[Cite as *Woodrow v. Dept. of Rehab. & Corr.*, 2017-Ohio-8278.]

JERRY D. WOODROW Plaintiff v. OHIO DEPARTMENT OF REHABILITATION AND CORRECTION Defendant	Case No. 2014-00471 Magistrate Robert Van Schoyck DECISION OF THE MAGISTRATE

{¶1} This case arises from a July 21, 2013 accident in which plaintiff, an inmate in the custody and control of defendant, fell and was injured while adjusting a window at the Chillicothe Correctional Institution (CCI). The issues of liability and damages were bifurcated, trial was held on the issue of liability, and the magistrate recommended judgment in favor of plaintiff. The court adopted the magistrate's decision and entered judgment accordingly. The case then proceeded to trial on the issue of damages.

{¶2} It was established during the liability phase of trial that the accident occurred while plaintiff climbed up a wall above the top of the recreation cage in the segregation unit at CCI and that plaintiff fell backward and landed on the metal covering atop the cage. At the damages phase of trial, plaintiff testified that he was at least five feet above the cage when he fell. Plaintiff stated that he remembers landing on top of the cage but that he apparently lost consciousness for a moment and then regained it while people were attending to him. Plaintiff further stated that he vomited around that time.

{¶3} Plaintiff recalled inmates and corrections officers carrying him off the top of the cage and putting him on a bench. Plaintiff testified that his back and his head hurt, that he continued to vomit, and that he was bleeding from the right elbow where a piece of metal atop the cage had punctured his arm by a half inch or less. Someone gave him a towel to stop the bleeding on his arm, plaintiff stated. Plaintiff recalled a nurse coming

to the segregation unit and asking him what happened, and that after he explained it to her, she and the corrections officers went aside and talked amongst themselves, whereupon she came back and told him he would be taken to the infirmary only because of the wound on the elbow. Plaintiff testified that he was put in a cart and transported to the infirmary, where he received a tetanus shot and was then sent back to the segregation unit. Plaintiff stated that he was not given any medication, that his lower back and neck hurt, and that he remained awake and nauseous all night, afraid to go to sleep.

{¶4} According to plaintiff, when the first shift corrections officer arrived in the unit the next morning and learned about the accident, he sent plaintiff back to the infirmary. Plaintiff stated that a nurse looked at him but provided no treatment and sent him back to the segregation unit. At this point, plaintiff stated, he remained in pain and did not know what to do. Plaintiff explained, though, that the warden subsequently came through the segregation unit while making rounds and he was able to get the warden's attention and tell him what happened. By plaintiff's account, the warden seemed surprised that he had not heard about the accident and he ordered that plaintiff be sent to the infirmary and provided treatment. Plaintiff stated that when he went to the infirmary this time, he was given an x-ray of the skull and was told that he showed signs of having a concussion. Plaintiff related that he was sent back to the segregation unit again, still feeling pain in his neck, back, and head. Plaintiff acknowledged that in his visits to the infirmary at CCI, he did receive some treatment from nurses, but in his opinion the treatment was inadequate.

{¶5} Early the next morning, plaintiff testified, he was transferred to the Noble Correctional Institution (NCI). Plaintiff acknowledged that in the following weeks he received medical attention several times at NCI, including multiple doctor visits, but from his perspective he did not get treatment that he felt was appropriate. Plaintiff admitted that in addition to the x-ray he underwent on July 24, 2013, medical records reflect that

he received another skull x-ray on August 1, 2013, thoracic and lumbar spine x-rays on August 7, 2013, thoracic spine and elbow x-rays on September 6, 2013, and a cervical spine x-ray on September 13, 2013, none of which identified any fractures. (Defendant's Exhibit C.) According to plaintiff, however, he felt that he should have been given an MRI, which he never received. To the extent that the records from the x-rays show that they were interpreted as indicating mild scoliosis in the thoracic spine and mild degenerative changes in the cervical spine, plaintiff testified that no one had ever diagnosed him with these conditions prior to the accident, and he testified that he never had any back problems at all before the accident.

{¶6} Plaintiff testified about submitting an Informal Complaint Resolution form on September 9, 2013, in which he complained that a doctor who examined him at NCI apparently thought he might have a vision problem, whereas plaintiff thought that he should have undergone an MRI or additional x-rays. (Plaintiff's Exhibit 15.) Plaintiff admittedly complained to NCI medical personnel about having blurry vision at some point and underwent an eye exam which resulted in a finding that his blurry vision was caused by an eyesight problem, but he stated that he never had any such problems before the accident. Plaintiff also testified about an Informal Complaint Resolution form that he submitted on September 25, 2013, complaining that he had been denied an MRI. (Plaintiff's Exhibit 16.) Plaintiff stated that on October 2, 2013, he sent a "kite" (a handwritten form of institutional correspondence) to the Health Care Administrator at NCI complaining about having been prescribed rubber band exercises for his back, which were painful, rather than an MRI. (Plaintiff's Exhibit 13.) Plaintiff further stated that on October 17, 2013, he submitted another kite to the Health Care Administrator at NCI complaining about medications he had been prescribed for high blood pressure and migraine headaches, which he felt were not applicable to his symptoms. (Plaintiff's Exhibit 14.) Plaintiff admitted that he received responses to his complaints, whether he agreed with them or not, including explanations that his treatment plan was ordered by

the doctor, that he needed to start out slowly with the rubber band exercises and build strength, and that a collegial review panel had reviewed his case and determined that an MRI was not warranted, and he was also scheduled for follow-up visits with the doctor. According to plaintiff, however, in spite of the medical attention that he received at NCI, he felt that overall nothing was really done for him.

{¶7} The pain and stiffness in his neck eventually went away, plaintiff stated, and although the head and back pain persisted, the level of pain decreased somewhat over time. Plaintiff related that he served out his sentence and was released after about a year and a half at NCI, at which time he still suffered from headaches and low back pain. According to plaintiff, when he returned home to Gallipolis he had difficulty obtaining medical attention on account of not having health insurance, but there was a physician he was able to see a couple of times who performed tests and prescribed some kind of medication for him. Plaintiff described getting some temporary relief from the medication but that the underlying problems remained.

{¶8} About one year after being released from NCI, plaintiff stated, he was arrested and jailed in Meigs County for about seven months. Plaintiff testified that the pain in his head would come and go and was intense when it would happen, while the lower back pain was more constant. Plaintiff stated that he got some medical attention in the jail, including some medication which was ineffective for relieving his pain, and that he was scheduled to undergo an MRI and a CAT scan, but before the tests could be performed he was convicted on a felony charge and conveyed to defendant's custody. Plaintiff related that he was admitted into defendant's Correctional Reception Center (CRC) and that he sought medical attention there but nothing was done for him. Plaintiff testified that defendant transferred him to NCI in 2016 and that he had been there for about one year at the time of trial. Plaintiff testified that he is not taking any medication and that he still feels that he is not getting appropriate care. Plaintiff described the present symptoms that he attributes to the accident as intense low back

pain, slightly below his belt line, in both sides of the back, and also headaches, which are more problematic to him than the back pain.

{¶9} Rayma Jensen, R.N. testified by way of deposition. (Plaintiff's Exhibit 17.) Jensen has worked for defendant at CCI since 2009, and at the time when the accident occurred she probably served as a Nurse I assigned to an "ER" role in the infirmary, she stated. Jensen testified that on the evening when the accident took place she was summoned to the segregation unit to examine plaintiff. Jensen testified that she vaguely recalled the encounter, at which time she believes plaintiff was seated on a bench or chair, but that she filled out a Medical Exam Report to document what occurred. (Plaintiff's Exhibit 7.)

{¶10} Jensen stated that, according to what she wrote in the Medical Exam Report, plaintiff told her that he fell and hurt his back and sustained a puncture wound to his arm. The Medical Exam Report shows that Jensen measured plaintiff's vital signs and his pupils, which were normal, and determined that he was alert and oriented, she stated. Jensen stated that she documented a small hole in the right arm below the elbow with minimal bleeding, which she cleaned and applied ointment to before covering it with a bandage. Jensen also noted a small knot on the back of the head which she advised plaintiff to apply ice to, she stated. Jensen stated that she did not note any discoloration in the lower back where plaintiff complained of pain, but she acknowledged that bruises do not typically appear immediately after an accident. Jensen testified that she apparently transported plaintiff to the infirmary on a cart and set up a referral for him to see the doctor during "sick call" hours, but that she is not personally aware of any other treatment plaintiff received. When questioned about a July 21, 2013, doctor's order by a Dr. Akhtar, Jensen testified that it appears to reflect that the doctor gave an order over the telephone to another nurse that night for plaintiff to be given a tetanus shot. Plaintiff's medical chart shows that he was transferred from CCI to NCI on July 25, 2013, Jensen testified.

{¶11} Nicole Estep, R.N. testified by way of deposition. (Plaintiff's Exhibit 18.) Estep, who stated that she has been employed with defendant for 10 years as a nurse at CCI, related that she prepared a Medical Exam Report during an examination that she performed on plaintiff on July 22, 2013, at 9:40 a.m. (Plaintiff's Exhibit 12.) According to what she wrote in the Medical Exam Report, Estep stated, plaintiff complained of headaches and back pain which he attributed to falling the day before. Estep stated that she does not recall if she examined plaintiff's head, but that the only visible injury she noted was a small abrasion on the right elbow. Estep further stated that this was the only time she saw plaintiff. Estep stated that she does not have any knowledge about the x-rays that plaintiff underwent, but she explained that they can be performed at CCI.

{¶12} Vanessa Sawyer, R.N. testified that she is employed with defendant as the Health Care Administrator at NCI, where she has worked for approximately 21 years, and that her job entails overseeing all aspects of the medical department of NCI in conjunction with the chief medical officer.

{¶13} Sawyer authenticated and gave testimony about medical records maintained by defendant during plaintiff's first term of incarceration. (Plaintiff's Exhibit 12.) Sawyer stated that on July 25, 2013, when plaintiff arrived at NCI for the first time, a nurse conducted an intake screening and prepared an Interdisciplinary Progress Note in which she documented that plaintiff complained of back pain from the accident at CCI, and that he would be scheduled to see a doctor. The next day, Sawyer testified, another nurse prepared a progress note documenting that she followed up with plaintiff and that he complained about blurred vision, headaches, and his back. Sawyer stated that an August 6, 2013 progress note by a Dr. Weidman pertained to his evaluation of plaintiff at a doctor's sick call appointment, with Dr. Weidman noting that plaintiff complained of frequent headaches, right and left lower back pain, and blurred vision following the accident. Sawyer stated that in the assessment portion of the note Dr.

Weidman wrote "concussion", and that in the treatment plan portion of the note Dr. Weidman noted medication to prevent headaches and an optometry follow-up. According to Sawyer, an August 19, 2013 progress note documented that plaintiff saw Dr. Scott Wolf that day for an optometry appointment.

{¶14} Sawyer testified that a September 5, 2013 progress note corresponds to another doctor's sick call appointment with Dr. Weidman to follow up regarding plaintiff's concussion. In that note, Sawyer stated, Dr. Weidman noted that plaintiff reported the frequency of his headaches had decreased to 5 days per week, that plaintiff complained of blurred vision but declined the optometrist's recommendation to wear prescription glasses, and that plaintiff reported continued pain in the thoracic and lumbar spine. Sawyer stated that Dr. Weidman's assessment included a concussion, persistent pain in the head, neck, back, and right arm, and slight right upper extremity weakness, and that the plan of care included requesting an MRI of the brain and cervical spine, reviewing x-rays of the spine, and having plaintiff perform rubber band exercises for his back.

{¶15} Sawyer also testified that in a progress note dated September 24, 2013, Dr. Weidman documented a follow-up visit with plaintiff in which he noted, among other things, x-ray results showing mild degenerative changes in the cervical spine and showing normal results for the thoracic and lumbar spine. Sawyer stated that Dr. Weidman's assessment was that plaintiff had suffered a concussion, neck sprain, back sprain, and post-concussive headaches, and that his plan of care included starting plaintiff on the prescription drug Topamax and instructing plaintiff to exercise at a gradually increasing level and to avoid a sedentary lifestyle.

{¶16} Sawyer testified about a form titled Treatment and Blood Pressure Record, which includes a September 26, 2013 notation by a nurse who wrote that plaintiff was given instructions for rubber band exercises to strengthen his back, pursuant to the doctor's order, and that he was to perform the exercises twice a week. Sawyer stated that in this same document, on October 1, 2013, another nurse wrote that when

instructing plaintiff on exercises and having plaintiff perform them, plaintiff said he felt something was wrong with his back and that he could not do the exercises. Sawyer further stated that it was noted by another nurse in this same document on November 26, 2013, that plaintiff was being restarted on the exercises to be performed twice a week for twelve weeks, but that two days later it was noted that plaintiff refused the treatment. Sawyer related that the instructions for the exercises that plaintiff was supposed to perform is included with these medical records, one page below the Treatment and Blood Pressure Record.

{¶17} According to Sawyer, an October 24, 2013 progress note from Dr. Weidman corresponds to a follow-up visit he had with plaintiff because of plaintiff reporting no relief for his back pain. Sawyer testified that Dr. Weidman noted that plaintiff told him he was unable to do the prescribed exercises because it was too painful. Sawyer stated that Dr. Weidman's assessment was that the back pain was becoming chronic, and that his plan of care was to encourage plaintiff again to increase his physical activity, especially with resistance exercises, because he felt that this would ultimately relieve plaintiff's back pain.

{¶18} Sawyer also authenticated a set of medical records accumulated during plaintiff's present term of incarceration at CRC and NCI, and she stated that from her review of these records there were no complaints by plaintiff of headaches or back pain. (Defendant's Exhibit E.) Sawyer testified that the records include documentation from intake screenings performed by nurses when plaintiff arrived at CRC on November 15, 2016, and when he arrived at NCI on December 21, 2016, and that although these documents noted a history of head injury and a history of chronic pain, plaintiff was noted to have no present complaints. (Defendant's Exhibit E.)

{¶19} "In order to sustain an action for negligence, a plaintiff must show the existence of a duty owing from the defendant to the plaintiff or injured party, a breach of that duty, and that the breach was the proximate cause of resulting damages." *Sparre*

v. Ohio Dept. of Transp., 10th Dist. Franklin No. 12AP-381, 2013-Ohio-4153, ¶ 9. "'It is axiomatic that every plaintiff bears the burden of proving the nature and extent of his damages in order to be entitled to compensation.'" *Jayashree Restaurants, LLC v. DDR PTC Outparcel LLC* , 10th Dist. Franklin No. 16AP-186, 2016-Ohio-5498, ¶ 13, quoting *Akro-Plastics v. Drake Indus.*, 115 Ohio App.3d 221, 226 (11th Dist.1996). "As a general rule, the appropriate measure of damages in a tort action is the amount which will compensate and make the plaintiff whole." *N. Coast Premier Soccer, LLC v. Ohio Dept. of Transp.*, 10th Dist. Franklin No. 12AP-589, 2013-Ohio-1677, ¶ 17. "[D]amages must be shown with reasonable certainty and may not be based upon mere speculation or conjecture * * *." *Rakich v. Anthem Blue Cross & Blue Shield*, 172 Ohio App.3d 523, 2007-Ohio-3739, ¶ 20 (10th Dist.). "Generally, where an issue involves a question of scientific inquiry that is not within the knowledge of a layperson, expert testimony is required." *Harris v. Ohio Dept. of Rehab. & Corr.*, 10th Dist. Franklin No. 13AP-466, 2013-Ohio-5714, ¶ 16; *see also Tunks v. Chrysler Group LLC*, 6th Dist. Lucas No. L-12-1297, 2013-Ohio-5183, ¶ 18 ("Where complicated medical problems are at issue, testimony from a qualified expert is necessary to establish a proximate causal relationship between the incident and the injury.").

{¶20} Upon review, the magistrate makes the following findings. On the evening of July 21, 2013, plaintiff was about five feet above the top of the recreation cage when he fell backward and landed on the covering made of steel beams and wire mesh. Plaintiff landed on his back but also hit his head, and a piece of metal made a small puncture wound in his right elbow. Plaintiff lost consciousness for a moment. Plaintiff was in pain in his back and head, and he bled from the wound on the elbow. Nurse Jensen came to the unit and noted plaintiff's complaints of acute low back pain, a bump on his head, and the small puncture wound on the right elbow. Jensen took plaintiff to the infirmary, cleaned the wound and advised plaintiff to apply ice for his other injuries. Plaintiff also received a tetanus shot.

{¶21} The following morning, on July 22, 2013, plaintiff was seen in the infirmary by Nurse Estep, who noted his complaints of back pain and headaches, in addition to the elbow wound, which she documented to be small and not bleeding. Estep provided a bandage for the elbow and ibuprofen for the pain. On July 24, 2013, plaintiff was seen in the infirmary by Nurse Harmon, to whom plaintiff complained of back pain, blurry vision, and headaches. On that same date, plaintiff underwent a skull x-ray which did not reveal a fracture.

{¶22} On July 25, 2013, defendant transferred plaintiff to NCI, where, upon arrival, his complaints of back pain were noted. A nurse followed up with plaintiff on July 26, 2013, and noted his complaints of back pain, headaches, and blurred vision. On August 6, 2013, plaintiff saw a doctor who noted his complaints of bilateral back pain, frequent headaches, and blurred vision, and, in the doctor's assessment, plaintiff had a concussion. The doctor prescribed medication to prevent headaches and arranged an optometry consult. On August 19, 2013, plaintiff saw an optometrist who recommended prescription eyeglasses, but plaintiff declined.

{¶23} On September 5, 2013, plaintiff saw the general practice doctor at NCI again, who noted a reduction in the frequency of plaintiff's headaches, that plaintiff still had blurred vision and back, neck, head, and right arm pain. The doctor prescribed rubber band exercises to alleviate the symptoms in plaintiff's back. The doctor also sent plaintiff for x-rays of the spine which showed mild degenerative changes in the cervical spine, and normal results in the thoracic and lumbar spine. On September 24, 2013, the doctor saw plaintiff again and, in the doctor's professional assessment, it was reiterated that plaintiff had suffered a concussion, as well as a neck sprain, back sprain, and post-concussive headaches. The doctor put plaintiff on Topamax to address the headaches and once again prescribed exercise.

{¶24} One month later, on October 24, 2013, the doctor followed up again due to plaintiff's complaints of persistent back pain with no relief. No complaints or symptoms

of headaches or blurred vision were noted and it is probable that such conditions resulting from the accident had resolved by this time, as did the neck strain. The doctor noted that plaintiff felt he could not do the exercises that had been prescribed to help his back, but the doctor told plaintiff that he needed to follow through and that, in the doctor's professional opinion, this would ultimately relieve the back pain.

{¶25} Nurses made appointments to assist plaintiff with the prescribed exercise regimen on multiple occasions from September into late November 2013, but plaintiff ultimately refused to follow this program. Although it may have been painful at first for plaintiff to perform the exercises and it is understandable that he would have been frustrated, he was instructed to start slowly and build up his strength and that this would resolve his back pain, but it appears that plaintiff was unwilling to follow the regimen and ultimately refused to participate, well shy of completing the 12-week program that was set for him.

{¶26} Considering the lack of subsequent complaints about back pain, it is more likely than not that those symptoms subsided in late 2013. Although evidence of back pain persisting beyond that time is lacking, even if it had persisted it must be concluded that the greater degree of fault for any such prolonging of the symptoms rests with plaintiff for not following the exercise program prescribed by the doctor.

{¶27} In sum, plaintiff injured his head, back, and neck in the fall, and he suffered a small puncture wound on the right elbow that healed within a short time. Plaintiff was briefly knocked unconscious and suffered an apparent concussion. Plaintiff was in significant pain and discomfort for a few days after the fall. Plaintiff suffered very frequent headaches that started to diminish about a month later. About three months after the accident, plaintiff's headaches were substantially resolved, as was the discomfort from the neck strain that plaintiff apparently suffered. Plaintiff's lower back pain persisted for more than three months after the accident, but this too was substantially resolved by late 2013.

{¶28} Although plaintiff contends that he still suffers from back pain and headaches today, this has little support in the medical records that have been maintained for him in recent years. Plaintiff's explanation, being that he saw no use in complaining of these maladies because nothing was ever done for him, is contradicted by the record of medical attention that plaintiff received for his complaints in 2013. Plaintiff was seen many times by nurses and doctors, he was prescribed medication, he was given diagnostic testing, and he was prescribed physical therapy, all in response to his complaints at the time, so plaintiff did receive care and treatment, even if it was not the care and treatment that he deemed appropriate. Even if plaintiff has continued to suffer headaches and back pain, plaintiff failed to establish that such symptoms were proximately caused by the accident. Plaintiff received several x-rays which did not reveal any fractures or other acute injury to his vertebrae or skull. Furthermore, the evidence shows that plaintiff has some degenerative disc disease, making it all the more speculative to attribute any current back pain to the accident. There is also evidence that plaintiff has a vision deficit but will not wear eyeglasses, which adds to the speculative nature of determining the cause of any blurred vision or headaches which he may suffer today.

{¶29} Plaintiff also provided no expert testimony to attribute any current symptoms to the accident. While defendant does not dispute that plaintiff temporarily suffered some pain and headaches, and under the circumstances in this case those symptoms are understandable by a layperson, plaintiff argues that four years after the accident he has chronic headaches and back pain, but the source of such long-term conditions inside the human body are not sufficiently observable and comprehensible by a layperson. *See Wright v. Columbus*, 10th Dist. Franklin No. 05AP-432, 2006-Ohio-759, ¶ 19; *see also Choate v. Tranet, Inc.*, 12th Dist. Warren No. CA2003-11-112, 2004-Ohio-3537, ¶ 17, quoting *Stacey v. Carnegie-Illinois Steel Corp.*, 156 Ohio St. 205 (1951), syllabus ("Because the cause of lower back pain is not within the scope of

common knowledge, 'medical testimony is essential.'"). Moreover, there is medical evidence contradicting the alleged long-term symptoms, as the records prepared by defendant's medical professionals reflect that plaintiff's headaches diminished and that he stopped complaining of them, and that the doctor felt that his back pain would resolve with exercise rather than persisting chronically as plaintiff claims.

{¶30} Finally, it is noted that plaintiff's medical expenses were covered by the state while he was in defendant's custody and he did not establish an entitlement to recover for any other medical expenses, nor did he establish any entitlement to lost wages.

{¶31} In terms of placing a monetary value on plaintiff's temporary pain and suffering, it is instructive to review damage valuations in other recent cases. In *Robinson v. Ohio Dept. of Rehab. & Corr.*, Ct. of Cl. No. 2012-06041, 2015-Ohio-5628, damages were valued at $8,500 for an inmate who suffered temporary pain and suffering, for a slightly shorter duration than plaintiff, from head, back, and hip injuries resulting from a fall out of an upper bunk bed. In *Brooks v. Dept. of Rehab. & Corr.*, Ct. of Cl. No. 2012-06181, 2016-Ohio-7810, damages were valued at $6,500 for an inmate who suffered several weeks of pain in his back and other areas after a fall from a bunk.

{¶32} Based upon the foregoing, for the past pain and suffering associated with the injuries caused to plaintiff as a result of defendant's negligence, plaintiff is entitled to damages in the amount of $9,500. Accordingly, it is recommended that judgment be entered for plaintiff in that amount.

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

whether or not specifically designated as a finding of fact or conclusion of law under Civ.R. 53(D)(3)(a)(ii), unless the party timely and specifically objects to that factual finding or legal conclusion within 14 days of the filing of the decision, as required by Civ.R. 53(D)(3)(b).

ROBERT VAN SCHOYCK
Magistrate

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