[redacted], DOC #[redacted],	*	**BEFORE LORRAINE FRASER,**
GRIEVANT	*	**AN ADMINISTRATIVE LAW JUDGE**
v.	*	**OF THE MARYLAND OFFICE**
THE MARYLAND DIVISION	*	**OF ADMINISTRATIVE HEARINGS**
OF CORRECTION	*	**OAH No.: DPSC-IGO-002V-23-21449**
	*	**IGO No. [redacted]**

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DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
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DISCUSSION
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ORDER

STATEMENT OF THE CASE

On February 3, 2023, the Grievant filed a grievance[1] with the Incarcerated Individual[2] Grievance Office (IGO).[3] In referring the matter to the OAH, the IGO prepared a summary of the grievance. At the hearing, I read the IGO's prepared summary to the Grievant and asked the Grievant to advise if the Grievant agreed with the IGO's summary.

[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] Effective October 1, 2023, "in every law, executive order, rule, regulation, policy, or document created by any official, employee, or unit of this State, inmates are renamed incarcerated individuals." 2023 Md. Laws 721. Although the applicable regulations and some statutes have not yet been updated to reflect this change, for consistency, the term "incarcerated individual" is used throughout this decision.

[3] The IGO is part of the Department of Public Safety and Correctional Services (Department). Md. Code Ann., Corr. Servs. § 2-201(12) (Supp. 2023). The IGO receives complaints from incarcerated individuals and refers those not found "wholly lacking in merit" to the Office of Administrative Hearings (OAH) for hearings. *Id.* § 10-207(c)(1) (2017).

> On October 8, 2022 around [redacted] am, the Grievant was in the process [of] entering his cell for lock down, when his wheel chair became stuck in the doorway. He alleges that CO II [redacted] [[redacted]], who was in charge of closing the cell doors, failed to [ensure] that the doorway was clear resulting in injuries to his right shoulder and neck. This dereliction of duty caused him pain and severely limited his range of motion. The Grievant asks for unspecified compensation and medical treatment for his injury and demands that CO II [[redacted]] be assigned to a different post to include training in the protocols for closing cell doors.

The Grievant agreed with the summary.

On September 5, 2023, I held a hearing via videoconference. Md. Code Ann., Corr. Servs. § 10-207(c)(2) (2017);[4] Md. Code Ann., State Gov't § 10-211 (2021); and COMAR 28.02.01.20B(1)(b). I was located at the OAH, and the parties were at [redacted] ([redacted]), a facility of the Division of Correction (DOC). The Grievant represented himself. [redacted], Correctional Case Management Specialist II, [redacted], represented the DOC.

The contested case provisions of the Administrative Procedure Act, the IGO's General Regulations, and the OAH's Rules of Procedure govern procedure. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2021 & Supp. 2023); COMAR 12.07.01; and COMAR 28.02.01.

ISSUES

Did the officer operating the Grievant's cell door act negligently on October 8, 2022 and was the Grievant injured as the result of the officer's negligence? If so, what remedy is available to the Grievant?

SUMMARY OF THE EVIDENCE

Exhibits

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

[4] Unless otherwise noted, all references to the Correctional Services Article are to the 2017 Volume of the Maryland Annotated Code.

IGO Ex. 1 Request for Administrative Remedy, 10/8/22; Receipt of Warden's Response, 11/17/22; received 12/1/22
IGO Ex. 2 Warden's Response, 11/14/22
IGO Ex. 3 Appeal of Administrative Remedy Response, 11/19/22
IGO Ex. 4 Commissioner's Response, 1/5/23
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IGO Ex. 16 Prehearing request from the Grievant, 8/10/23
IGO Ex. 17 Second Supplemental Prehearing Order, 8/11/23

I admitted the following exhibits offered by the DOC:

DOC Ex. 1 Medical Report, 8/2/23
DOC Ex. 2 Administrative Remedy Procedure Case Summary, 11/10/22; Information Report Form, 10/31/22
DOC Ex. 3 Results of MRI of the Grievant's left shoulder, 1/30/23
DOC Ex. 4 Medical Records from the Grievant's electronic patient health record, 10/6/22-6/19/23, 326 pages
DOC Ex. 5 Sick call requests from the Grievant, 10/3/22-6/6/23, 99 pages
DOC Ex. 6 Photograph of a wheelchair in the doorway to a cell at [redacted]
DOC Ex. 7 Photograph of a wheelchair with a measuring tape, showing width 30 ½ - 31 inches
DOC Ex. 8 Video showing a cell door closing on a wheelchair in a cell doorway

I admitted the following exhibit offered by the Grievant:

Griev. Ex. 1 Medical Report, 8/30/22; Medical Report, 8/31/23

Testimony

The Grievant testified and presented the following witnesses: Correctional Officer II [redacted]; and [redacted], an incarcerated individual assigned to push the Grievant in his wheelchair.

[redacted], Correctional Case Management Specialist II, [redacted], testified for the DOC.

FINDINGS OF FACT

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

1. On October 8, 2022, and at all times relevant to this proceeding, the Grievant was housed at [redacted], a DOC facility.

2. On October 8, 2022, the Grievant was returning to his cell on Housing Unit #[redacted] in a wheelchair. [redacted] was pushing the Grievant in the wheelchair.

3. The wheelchair the Grievant was using was assigned to Housing Unit #[redacted], not to the Grievant individually.

4. Correctional Officer II [redacted] was operating the control panel for Housing Unit #[redacted]. Officer [redacted] opened the cell door for the Grievant, saw the Grievant stand up and walk into his cell, and hit the close button on the panel to close the door.

5. The Grievant then walked back into the cell doorway to pull the wheelchair into the cell and the cell door closed on the Grievant. [redacted] alerted correctional officers that the door had closed on the Grievant. Officer [redacted] immediately opened the cell door.

6. Cell doors make an audible click and then a hissing noise as they slowly close. Cell doors stop if they hit something while closing although they maintain pressure.

7. On October 17, 2022, the Grievant was examined by a registered nurse. He reported that he had been shut in a cell door and injured his shoulder. He refused to allow the nurse to examine his range of motion saying that it was painful. He was referred for further evaluation.

8. On October 18, 2022, the Grievant was examined by a registered nurse. He reported arm and shoulder pain and requested to see Dr. [redacted].

9. On November 7, 2022, the Grievant was examined by a registered nurse for regular wound care.

10. On November 13, 2022, the Grievant was examined by Dr. [redacted] for wound care. The Grievant did not report shoulder and arm pain to Dr. [redacted].

11. On November 14, 2022, the Grievant was examined by a registered nurse. He requested to see Dr. [redacted] to get pain medication. He did not specifically mention shoulder and arm pain.

12. On November 23, 2022, the Grievant was examined by a registered nurse. He requested Dove soap.

13. On November 24, 2022, the Grievant was examined by a registered nurse. The nurse noted he did not have the correct wound dressing on his legs and he said he had removed it. He requested tape, which was denied.

14. On November 28 and December 1, 2022, the Grievant was examined by a registered nurse and received wound care.

15. On December 3, 2022, the Grievant was examined by Dr. [redacted]. The Grievant reported left shoulder pain from a fall in the spring of 2022 and right shoulder pain from getting caught in a cell door in October 2022. He described the pain as moderate and exacerbated by movement. Dr. [redacted] also addressed the Grievant's other chronic medical conditions. Dr. [redacted] noted the Grievant had a history of hoarding pain medications and not taking pain medication as prescribed. He ordered a right shoulder x-ray and follow up.

16. The Grievant continued to receive medical care on a regular basis approximately twice per week.

17. On December 30, 2022, the Grievant was examined by a registered nurse. He complained of pain in his legs, feet, and shoulders. The nurse did not observe any bruising on his right shoulder and did not hear or feel a pop on his left shoulder as he claimed. He requested [redacted] which was denied.

18. On January 25, 2023, the Grievant was examined by Dr. [redacted] and treated for his chronic conditions. He complained of pain in his left shoulder but not his right shoulder.

19. On April 28, 2023, the Grievant was examined by Dr. [redacted]. He complained of pain in his left shoulder and right hand.

20. On June 5, 2023, the Grievant was examined by a registered nurse. He complained of pain in both of his shoulders for two years. He claimed that his shoulders had not been examined in two years. He refused to lift his arms so that the nurse could assess his range of motion, claiming that it hurt too much.

DISCUSSION

In a 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 12.07.01.08A(1), C(1). To prove an assertion or a claim by a preponderance of the evidence means to show that it is "more likely so than not so" when all the evidence is considered. *Coleman v. Anne Arundel Cnty. Police Dep't*, 369 Md. 108, 125 n.16 (2002). 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 asserted that he was attempting to pull the wheelchair into his cell when the cell door closed on him. He claimed his right shoulder was pushed into the frame of the door. He maintained that it takes time to enter and exit his cell. He argued that it was Officer [redacted]'s responsibility to ensure he was in the cell before closing the door. He asserted that he did not receive any medical care for his shoulder. He claimed the door can crush a person and inflict serious injury.

The DOC argued that Officer [redacted] did not breach his duty of care to the Grievant. The DOC maintained that Officer [redacted] watched the Grievant walk into his cell before closing the cell door. The DOC claimed that the Grievant put himself at risk when he stepped back into the doorway. The DOC asserted that the Grievant did not have a wheelchair assigned to him personally that he kept in his cell; rather, he used a wheelchair assigned to the housing unit when he left his cell. The DOC maintained that the Grievant has received medical attention several times per week for regular care of his chronic health conditions, relying on eight months of medical records. The DOC noted the Grievant was examined several times for his reported right shoulder pain but no injury was documented by medical staff.

I find that Officer [redacted] did not breach his duty of care to the Grievant. I found Officer [redacted]'s testimony and report credible that he saw the Grievant walk into his cell before closing the door. The documentation presented shows the Grievant used a wheelchair; however, it does not show the Grievant was authorized to keep a wheelchair in his cell. Rather, the Grievant was to use a wheelchair assigned to his housing unit when he left his cell. There is no evidence that Officer [redacted] was negligent. The evidence shows that the Grievant walked into his cell then returned to the doorway after the cell door started to close. The cell door makes an audible click

and hissing noise when closing and it closes slowly. The Grievant could have removed himself from the doorway. Instead, the Grievant attempted to bring the wheelchair into the cell. Officer [redacted] immediately opened the Grievant's cell door once he was alerted that the door had closed on the Grievant.

I further find that the Grievant was not denied medical care for any alleged injuries to his right shoulder and arm. The Grievant's medical records show that he has received medical care on a weekly basis, his right shoulder and arm have been examined repeatedly, and no injuries have been identified.

Therefore, I find that the Grievant has not met his burden and his grievance should be dismissed.

CONCLUSION OF LAW

I conclude as a matter of law that the officer operating the Grievant's cell door did not act negligently on October 8, 2022 and the Grievant was not injured as the result of the officer's negligence. COMAR 12.07.01.08A(1), C(1), (2).

ORDER

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

[redacted]
Signature Appears on Original

November 22, 2023
Date Decision Issued

Lorraine Fraser
Administrative Law Judge

LF/lp
#208552

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) (2021). 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) (2021). The Office of Administrative Hearings is not a party to any review process.

Copies Mailed To:

[redacted]

[redacted]

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