

IN THE CIRCUIT COURT OF FORREST COUNTY, MISSISSIPPI

JESSIE LEE JOHNSON

PLAINTIFF

VERSUS

CAUSE NO. 1999-0176

FORREST GENERAL HOSPITAL

DEFENDANT

**FINDINGS OF FACT AND CONCLUSIONS OF LAW**

THIS CAUSE came before the Court on the trial of this matter without a jury pursuant to Miss. Code Ann. §11-46-13(1), and the Court, having heard the evidence in this matter, finds as follows, to wit:

**FINDINGS OF FACT**

Jessie Lee Johnson (hereinafter, plaintiff) underwent a knee replacement surgery to her left knee on August 25, 1998, which was performed at Forrest General Hospital (hereinafter, defendant) by Dr. William Morrison. After an apparently successful surgery, the plaintiff was transferred to the rehabilitation unit. The crux of this case concerns an injury suffered by the plaintiff either on the evening of September 7, 1998, or the morning of September 8, 1998, which caused a dislocation of the knee. Subsequent to this event, the plaintiff suffered numerous dislocations requiring a surgery to reduce the dislocation (these occurred on 10/5/98, 11/6/98, 11/30/98, 2/1/99, 2/19/99 and 3/3/99 as reflected in Exhibit D-16). Eventually, a new apparatus was installed in the plaintiff's knee on March 3, 1999. However, the plaintiff ultimately contracted an infection in the knee that could not be cured resulting in an above the knee amputation of the left leg.

There is no disagreement that the plaintiff's knee was dislocated on September 7

or 8 of 1998. The mystery surrounds how the plaintiff's knee became dislocated. The plaintiff, who is now deceased, offered testimony through her deposition which was taken on August 10, 2000. According to her testimony she was being moved back into her room in a wheelchair on the evening of September 7, 1998. An aide, Twila Sanders-Nash, came around asking if anyone needed to use the restroom before turning in for the night. The plaintiff did, so the aide removed the left foot rest on the wheelchair she was in and backed into the restroom.

After helping the plaintiff on and then off of the toilet, the aide began pushing the wheelchair out of the restroom. It was at this point that the plaintiff caught her foot under the wheelchair when they neared the door. When her leg got caught she testified that she hollered and the aide stopped. She told the aide she hurt her leg. The aide apologized and then helped the plaintiff into her bed for the night. Because of the pain she was having from the injury a nurse gave her a pill and a shot. She testified that she did not get out of bed the next morning until the doctor came to see her.

Dr. Morrison, who performed the knee replacement surgery, testified that the surgery went as expected and had a good result. Referring to exhibit P-18 Dr. Morrison said the apparatus used was in good position and had good alignment. After surgery the plaintiff was transferred to begin the rehabilitation process. According to the evidence presented the rehabilitation process was going well for the plaintiff. It was some twelve or thirteen days after the surgery that this incident occurred.

Dr. Morrison testified that the description of the incident by the plaintiff was consistent with the injury he saw where the femur is displaced forward over the tibia. It takes a force similar to one that would be experienced if a patient's leg were caught under a wheelchair and

had that type of backwards force placed on her lower leg. He described the injury as one that would be very painful and would make it more likely to suffer subsequent dislocations because of the disruption of the joint. He also found it hard to believe that the plaintiff would have been able to sleep through the night of September 7, 1998, without some pain medication after a dislocation such as this. There were several subsequent dislocations of the plaintiff's knee requiring operations to reduce and immobilize the dislocation. On February 9, 1999, she had a dislocation after which he installed a different polyethylene in the apparatus. Another dislocation occurred on February 19, 1999.

On March 3, 1999, another dislocation occurred. At this time she came to the defendant's emergency department and was treated by Dr. Moore, who assumed her treatment from that point forward. Dr. Moore installed a hinged knee replacement device that offered more stability in the joint. At that time there was no infection present in the knee. Dr. Morrison described each of the dislocations as very painful events. He also described the negative effect the whole process had on the psychological well-being of the plaintiff. Dr. Moore further testified that even though the plaintiff had other health issues such as diabetes, vascular problems and heart issues, they played no role in the subsequent loss of the plaintiff's leg. His opinion was that the initial dislocation of the knee made it more susceptible to future dislocations and started this chain of events.

Linda Thomas was one of the nurses on staff with the defendant who worked the 7 a.m. to 7 p.m. shift. She reported to work on the morning of September 8, 1998. As was usual, she discussed the patients on the floor with Tracey Gandy, the 7 p.m. to 7 a.m. nurse on duty. She was told by Gandy that the plaintiff complained to her about a pop she felt in her knee, and she was given pain medication at that time. The patient medication administration record, exhibit D-

2, shows that from 8 a.m. on September 7, 1998, until 8 a.m. on September 8, 1998, the only medication for pain was demerol 50 m.g. and finnergin 25 m.g. given at 7:30 a.m. on the morning of September 8, 1998.

Thomas assessed the plaintiff in the dining room. She was taken back to her room and placed in her bed. She was not able to tell just by observation that the plaintiff's knee was dislocated. The patient flow sheet, exhibit D-3, shows that the plaintiff was alert and oriented, but forgetful on the morning of September 8, 1998. The rehab nurse's note, P-27, shows that the knee was observed to be a +3 +4 with regard to swelling. Thomas paged a doctor to notify them of the situation so they could make an assessment. After that Josie McCorkle, patient care manager for the rehabilitation unit, arrived to speak to the plaintiff. She was told the same story about the wheelchair incident. Twila Sanders-Nash, the nurses aide who transported the plaintiff in to the bathroom, was in the room at that time and denied the incident occurred. When discussing the matter with Sanders-Nash, she stated that no accident had happened and that both foot rests were on the wheelchair when she transported the plaintiff.

McCorkle testified that she was asked to check on the patient by Thomas. She arrived between 7:30 a.m. and 7:45 a.m. on September 8, 1998. At that point the plaintiff relayed the story to her regarding the wheelchair incident. On observation she could not tell that the knee was dislocated, but there was abnormal swelling noticed. Based on the plaintiff's story McCorkle had Thomas write a report on the incident. The report was sent to the defendant's risk management division. Sanders-Nash was suspended for two or three shifts while they investigated.

McCorkle also testified regarding a late entry into the nursing notes made by Gandy in

exhibit P-24. She stated that documentation should be made in the nurse's notes when medications are administered. Here, she said Gandy made no such notation in her notes. She called Gandy and told her to make an entry to document why certain medication was given because all the medication administration chart shows is what medication is given. Based on everything McCorkle knew of the incident, she could not state how, when or even if the accident actually occurred.

Twila Nash-Sanders testified to her recollection of the incident. She recalled that on the evening of September 7, 1998, she gave the plaintiff a bath around 7 p.m. or 8 p.m. She next recalled taking the plaintiff to the bathroom around 4 a.m. on the morning of September 8, 1998. She testified that she would have had no reason to transport the plaintiff in a wheelchair without the footrests in place. She did not recall anything out of the ordinary with the trip to the bathroom at that time. She returned to the plaintiff's room around 5:30 a.m. to get her up and dressed for the day. She still noticed nothing out of the ordinary. She next saw the plaintiff at 6:30 a.m. when she was asked to see about getting some pain medication. The plaintiff did not seem distressed at that time.

Trahan, an R.N. for seventeen years, was offered in the plaintiff's case in chief as an expert in the field of nursing. According to her testimony the standard of care applicable to wheelchair transport of a patient such as the plaintiff would be to have the leg rests on the wheelchair. The left leg had recently undergone surgery and required the support offered by the footrest. Leaving a footrest off or even moved out of the way would fall below the standard of care in this case.

She further testified regarding the late entry into the nurse's notes by Gandy. After her

review of the records in this matter, it was Trahan's opinion that a late entry should not have been done in this case. Because of the significant nature of the event, it was her opinion that a contemporaneous notation should have been made in exhibit P-24. Even though the defense may claim that the incident occurred the night before but was not reported by the plaintiff until the next day, it was reported to Gandy before her shift ended leaving no need to make the documentation the next day.

Trahan also commented on the apparent confusion of the plaintiff, especially that exhibited in her deposition. She was aware of the notations in the medical records regarding the plaintiff's forgetfulness at times; however, she was also noted to be alert and oriented. She based her opinions mainly on the medical records and what they revealed and did not rely as heavily on the deposition testimony to form her opinions. Trahan noted that at the time of the plaintiff's deposition in August of 2000, she had undergone several surgeries, including an above the knee amputation in May of 1999. Due to the plaintiff's condition there was a noticeable difference in the mental capabilities of the plaintiff reflected in the medical records and her ability to recollect events demonstrated in her deposition.

The plaintiff's son, Chester Johnson, testified regarding the incident, the life his mother led before the incident and the effect it had on her until her death. She was born in 1929 and was married for about 21 or 22 years. Her husband died in 1972. She was very active in her yard, kept a garden and stayed busy with work for her church. While she may have had other health issues such as diabetes or high blood pressure, those conditions did not keep her from maintaining her normal activities.

In November, 1997, she underwent a right knee replacement. She completed her physical

therapy and had a very good result from that surgery. Following that surgery she was able to return to her activities just as she been doing in the past. After the left knee replacement in August, 1998, she began her physical therapy just as before and was progressing very well. After the wheelchair incident, all that changed

Johnson testified that his mother had numerous dislocations. She had to be taken into surgery after each one and had to maintain some form of physical therapy. With the number of trips in and out of surgery it began to take a toll on her both physically and mentally. The final result was an above the knee amputation. Although she was fitted for a prosthesis, it never worked right. She could not get around on her own, her pain was constant, as if the leg was still there (phantom pain as it was described by witnesses). She was not able to carry on her normal activities; she could not keep up a garden or participate in church activities to the extent she had in the past.

He further explained that there was some confusion on his mother's part during her stay at the hospital and at her deposition. It was logical to him that it was because of the drawn out process of the left knee replacement, even more so at her deposition after she had gone through the amputation. However, he testified that on morning of September 8, 1998, he was called by someone at the hospital about the incident. When he arrived at his mother's room, she told him that they hurt her when she caught her leg under the wheelchair when she was taken to the bathroom.

Dr. Guy Vise testified as an expert on behalf of the defendant in this matter. Dr. Vise is a board certified orthopaedic surgeon who reviewed this matter. According to Dr. Vise the type of injury suffered by the plaintiff was a posterior dislocation, which is the most common type of

dislocation with a knee replacement. He described the injury as being extremely painful and taking a fair amount of force to accomplish.

Dr. Vise was critical of the installation of the knee replacement apparatus. According to his testimony, the tibial surface was not prepared correctly because it was sloped forward at about a five degree angle when it should have been level or sloped slightly to the rear. The tibial implant was likewise incorrect. It sat back from the front edge of the tibia as demonstrated in Exhibit P-19, too far back on the back edge of the tibia as in Exhibit P-19 and the stem of the implant was too far to the rear shown in Exhibit D-17. With the substandard installation it was Dr. Vise's opinion that the knee was much more susceptible to dislocation when coupled with the overall condition of the plaintiff in the first place. He further opines that with this installation, the knee could have dislocated even without trauma. The fact that there were multiple dislocations, he opines, support his conclusions.

Concerning the dislocation of the knee in the hospital, Dr. Vise opined that the event could not have occurred as described by the plaintiff. With the type of event described, Dr. Vise said that there would be too much pain and discomfort for someone to be able to sleep through the night without substantial pain medication. There is no indication in the medical records of the plaintiff asking for pain medication until the morning. There would also be evidence found in the vital signs such as an increase in blood pressure or heart rate. Based upon the information contained in the records, it was Dr. Vise's opinion that the dislocation would have occurred sometime in the morning of September 8, 1998. Furthermore, Dr. Vise stated that the recurrent dislocations were not necessarily the cause of the amputation. He said that more of the cause was due to the plaintiff's other underlying health issues such as diabetes, heart disease and smoking.

The plaintiff introduced medical bills they claim were incurred as a result of the knee dislocations and resulting amputation. (See Exhibit P-4). Those medical bills combine for a total of \$199,789.54 in medical expenses. They also offered testimony regarding the pain and suffering and mental anguish the plaintiff had to endure throughout this process until she passed away.

### CONCLUSIONS OF LAW

“The Mississippi Tort Claims Act provides the exclusive remedy for a party injured by a governmental entity's tortious acts or omissions.” *Schepens v. City of Long Beach*, 924 So. 2d 620 (¶11) (Miss. App. 2006). Here, there is no dispute that the defendant is a governmental entity, and the Tort Claims Act applies.

“A claim of negligence has four elements: duty, breach, causation, and damages.” *Price v. Park Management, Inc.*, 831 So.2d 550( 5) (Miss.Ct.App.2002). To establish a claim of negligence, the plaintiff must offer proof by a preponderance of the evidence on each of the elements. *K-Mart Corp. v. Hardy ex rel. Hardy*, 735 So.2d 975( 14) (Miss.1999).

In the case at bar, the plaintiff claims that a nurse's aide caused her foot to catch underneath a wheelchair as she was exiting the bathroom which dislocated her left knee. The left knee underwent replacement surgery about twelve or thirteen days earlier, and the plaintiff was in the physical therapy phase of her recovery. In order to prevail on this claim the plaintiff had the burden to prove the defendant's duty, how they breached that duty, how that breach caused the injury suffered and the damage that resulted.

The plaintiff offered evidence through her pretrial deposition of how the incident occurred. She offered the only firsthand account of the mechanism of her injury. The nurse's

aide, of course, denied that any incident happened at all. Even though the plaintiff may have demonstrated some confusion in her testimony, the facts regarding how she was injured remained relatively consistent each time she described the incident. The state of the nursing notes, in particular the late entry found in Exhibit P-24), left a question as to their accuracy considering they were not necessarily done contemporaneously with the events as they happened.

The best, and more credible, evidence of the event is that of the plaintiff. Her testimony, along with the nurses' notes and testimony from other witnesses who were told of the incident immediately thereafter, lend credence to the plaintiff's story with regard to how the incident happened. Even though she may have been confused about the timing of the incident, the proof introduced at trial makes it evident that this incident occurred in the early morning hours (probably during the trip to the bathroom that occurred at approximately 4:00 a.m., September 8, 1998).

With those facts in mind, the plaintiff proved by a preponderance of the evidence that there was a duty owed by the defendant. In this case that duty was for the nurses' aide to transport the plaintiff in a wheel chair with the foot rests in place, especially on the left side to support the surgical knee.

The proof here showed by a preponderance of the evidence that the foot rest on the left side was not in place, thus allowing the plaintiff's foot to become lodged underneath the wheelchair and dislocating the left knee. This action fell below the applicable standard of care shown by the evidence before the Court and was a breach of the duty owed by the Hospital to the plaintiff.

The plaintiff, having demonstrated a duty and breach of duty by a preponderance of the

evidence, offered evidence via expert testimony that the breach by the hospital did lead to the injuries suffered by the plaintiff. The testimony offered by the plaintiff's experts on this issue was compelling and credible. The evidence adduced at trial leads to the conclusion that the wheelchair incident started this concatenation of events that eventually led to the amputation of the plaintiff's left leg above the knee.

The last of the elements was well established by the evidence. The medical expenses totaled \$199, 789.54. The pain and suffering was well documented by both the testimony of the plaintiff, her son and the doctors who testified and the medical evidence presented by way of the charts, notes and records compiled throughout the plaintiff's medical treatment. They also testified as to the toll these events took on the psychological well being of the plaintiff.

Determining awards in personal injury cases "is one of the most troublesome questions with which the courts have to struggle." *Peerless Supply Company v. Jeter*, 218 Miss.61, 65 So.2d 240, 243 (1953). Each case must depend upon its own facts, as there exist no yardstick or measurement with which to gage an award. *Id.*

The amount of physical injury, mental and physical pain, present and future, temporary and permanent disability, medical expenses, loss of wages and wage-earning capacity, sex, age and health of the injured plaintiff, are all variables to be considered by the jury in determining the amount of damages to be awarded.

*Woods v. Nichols*, 416 So.2d 659, 671 (Miss.1982). Ms. Johnson has no claim for loss of wages or wage earning capacity, and was obviously plagued by pre-existing, but not debilitating, medical conditions.

Having considered these factors, and based upon a preponderance of the credible

evidence presented at trial, the Court finds that the defendant acted in a negligent manner which resulted in an injury and damages to the plaintiff for which she should be compensated. The damages proven in this matter are medical expenses in the amount of \$199,789.54 and pain and suffering during at least seven dislocations and a resulting above-the-knee amputation in the amount of \$380,000.00, for total damages of \$579,789.54.

A final judgment will not be entered at this time as all issues have not been resolved. The court invites the parties to brief their arguments regarding recoverable damages, considering the applicability of the Tort Claims Act damages cap, limits of insurance coverage, if any, or other matters that may impact the amount and entry of a final judgment. Briefs should be submitted within twenty (20) days of the date hereof, and should further hearings be necessary same will be scheduled in due course.

**SO ORDERED AND ADJUDGED**, this the 14<sup>th</sup> day of April, 2010.

  
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CIRCUIT COURT JUDGE