (COs) that he had not received his medications, and each time he was told that the medications would arrive "in a few days." During cross examination, plaintiff admitted that he had some difficulty with his memory, but he believed his long-term memory was better than his short-term memory. Plaintiff was adamant that he recalled both submitting his HSR on August 22, 2012, and that he complained to COs on his unit that he had not received his medication. Plaintiff eventually ran out of his prescription medication. On October 22, 2012, PCI nurses processed plaintiff's HSR which was dated August 22, 2012. Nurse Rosemary Marine testified that the HSR in

question was received and processed on the same day. On October 24, 2012, plaintiff suffered a hemorrhagic stroke, or intracerebral hemorrhage, which caused permanent, disabling injuries.

{¶5} Plaintiff alleges that defendant's employees failed to process the August 22, 2012 HSR in either an appropriate or a timely manner, that defendant's medical staff failed to adequately monitor his medical condition and treatment, and that such negligence was a proximate cause of his stroke and injuries. Defendant contends that plaintiff failed to prove either that the conduct of its medical staff fell below the standard of care in treating him or that plaintiff's stroke was caused by the discontinuation of his medication.

{¶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} Arthur Hale, M.D., the Medical Director and Chief Medical Officer at PCI, testified that he was ultimately responsible for clinical decisions made at PCI. Dr. Hale identified PCI policies and procedures and he testified that he shared responsibility for ensuring institution medical services policies and procedures were followed. Dr. Hale specifically identified numerous policies including those concerning hypertension and diabetes, nurses' sick call, pharmacy services, and chronic care clinic (CCC) protocols. Dr. Hale testified that PCI is accredited by the American Correctional Association (ACA) and that defendant's policies and protocols refer to ACA standards. Although Dr. Hale was responsible for reviewing and signing the above mentioned policies as the Chief Medical Officer, he admitted he had failed to do so.

{¶9} Dr. Hale acknowledged that plaintiff had been diagnosed with diabetes and hypertension, which for a diabetic is defined by defendant's policy as a blood pressure reading above 130/80. (Plaintiff's Exhibit 14A-000001.) Dr. Hale characterized plaintiff's hypertension and diabetes as a serious medical condition. Dr. Hale explained that Lisinopril was prescribed to treat both plaintiff's hypertension and diabetes, including preventing the progression of renal disease associated with diabetes. Dr. Hale testified that it was important to control plaintiff's blood pressure inasmuch as uncontrolled blood pressure is a major risk factor for stroke and that without his medications, plaintiff was not being protected against stroke.

{¶10} Dr. Hale reviewed plaintiff's medical chart and he noted that plaintiff was enrolled in a diabetes CCC and that, according to PCI protocols, defendant's medical staff was required to enroll plaintiff in a hypertension CCC, but he was not enrolled. According to defendant's protocol, "[a]ll inmate patients who are received at a DRC * * * institution with a diagnosis of hypertension and/or cardiac disease or who are subsequently diagnosed with hypertension and/or cardiac disease shall be referred to the physician or advanced healthcare provider for enrollment in Hypertension Chronic Care Clinic (CCC)." (Plaintiff's Exhibit 14A-000002.)

{¶11} With regard to plaintiff's diabetes, Dr. Hale noted that on May 4, 2011, plaintiff's glucose level, measured in an A1C lab, was 9.1, which was a "worrisome" level that showed poorly controlled diabetes. (Plaintiff's Exhibit 4A-000031.) An order was issued to re-evaluate plaintiff in three weeks. However, according to plaintiff's medical record, at his next medical visit, on June 22, 2011, neither A1C nor "fingerstick" accu-checks were recorded.

{¶12} A CCC follow-up report shows that on December 12, 2011, plaintiff had been without his medication for one month and that his blood pressure was 136/86, a reading which Dr. Hale characterized as hypertensive for a diabetic. (Plaintiff's Exhibit 4A-000034.) Dr. Hale testified that plaintiff's medications were wrongfully "held" and not reordered at that time. Although Dr. Hale did not specifically recall treating plaintiff, the medical records showed that plaintiff had been his patient at PCI and Dr. Hale testified that he first examined plaintiff on January 13, 2012. (Plaintiff's Exhibit 4A-000035.) Plaintiff's medical records also show that, on that date, plaintiff had been without his medications for the past two months and, according to Dr. Hale, plaintiff had uncontrolled hypertension with a blood pressure of 149/89. Dr. Hale testified that he educated plaintiff regarding both the disease process and the need to comply with medical treatment. Dr. Hale reordered plaintiff's medication, and on April 24, 2012, plaintiff's blood pressure was measured to be 136/81, and another appointment was to be scheduled within 90 days. (Plaintiff's Exhibit 4A- 000036.) However plaintiff did not appear for his August 24, 2012 CCC visit, and that appointment was apparently not rescheduled. Dr. Hale reviewed the HSR form dated August 22, 2012, and he admitted that plaintiff was not receiving his medications for two months prior to his stroke. Dr. Hale testified that PCI medical staff should have known that and taken action to correct the situation.

{¶13} Emily Patrick, an LPN who worked in the PCI medical supply room, testified that her duties included processing prescription refill requests. Patrick

explained that it was the practice of "sick call" nurses to retrieve HSR forms from the inmate mailbox each morning after 8:00 a.m. and then immediately process the requests. Patrick testified that information on stickers affixed to the HSR was transferred into the patient's medical administration record (MAR), which is essentially a chronological record of the patient's medications. According to Patrick, each HSR is stamped with the date on which the information is processed into defendant's "SIPS" computer system. The HSR form includes an information box wherein the reviewing nurse would record her name and both the date and time the request was received. Patrick stated that the nurses' information box on the HSR dated August 22, 2012, was not completed and, therefore, there is no record of who reviewed the request. Patrick testified that there is "no good reason" for that omission. Patrick testified that nurses who reviewed the HSR forms used either the prescription number or inmate's name to input information into the SIPS computer system and that the reviewing nurse had no reason to investigate when an inmate had last received his medication.

{¶14} Anthony Ayers, who was the medical operations manager at PCI, testified that he and the Chief Medical Officer were responsible for supervising the institution's medical operation, including the nursing staff. Ayers explained the process for scheduling CCC patient appointments and he stated that when an advanced level provider orders an appointment, PCI nurses are responsible for ensuring that the appointment is scheduled in a timely manner. Ayers testified that when a patient fails to appear for a scheduled appointment, nurses need to take steps to have the patient seen as soon as possible. Ayers agreed that there was no good reason for the reviewing nurse's failure to complete the August 22, 2012 HSR form. Ayers identified plaintiff's medication report from central pharmacy and he testified that the nurses who processed plaintiff's HSR had such information available to them and that the information "on its face" suggested that plaintiff had not received his necessary medication after July 5, 2012. Ayers related that he was involved in the internal audit

process and he admitted that audits conducted during the times at issue revealed concerns about a need to improve completion of forms, medication logs, and the timely treatment of inmates. Ayers testified that action plans were in place to address concerns identified in the audits. Ayers stated that inmates who did not receive their medication in a timely manner could obtain necessary medication by either informing a CO or attending pill call.

{¶15} Plaintiff presented two experts on the standard of care in correctional healthcare.

Plaintiff's medical expert, David Hellerstein, M.D., is board certified in internal medicine and a former Chief Medical Officer in the California department of corrections. Dr. Hellerstein works as an independent consultant, primarily for state attorneys general. Plaintiff's nursing expert, Lori Roscoe, is a nurse practitioner and a certified correctional health professional, with a Ph.D. in healthcare administration. Both Dr. Hellerstein and Roscoe testified that the failure of PCI's medical staff to follow its policies and protocols fell below the recognized standards for correctional healthcare. They were particularly critical of the alleged failures to both document and deliver plaintiff's essential medications. Specifically, Dr. Hellerstein testified that PCI medical staff had an obligation to investigate why plaintiff had failed to appear for his August 24, 2012 CCC appointment and to reschedule the appointment. Dr. Hellerstein stated that the only documented occasion of plaintiff refusing medical services was plaintiff declining to receive a flu shot. According to Dr. Hellerstein, plaintiff's medical records showed that he was a generally compliant patient and that the HSR dated October 22, 2012, "raised a red flag" which should have caused PCI nurses to contact a physician. Dr. Hellerstein and Roscoe testified that PCI nurses negligently failed to review either the HSR that was processed on October 22, 2012, or plaintiff's medication information on the SIPS computer system. Dr. Hellerstein and Roscoe opined that based upon the

information that was available to PCI nurses on October 22, 2012, plaintiff should have received immediate medical attention. Roscoe testified that plaintiff "fell through the cracks," particularly with regard to monitoring plaintiff's hypertension and diabetes and ensuring he received medications which were prescribed to treat his chronic diseases.

{¶16} Defendant's experts, John Askins, R.N. and Michael Yaffe, M.D., both testified that defendant's employees met the standard of care if plaintiff submitted the HSR in question on or about October 22, 2012. Askins testified that the standard of care applied to malpractice claims brought by inmates is the same as that applied to non-inmates. Both Askins and Dr. Yaffe agreed that it was plaintiff's responsibility to follow-up with PCI medical staff in the event that he did not receive his medication. Askins stated that plaintiff had several options for requesting his medication, including completing an additional HSR, submitting an informal complaint (kite), and complaining to COs. According to Askins, PCI nurses performed their responsibility for placing the medication order with the institution pharmacy on October 22, 2012, and they did not have a duty to notify advanced level providers about the possibility that plaintiff had not received his medication. Askins testified that the failure by PCI's nurses to complete the HSR dated August 22, 2012, was a "typographical error" and not a breach of the standard of care; however, he agreed that error should have been investigated. During cross examination, Askins admitted that the HSR dated August 22, 2012 should have caused nurses to be concerned about plaintiff not having his medication.

{¶17} Dr. Yaffe is board certified in internal medicine and an assistant professor of medicine at The Ohio State University. With regard to the treatment of hypertension, Dr. Yaffe described the concept of a target blood pressure as part of a "dynamic science" inasmuch as such targets have been debated among various professional groups and modified over the years as additional research has been conducted. Dr. Yaffe testified that each patient who has been diagnosed with

hypertension has a unique set of risk factors which requires an individualized treatment plan.

{¶18} According to Dr. Yaffe, plaintiff's history of hypertension at PCI was variable, with some blood pressure readings falling in the low range and other readings in the elevated range of hypertension. Dr. Yaffe opined that plaintiff's history of hypertension was consistent with "stage one" hypertension, which is different than a diagnosis of uncontrolled hypertension. Dr. Yaffe testified that plaintiff's Lisinopril prescription was a "very low dosage," which represents one-fourth of the usual maintenance dosage for treating hypertension. Dr. Yaffe explained that there is a known and predictable response to drugs such as Lisinopril and he opined that the dosage plaintiff received, 5 mg., would likely result in an increase of only two to four millimeters of mercury in blood pressure when plaintiff was not taking his medication. With regard to the cause of plaintiff's stroke, Dr. Yaffe testified that over time, chronic hypertension and diabetes increase the likelihood of having a hemorrhagic stroke, and given plaintiff's age and the number of years he was known to have had those risk factors, Dr. Yaffe ascribed his stroke equally ("about 50/50" chance) to either the chronic effects of hypertension and diabetes or unknown (idiopathic) causes. However, Dr. Yaffe opined that there was no relation between the two periods of time when plaintiff was without Lisinopril in 2011 and 2012 and plaintiff's stroke inasmuch as it would require a long-term period of hypertension over a period of years, rather than a short-term elevation for merely a few months, to create a risk of developing a hemorrhagic stroke. Dr. Yaffe testified that by October 22, 2012, plaintiff's stroke was not preventable and providing him with Lisinopril on October 22, 2014, the date his HSR was processed, would not have changed the outcome of his medical condition.

{¶19} Plaintiff's medical expert, Jon Mukand, M.D., is board certified in rehabilitation medicine and he is the director of a rehabilitation center where he provides post-stroke treatment and stroke prevention. Dr. Mukand explained that

hypertension is generally defined as blood pressure readings above systolic pressure of 140 or the diastolic pressure of 90. However, because both diabetes and hypertension affect cardiovascular health, in the diabetic population, hypertension has a lower threshold for diagnosis and treatment; 130 systolic and 80 diastolic with patients with diabetes or renal failure. Dr. Mukand noted that this definition is consistent with both defendant's chronic disease management protocol and guidelines from the World Health Organization. Dr. Mukand testified that, as an African-American, plaintiff was also at a very high risk of cardiovascular events based on a known genetic association with his race, in conjunction with his diabetes and being overweight. Given plaintiff's risk factors, the extent that his blood pressure rose when he was not taking his medication could not be considered mild hypertension.

{¶20} Dr. Mukand explained that a stroke is a vascular event in the brain which causes damage to brain tissue. An ischemic stroke, the most common type, results from a lack of blood flow to the brain and is commonly associated with blood clots or blocked arteries. Hemorrhagic, or intracerebral hemorrhage (ICH), strokes are less common and usually related to hypertension, which leads to weakening and bulges of blood vessels that eventually rupture, causing bleeding in the brain. A hemorrhagic stroke typically occurs in small arteries located in the subcortical region of the brain, known as the basil ganglia. Dr. Mukand estimated that, in the general population, approximately 70 percent of hemorrhagic strokes are caused by uncontrolled hypertension and that the rate is even higher among African-Americans. Dr. Mukand identified four other causes of ICH; aneurysm due to an abnormal blood vessel in the brain, vasculitis, amyloid deposits, and brain tumor, each of which is very uncommon.

{¶21} Dr. Mukand reviewed plaintiff's medical records, and he testified that CT scan images showed an ICH in the subcortical region which was most likely caused by uncontrolled hypertension. According to Dr. Mukand, OSU neurology physicians agreed that plaintiff's stroke was caused by hypertensive vascular disease and made

the following assessment: "51 y.o. [male] prisoner with a history of [diabetes mellitus] and [hypertension] presented with acute left sided weakness and facial droop due to [right] basal ganglia/thlamic ICH probably due to hypertensive vascular disease * * *." (Plaintiff's Exhibit 5A-000120.) Dr. Mukand testified that OSU physicians concluded that plaintiff had a hypertensive hemorrhagic stroke after ruling out alternative causes by performing imaging and laboratory studies. Dr. Mukand stated that the OSU physicians' records not only indicate that plaintiff's stroke was a hypertensive vascular stroke, they also treated it as such.

{¶22} Dr. Mukand opined that had plaintiff been taking his medication as prescribed, he would not have suffered the ICH on October 24, 2012. Dr. Mukand testified that plaintiff's blood pressure was generally controlled below a systolic pressure of 130 when he was taking Lisinopril. According to Dr. Mukand, plaintiff's blood pressure became dangerously high when he did not receive Lisinopril in November 2011 through January 2012. Dr. Mukand characterized plaintiff's systolic pressure reading of 149, in January 2012 as a major problem for an African-American male with diabetes. Dr. Mukand opined that plaintiff's stroke was preventable and would not have occurred if he had received his medication as prescribed. Dr. Mukand testified that there is no doubt that plaintiff's disabilities were caused by the October 24, 2012 stroke.

{¶23} Dr. Mukand was also critical of the failure of PCI's medical staff to recognize that plaintiff had been without medication at least by the time that the August 22, 2012 HSR was reviewed on October 22, 2012. Dr. Mukand testified that the standard of care would have required plaintiff to receive prompt medical attention on October 22, 2012, and if plaintiff's blood pressure had been dangerously high, he would have been treated at a hospital. According to Dr. Mukand, if plaintiff's blood pressure was high but had not risen to the level of an emergency, he would have been closely monitored until his hypertension was controlled. Dr. Mukand opined that in either case,

medical intervention on October 22, 2012, would have prevented the outcome that occurred. Furthermore, Dr. Mukand testified that even if a small bleed had occurred on October 22, 2012, had he been treated appropriately and provided immediate medical attention to reduce his blood pressure, the extent of the bleeding would not have been nearly as severe and, therefore, his disabilities would not have been as severe and extensive.

{¶24} Defendant's neurology expert, Matthew Flaherty, M.D., is an associate professor of neurology at the University of Cincinnati College of Medicine and he is board certified in neurology with a subspecialty in vascular neurology. Dr. Flaherty treats almost exclusively stroke patients and he has conducted significant research in the area of hemorrhagic stroke. Dr. Flaherty defined hypertension as blood pressure greater than 140/90 and he explained that there are different stages of hypertension, which he described as follows: stage one hypertension, 140-159 of systolic pressure; stage two hypertension, 160-179 of systolic pressure; and stage three hypertension is above 180 of systolic pressure. Dr. Flaherty characterized plaintiff's blood pressure at PCI as being normal and controlled by a low dosage of Lisinopril. Dr. Flaherty testified that plaintiff's highest blood pressure readings at PCI were within stage one.

{¶25} Dr. Flaherty identified risk factors for ICH, including hypertension, increasing age, use of anticoagulant medications, and a family history of stroke. According to Dr. Flaherty, in some cases the causes of an ICH are unknown. Dr. Flaherty testified that hypertension has a cumulative effect in the cause of ICH and both severity and duration of hypertension are important factors. Dr. Flaherty opined that based upon his review of plaintiff's medical records, plaintiff's stroke was "multifactorial," meaning that multiple factors played some role and no dominant factor can be identified as the cause. Dr. Flaherty opined that plaintiff's stroke was not caused by the discontinuation of his medication inasmuch as ICHs are typically caused by chronic and severe hypertension and plaintiff did not have such a history of

hypertension. Dr. Flaherty testified that the benefits of taking Lisinopril for stroke prevention would be significant only over a period of years, rather than a few months. Dr. Flaherty explained that while plaintiff's blood pressure was severely elevated when he arrived at OSU on October 24, 2012, such elevated levels were caused by the stroke itself and were not indicative of plaintiff's blood pressure prior to the stroke.

{¶26} Dr. Flaherty testified that while the OSU neurologists attributed plaintiff's ICH to a hypertensive vascular event, he believed those physicians did not have the details of plaintiff's blood pressure history which Dr. Flaherty had to review. Dr. Flaherty disagreed with Dr. Mukand's opinion that plaintiff's bleeding and damage from the stroke would have been less severe if he had received his medications on October 22, 2012. According to Dr. Flaherty, the severity of a stroke depends on factors other than blood pressure, such as the timeliness of treatment, the location of bleeding, and the use of anti-coagulant drugs. Dr. Flaherty testified that he participated in a study which did not produce any evidence that giving a low dose of Lisinopril to a stroke victim prior to the stroke would influence the outcome of the stroke.

{¶27} The legal standard established in *Bruni, supra* is applicable to a claim for medical malpractice brought by an inmate. *Gordon v. Ohio State Univ.*, 10th Dist. Franklin No. 10AP-1058, 2011-Ohio-5057, ¶ 67, citing *Sloan v. Ohio Dept. of Rehab. & Corr.*, 119 Ohio App. 3d 331, 334 (10th Dist.1997). PCI's written policies do not establish the standard of care, as a matter of law; however, the policies provide some evidence of the applicable standard of care. *Jenkins v. Ohio State Univ. Hosps.*, 10th Dist. Franklin No. 96API01-119, 1996 Ohio App. LEXIS 3218 (July 23, 1996).

{¶28} There is no dispute that plaintiff was dependent on PCI's medical staff for care and treatment of his chronic diseases, including access to prescribed medication. Dr. Hale testified that it was important for PCI medical staff to closely monitor plaintiff's chronic hypertension and diabetes. Although Dr. Hale acknowledged that defendant's medical staff was required to enroll plaintiff in a hypertension CCC, he admitted that

plaintiff was not so enrolled. With regard to monitoring plaintiff's blood pressure, Dr. Hale admitted that plaintiff "fell through the cracks" inasmuch as his blood pressure was taken only three times between February and October 24, 2012; an insufficient number of times to aggressively control his blood pressure. Plaintiff was enrolled in a diabetes CCC and Dr. Hale testified that on May 4, 2011, his glucose level was "worrisome." Plaintiff's medical records indicate that medical orders were not followed and plaintiff was not reevaluated within the three-week time that was ordered and that his record did not reflect glucose readings for his next visit, on June 22, 2011.

{¶29} As discussed above, the evidence showed that there were periods of time when plaintiff did not receive his prescription medication. The information stickers that are applied to the HSR indicate when there are no refills remaining, and according to defendant's policy, the reviewing nurse is required to fill the order and forward the HSR to have the patient scheduled for sick call. The advanced level provider then has the opportunity to evaluate the patient and determine whether a new order for medication should be issued.

{¶30} Plaintiff's October 20, 2011 HSR was processed and plaintiff received his medications, but he was not scheduled for sick call. On December 8, 2011, plaintiff submitted another HSR, wherein he stated: "I WAS ON DIABETIES AND HIGH BLOOD PRESSURE MEDICATION MY ORDER RAN OUT 11/7/11, AM I OKAY NOW OR WHAT?" (Plaintiff's Exhibit 4A-000049.) Dr. Hale admitted that plaintiff's medications were wrongfully held even after a December 12, 2011 CCC report indicated that he had been off his medication for one month. Rather than refill plaintiff's medication, a decision was made to "hold meds" until new lab work had been completed. According to Dr. Hale, after two months without his medication, plaintiff had developed a blood pressure that Dr. Hale characterized as "uncontrolled hypertension" (149/89).

{¶31} An HSR dated May 10, 2012, was processed by PCI nurses on May 29, 2012. Although the evidence shows that plaintiff did not timely submit the HSR form

and that it was processed on the day it was received, PCI staff did not investigate the reason for the 19-day discrepancy even though plaintiff's pharmacy report indicated that plaintiff had been without his medication for approximately two weeks. (Plaintiff's Exhibit 20.) When plaintiff did not appear for his August 24, 2012 CCC visit, the appointment was not rescheduled as required by defendant's policies.

{¶32} With regard to the HSR dated August 22, 2012, PCI nurses testified that inmate HSRs were processed on the day that they were received and no plausible explanation was provided which would explain why this particular HSR would not have been processed in the same manner. Nurse Marine testified that she was not aware of any other HSR form that had been lost, misplaced, or otherwise not timely processed. However, Nurse Marine was aware of other HSRs that were received on a date that was different than the date of the request. Indeed plaintiff's HSR that was dated May 10, 2012 was received and processed on May 29, 2012; indicating that plaintiff had been without his medication for approximately two weeks. Based upon the evidence, and considering the credibility of the witnesses, the court finds that, more likely than not, plaintiff submitted the HSR on or about October 22, 2012.

{¶33} Even assuming the HSR was processed on the date it was received, according to both Ayers and Dr. Hale, the August 22, 2012 HSR "on its face" indicated that plaintiff had not received his prescription medication, and Dr. Hale testified that he would have been concerned about an increased risk of high blood pressure and stroke. Askins admitted that the form should have raised concerns that plaintiff had been without his medications for weeks when it was reviewed by PCI nurses, two days before plaintiff's stroke. Dr. Hale testified that he would expect a nurse to notify him of the discrepancy and that he would have examined plaintiff if he had been so notified.

{¶34} Although defendant contends that plaintiff was non-compliant with taking his medication, Dr. Hale testified that plaintiff's medical record showed that he was generally compliant with his essential medication regimen. PCI CCC "follow-up" forms

include spaces to record patient compliance with medications, diet, and exercise, and plaintiff's records indicate that he was generally compliant with taking medications when he had them. On at least one occasion, plaintiff inquired via an HSR when he did not get his medication.

{¶35} Based upon the evidence, the court finds that PCI medical staff committed a breach of the applicable standards of care in the delivery of health care to plaintiff. Specifically, plaintiff's chronic hypertension and diabetes were not closely monitored and PCI medical staff failed to follow its policies for chronic care, including scheduling CCC appointments and follow-up visits that were ordered by advanced level providers. Although there is no doubt that plaintiff should have been enrolled in a hypertension CCC, his blood pressure was rarely checked in the months prior to his stroke.

{¶36} With regard to his medication, as discussed above, PCI polices for reordering medications were not followed and plaintiff was without his essential medications for periods of time in 2011 and 2012. PCI nurses had access to plaintiff's medication records and both PCI's medical operations manager and its chief medical officer agreed that the reviewing nurses should have recognized that PCI records indicated plaintiff medications had not been refilled. No one at PCI recognized that plaintiff had not received his essential medications for over two months prior to his stroke.

CAUSATION

{¶37} Although plaintiff proved that defendant committed a breach of the applicable standard of care in providing healthcare to him, plaintiff must also prove that his injury was the direct and proximate result of defendant's breach. *Bruni, supra*. While the court is sympathetic to the severe injury plaintiff suffered, there is no presumption of malpractice merely because the patient has sustained an injury. *Ault v. Hall*, 119 Ohio St. 422, 428 (1928).

{¶38} OSU's attending neurologist who examined plaintiff and reviewed his chart, labs, and CT images, after plaintiff's case was discussed with "house staff," agreed with the assessment that plaintiff's "ICH [was] *probably* due to hypertensive vascular disease." (Emphasis added.) (Plaintiff's Exhibit 5A-000120.) However, the OSU physicians did not state that plaintiff's stroke was the result of hypertension caused by his failure to take his blood pressure medication in the weeks or months preceding his stroke. The court notes that plaintiff did not present testimony from the OSU physicians and the evidence does not show that OSU physicians had reviewed plaintiff's PCI medical records. Furthermore, the OSU physicians who performed imaging studies of plaintiff's brain from October 24-30, 2012, determined that the "[e]tiology of the hemorrhage remains indeterminate." (Plaintiff's Exhibit 5A-000264.)

{¶39} Based upon the evidence presented, the court finds that the testimony of defendant's medical experts was more persuasive than the testimony of plaintiff's medical experts. Most notably, plaintiff did not offer any expert testimony from a neurologist. Dr. Flaherty is board certified in neurology and his testimony regarding the cause of plaintiff's stroke was particularly persuasive inasmuch as he has specialized training in vascular neurology, has conducted significant research on the area of hemorrhagic stroke, and has written a book chapter on the epidemiology of ICH. Dr. Mukand's practice in rehabilitation medicine focuses on providing post-stroke treatment to patients. Dr. Mukand admitted that he does not usually investigate the cause of his patients' strokes.

{¶40} The court is persuaded by the testimony of Drs. Flaherty and Yaffe that plaintiff's medical history does not support a finding that his stroke was caused by the lack of a low dosage of Lisinopril during the periods in question. Flaherty's testimony concerning the cause of plaintiff's stroke is supported by the evidence and was more persuasive than the testimony of Dr. Mukand. Dr. Flaherty opined that plaintiff's stroke was of unknown cause or multifactorial. Dr. Yaffe's testimony regarding the

predictable response to medication such as Lisinopril was credible and persuasive. Both Drs. Flaherty and Yaffe testified that plaintiff's lack of Lisinopril did not cause him to suffer his stroke. Dr. Flaherty emphasized that plaintiff would have had to have experienced severe hypertension over a period of several years for the cumulative effects of hypertension to cause his stroke. Dr. Yaffe opined that plaintiff's blood pressure readings at PCI were "generally quite good" and that his elevated readings were of relatively short duration such that his hypertension was not a significant risk for developing hemorrhagic stroke. Dr. Mukand agreed that for hypertension to cause an ICH, a patient must have chronic long-term hypertension for "certainly more than a matter of months." Furthermore, contrary to plaintiff's assertion, Dr. Flaherty's research showed that providing a low dose of Lisinopril to a stroke victim prior to the stroke would not improve the outcome for the patient. Inasmuch as plaintiff's medical record shows that plaintiff's blood pressure was controlled with a relatively low dose medication for the majority of his incarceration after his diagnosis, the court finds that the greater weight of the evidence does not support the causation element of plaintiff's claim.

COMPARATIVE NEGLIGENCE

{¶41} Even if plaintiff had proved that defendant's breach of the standard of care caused his stroke, plaintiff's own conduct in receiving healthcare would be at issue. Defendant contends that plaintiff did not alert PCI staff he did not have his medications and that he failed to appear for scheduled medical appointments.

{¶42} The defense of contributory negligence in medical malpractice cases, if proven, may serve to diminish recovery under comparative negligence principles. *Reeves v. Healy*, 192 Ohio App.3d 769, 2011-Ohio-1487, ¶ 70 (10th Dist.). "To prove the affirmative defense of contributory negligence, the defendant must prove that the plaintiff breached a duty, proximately causing his or her own injury. Thus, the plaintiff's

own 'want of ordinary care * * * [must have] combined and concurred with the defendant's negligence and contributed to the injury as a proximate cause thereof, and as an element without which the injury would not have occurred.'" *Id*.; *Segedy v. Cardiothoracic & Vascular Surgery of Akron, Inc.*, 182 Ohio App.3d 768, 2009-Ohio-2460, ¶ 61 (9th Dist.), quoting *Brinkmoeller v. Wilson*, 41 Ohio St.2d 223, 226 (1975). However, a patient's contributory negligence "must be contemporaneous with the malpractice of the physician," such that any negligence of plaintiff prior to being treated by defendant's medical staff does not constitute negligence contributing to his injury resulting from defendant's negligence. *Reeves*, at ¶ 71.

{¶43} The court finds that plaintiff's testimony regarding his daily routine was credible and, as discussed above, plaintiff was generally compliant in taking his medications when he had them. However, plaintiff was in the best position to know when he was running out of his essential medication and the court is convinced that the HSR in question was submitted on or about October 22, 2012. The evidence showed that plaintiff understood the various methods that were available to him to request refills. Plaintiff could have attended pill call, or sent either an informal complaint or another HSR to request additional medication. Although plaintiff testified that he told COs in his housing unit, including CO George Clay, that he was without his medication, both Sergeant Gerald Hansen and Clay testified that they did not recall any such conversation with plaintiff. Hansen and Clay testified that they would have called medical staff if plaintiff had made such a complaint. Hansen emphasized that plaintiff could have received his medication either by talking to any CO or staff member, or by sending a written notification. The court is convinced that plaintiff was aware of both the importance of taking his medication and the various means available to obtain refills. Indeed, plaintiff had successfully used an HSR to refill his medication in December 2011.

{¶44} Defendant's own medical expert, Dr. Hellerstein, agreed that plaintiff would be non-compliant if he failed to take responsibility to obtain his medication. Plaintiff, like any other patient, was ultimately responsible for refilling his essential medication and he understood the procedures that were available to him to do so. The court finds that plaintiff negligently failed to use reasonable care in obtaining and taking those medications in May 2012 and during the two months prior to his stroke. Plaintiff also failed to follow physician's instructions to undergo regular blood sugar checks. The court finds that plaintiff's own negligence for failing to use reasonable care to ensure his own safety and well-being outweighs defendant's negligence.

{¶45} Inasmuch as plaintiff failed to prove that the acts or omissions of defendant's employees caused his injuries, he cannot prevail on his negligent hiring, retention, and supervision claim. *Evans v. Ohio State Univ.*, 112 Ohio. App.3d 724, 739 (10th Dist. 1996).

{¶46} For the foregoing reasons, judgment is recommended in favor of defendant.

{¶47} *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).*

_____

ANDERSON M. RENICK
Magistrate

cc:

Brian M. Kneafsey, Jr.
Assistant Attorney General
150 East Gay Street, 18th Floor
Columbus, Ohio 43215-3130

Michael A. Hill
Nicholas A. DiCello
1001 Lakeside Avenue East, Suite 1700
Cleveland, Ohio 44114

Filed April 24, 2015
Sent to S.C. Reporter 2/3/16