[redacted] DOC # [redacted]	* **BEFORE JOHN T. HENDERSON, JR.,**
GRIEVANT	* **ADMINISTRATIVE LAW JUDGE**
v.	* **THE MARYLAND OFFICE OF**
MARYLAND DIVISION	* **ADMINISTRATIVE HEARINGS**
OF CORRECTION	* **OAH NO.: DPSC-IGO-002V-20-15214**
	* **IGO NO.:** [redacted]

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STATEMENT OF THE CASE

On January 7, 2020, the Grievant filed a grievance[1] with the Inmate Grievance Office (IGO),[2] which the IGO summarized as follows:

> On August 30, 2019 around [redacted] pm, the Grievant was on his way to dinner in the [redacted] Building at [redacted] When [the cell door] was opened by COII [redacted], the Correctional Officer in the control center, the Grievant followed his cellmate out of the cell. The Grievant paused on the open doorway to unfold his handicap walker, when CO II [redacted], without waiting for a signal from the tier officer, started closing the cell door. The Grievant alleges that COII [redacted] was negligent in the operation of the door and seeks the following remedy:
>
> 1. Proper medical attention for his injury;
> 2. $10,000 in nominal damages;

[1] A "grievance" is "the complaint of any individual in the custody of the Commissioner [of the Division of Correction] or confined to the Patuxent Institution against any officials or employees of the Division or the Patuxent Institution arising from the circumstances of custody or confinement." Code of Maryland Regulations (COMAR) 12.07.01.01B(8).

[2] The IGO is part of the Department of Public Safety and Correctional Services (Department). Md. Code Ann., Corr. Servs. § 2-201(12) (Supp. 2020). The IGO receives complaints from inmates and refers those not found "wholly lacking in merit" to the Office of Administrative Hearings (OAH) for hearings. *Id.* § 10-207(c)(1) (2017).

3. $35,000 in compensatory damages; and
4. $50,000 in punitive damages. [3]

On April 14, 2021, I held a hearing via videoconference. Md. Code Ann., Corr. Servs. § 10-207(c)(2) (2017); Md. Code Ann., State Gov't § 10-211 (2014); and COMAR 28.02.01.20B(1)(b). I was located at the Office of Administrative Hearings (OAH), the Grievant was located at [redacted], ([redacted]) a facility of the DOC, and [redacted] Correctional Coordinator, IGO, who represented the DOC, was at [redacted] The Grievant represented himself.

The contested case provisions of the Administrative Procedure Act, the IGO's General Regulations, and the OAH's Rules of Procedure govern procedure in this case. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2014 & Supp. 2020); COMAR 12.07.01; and COMAR 28.02.01.

ISSUES

1. Was the Grievant injured due to the negligence of the DOC when the cell door closed on him on August 30, 2019, and if so,

2. What, if any, remedy is available to the Grievant?

SUMMARY OF THE EVIDENCE

Exhibits

I incorporated into the record the IGO file, which contained the following pertinent documents:

- Part B-Response to ARP, November 7, 2019
- Grievant's Request for Administrative Remedy, September 22, 2019
- Administrative Remedy Response, November 17, 2019
- Letter from Grievant to IGO, December 28, 2019

[3] On September 22, 2019, the Grievant filed a Request for Administrative Remedy (ARP-[redacted]). The Warden dismissed the claim on November 7, 2019, stating there was no evidence that on August 30, 2019, staff intentionally closed the cell door on [the Grievant]. An appeal to the Commissioner was filed on November 17, 2019, who, on December 13, 2019, affirmed the Warden's decision.

- Referral to OAH Form, regarding grievance filed January 7, 2020
- Referral to the OAH from the IGO, March 26, 2020
- OAH Notice of Hearing, June 23, 2020
- Grievant's sick call medical record, August 30, 2019
- ARP Case Summary, November 3, 2019
- Memorandum from Captain [redacted] to Sergeant [redacted], November 3, 2019
- Grievant's medical record from radiologist, September 3, 2019
- Notice to Presiding ALJ, July 22, 2020
- Transmittal for Inmate Grievance Hearings, received by OAH, July 22, 2020
- Rules of Procedure for Grievance Hearings, faxed date August 13, 2020
- Referral to the OAH (Duplicate), March 26, 2020
- OAH Granted Postponement Request form, August 13, 2020
- Letter from ALJ Henderson to the parties, August 21, 2020
- OAH Notice of Hearing, August 31, 2020
- Grievant's Formal Request to IGO for Representative, Witnesses, Documents, Records and Physical Evidence, received by the IGO, September 2, 2020
- Letter from the Grievant to the IGO, received by IGO August 19, 2020
- Supplemental Prehearing Order from the IGO, September 14, 2020
- Emails to and from the IGO and [redacted] October 21, 2020
- Notice to Presiding ALJ, October 28, 2020
- Transmittal for Inmate Grievance Hearings, for hearing dated November 12, 2020
- Letter from the Grievant to the IGO, November 6, 2020
- Information Needed pleading from the IGO, October 23, 2020
- Emails to and from the IGO to [redacted] and [redacted] October 21, 2020, December 18, 2020, December 19, 2020, February 8, 2021, and February 10, 2021
- Memo to File from the IGO, February 10, 2021
- Notice of Hearing, February 10, 2021
- Emails from [redacted] to the IGO, February 24, 2021
- Grievant's Subpoena for witnesses, issued February 25, 2021
- Grievant's medical record, sick call, August 30, 2019
- ARP Case Summary, November 3, 2019
- Memorandum from Captain [redacted] to Sergeant [redacted], November 3, 2019
- Notice to Presiding ALJ, April 6, 2021
- Transmittal for Inmate Grievance Hearings, received by the OAH, April 6, 2021
- Emails from the IGO to the OAH, February 24 and 25, 2021

The Grievant did not offer exhibits for admission into evidence.

Testimony

The Grievant testified on his own behalf and presented the testimony of [redacted] Correctional Officer, II.

The DOC did not offer witness testimony.

FINDINGS OF FACT

I find the following facts by a preponderance of the evidence:

1. At all times relevant to this proceeding, the Grievant was housed at [redacted] a DOC facility.

2. The Grievant has used a walker and a wheelchair for mobility since May 2019 due to a lower back injury sustained in May 2019.

3. On August 30, 2019, at approximately [redacted] p.m., the Grievant was in the process of leaving his cell room to go to dinner. The Grievant's cell was located at Tier [redacted] [redacted], at [redacted]

4. CO II [redacted] was assigned to escort the Grievant from his cell to the dining area. CO II [redacted] gave instructions to CO II [redacted], who was in charge of opening and closing cell doors, to open the Grievant's cell door.

5. The Grievant's cell door was opened, and the Grievant proceeded to exit his cell. The Grievant stopped in the doorway to extend his walker and reach back into his cell for his hat. Before he could fully exit the doorway, the cell door closed and struck the Grievant on his left shoulder causing pain and injury.

6. The cell door was stopped on the Grievant's left shoulder for about thirty seconds.

7. The Grievant could not see the control center. CO II [redacted] was in front of him beyond the doorway in the tier hallway.

8. The Grievant has been incarcerated at [redacted] for about six years and is familiar with the procedures for inmate movement from in and out of his cell and onto the tier hallways.

9. The Grievant was taken to health services after the cell door closure incident and was treated by [redacted] R.N., of the Office of Inmate Health Services.

10. The Grievant was diagnosed as having an injury to his left shoulder. He rated his pain as a four out of ten on the pain scale. There was no swelling or open wound, no bruises or discoloration.

11. The Grievant was given Motrin for the pain.

12. On September 3, 2019, the Grievant had an x-ray on his left shoulder.

13. The x-ray revealed no evidence of an acute fracture, dislocation or subluxation. There was a suggestion of prior trauma which may have represented calcific tendonitis or bursitis.

14. On May 19, 2020, physical therapy was ordered for the Grievant's left shoulder.

15. The Grievant works in the inmate [redacted] as a [redacted] He earns $8.00 per day and works a forty-hour work week.

16. The Grievant returned to work after August 30, 2019, three weeks after the door closure incident. He worked from 6:00 a.m. to 1:00 p.m. Monday through Friday.

17. The Grievant was paid his base pay of $2.30 per day for the three weeks he did not work due to the August 30, 2019 incident.

DISCUSSION

In an inmate grievance concerning an institutional administrative decision, the grievant bears the burden of proving, by a preponderance of the evidence, that the DOC's action was arbitrary and capricious, or inconsistent with the law. COMAR 12.07.01.08C(1). An Administrative Law Judge may determine that an administrative decision is arbitrary and capricious or inconsistent with the law if:

(a) The decision maker or makers did not follow applicable laws, regulations, policy or procedures;

(b) The applicable laws, regulations, policy or procedures were intended to provide the grievant a procedural benefit; and

(c) The failure to follow applicable laws, regulations, policy or procedures prejudiced the grievant.

COMAR 12.07.01.08C(2).

The Grievant's Contentions

The Grievant contends that due to the DOC's negligence, he sustained personal injury and continues to experience pain. He asserts that on August 30, 2019, he was struck in the left shoulder by his cell door which he alleges, closed on him due to the negligence of CO II [redacted] who was operating the tier cell doors at the time. As a result, the Grievant claims, he suffered pain and injury to his left shoulder. He requests an award of proper medical attention for his injury, $10,000.00 in nominal damages, $35,000.00 in compensatory damages, and $50,000.00 in punitive damages.

The DOC's Response

The DOC denied the Grievant's claims. The DOC did not present evidence but argued at the conclusion of the hearing that the Grievance should be dismissed because the Grievant failed to prove DOC staff was negligent. The DOC argued that the Grievant admitted to pausing within the open doorway to open his walker. The DOC further argued that the nurse's notes showed no injury to the Grievant and the September 3, 2019 x-ray showed no evidence of injury due to the August 30, 2019 incident. The DOC further argued that despite not reporting to work after the injury, the Grievant continued to receive pay, and that he had a prior injury for which he was taking pain medication.

For the following reasons, I conclude that the Grievant has not met his burden of proof and that his claims for monetary damages and other relief must be denied.

Analysis

The Grievant's position is akin to that of a plaintiff in a civil action, and the DOC's to that of a defendant. To prove negligence, a plaintiff must prove four elements: (1) that the defendant was under a duty to protect the plaintiff from injury; (2) that the defendant breached the duty; (3) that the plaintiff suffered actual injury, and: (4) that the loss or injury proximately resulted from the defendant's breach of duty. *Insurance Co. of North America v. Miller*, 362 Md. 361, 387 (2001).

In a negligence action, the question of whether a duty exists is an issue of law. *Valentine v. On Target, Inc.*, 353 Md. 544, 549 (1999); *Rosenblatt v. Exxon*, 335 Md. 58, 75 (1994). I conclude that correctional personnel do have a duty to protect inmates. The Court of Special Appeals stated in *State v. Johnson*, 108 Md. App. 54 (1996):

> Ordinarily, courts will not impose a duty to protect the interests of another, absent a special relationship between the parties. *See* [W. Page Keeton, et al.], *Prosser [and Keeton on the Law of Torts* (5th ed. 1984)] § 56 at 373-375. That special relationship existed here; when the State incarcerates an individual, the inmate is entirely dependent on the State, which has exclusive control over the care and confinement of prison inmates. *See Prosser* § 56, at 376 (the special relationship between a jailer and his prisoner justifies imposing a duty to protect prisoners).

The Grievant, however, failed to prove by a preponderance of the evidence that DOC personnel breached the duty to protect him. I reject both contentions on which the Grievant bases his claim of negligence: (a) that the correctional officer who operated the tier cell door negligently closed the door upon the Grievant when the Grievant was standing in the doorway, and (b) that they negligently caused him to sustain injury to his left shoulder. Even if CO II [redacted] negligently closed the tier cell door on August 30, 2019, the Grievant was contributorily negligent by stopping his forward movement out of the cell, pausing and reaching

back through the cell door for his hat. In Maryland, contributory negligence is an absolute bar to recover for a negligence claim.[4]

CO II [redacted] who was subpoenaed to testify by the Grievant, provided no evidence that would assist the Grievant in meeting his burden of proof. CO II [redacted] could not remember any details of the August 30, 2019 incident. CO II [redacted] consistently testified that he did not recall the specific circumstances that led to the Grievant's injury and did not even recall if he worked on August 30, 2019. I do not find CO II [redacted]'s testimony credible.

Nevertheless, the Grievant has the burden of proof. He has offered no competent evidence tending to show that negligence of the DOC and its staff was the proximate cause of his injuries. Even if he provided competent evidence of negligence, the evidence he did provide tends to show that he was contributorily negligent for his injuries, barring any claim of negligence against the DOC.

For these reasons, I conclude that the Grievant did not sustain his burden of proving that DOC personnel breached their duty of care. Accordingly, his negligence claim must fail.

CONCLUSIONS OF LAW

I conclude, as a matter of law, that the Grievant failed to establish, by a preponderance of the evidence, that he was injured due to the negligence of the Doc when the cell door closed on him on August 30, 2019, and the DOC's actions were arbitrary and capricious, or inconsistent with the law. COMAR 12.07.01.08C.

[4] "Under the doctrine of contributory negligence, a plaintiff who fails to exercise ordinary care for his or her own safety, and thus contributes proximately to his or her injury, is barred from all recovery, regardless of the quantum of a defendant's primary negligence." *Coleman v. Soccer Ass'n of Columbia*, 432 Md. 679, 696 (2013) (Harrell, J., dissenting) (Internal quotation marks and citation omitted).

ORDER

Having concluded that the grievance is without merit, I **ORDER** that it is **DENIED** and **DISMISSED.**

July 7, 2021
Date Decision Mailed

John T. Henderson, Jr.
Administrative Law Judge

JTH/emh
#193096

REVIEW RIGHTS

You are entitled to file a petition for judicial review with the circuit court for the county in which the institution you are confined is located within thirty (30) days of the mailing of the decision. Md. Code Ann., Corr. Servs. § 10-210(b) (2017); Md. Rules 7-201 through 7-210. A separate petition may be filed with the court to waive filing fees and costs on the ground of indigence. Md. Rule 1-325. This decision may only be reversed or modified on appeal if any substantial right may have been prejudiced because a finding, conclusion, or decision of the final decision maker: (1) is unconstitutional; (2) exceeds the statutory authority or jurisdiction of the final decision maker; (3) results from an unlawful procedure; (4) is affected by any other error of law; (5) is unsupported by competent, material, and substantial evidence in light of the entire record as submitted; or (6) is arbitrary or capricious. Md. Code Ann., State Gov't § 10-222(h)(3) (Supp. 2020). Judicial review of disputed issues of fact shall be confined to the record for judicial review supplemented by additional evidence taken. Md. Code Ann., State Gov't § 10-222(f)(1) (Supp. 2020). The Office of Administrative Hearings is not a party to any review process.

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