



IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA,)
HUNTER, ATTORNEY GENERAL OF)
OKLAHOMA,)

Plaintiff,

v.

PURDUE PHARMA L.P., et al)
Defendants.)

Case No. CJ-2017-816

Honorable Thad Balkman

Special Discovery Master
William C. Hetherington, Jr.

PURDUE'S MOTION TO COMPEL WITNESS TESTIMONY

Purdue Pharma, L.P., Purdue Pharma Inc., and The Purdue Frederick Co. (collectively "Purdue") respectfully move to compel discovery pursuant to 12 Okla. Stat. § 3237. Purdue seeks an order that requires the State to present a properly educated and prepared corporate representative to testify as to the following topic:

The standards, practices, and procedures during the Relevant Time Period for the diagnosis and treatment of pain and for the use of opioid medications and opioid alternative medications for persons in the care and custody of the Oklahoma Department of Corrections.

Purdue previously issued a deposition notice to the State for testimony on this topic pursuant to 12 Okla. Stat. § 3230(C), but the State failed to comply with the notice. Instead, the State presented a witness who was not educated on the subject and was not adequately prepared to testify as a result. Purdue moves the Court for an order that requires the State to present a corporate representative who prepares for the deposition in advance by educating him or herself on the relevant standards, practices, and procedures of the Department of Corrections ("DOC") as to treatment of pain and use of opioids and opioid alternatives in advance of the deposition.

BACKGROUND – MR. CASTLEBERRY’S TESTIMONY

Given the State’s claims in this case, it is crucial to Purdue’s defense that it be able to investigate whether the State was actually misled by any of Purdue’s actions, and whether the state paid for medically unnecessary or excessive opioid prescriptions. In order to allow Purdue to fairly develop a defense, discovery regarding how the State makes medical decisions for its citizens and those in its care is required. The State administers medical and pharmaceutical benefits to various segments of the Oklahoma population, including state employees, state-run Medicaid recipients, and inmates housed in the state’s detention facilities. As it relates to inmates, the DOC “provides direct medical care to over twenty thousand incarcerated inmates and oversees the medical care of DOC inmates housed in private prisons.”¹ Discovery of the DOC’s standards, practices, and procedures as they relate to pain treatment and opioids, therefore, is essential to Purdue’s case.

Early in this case, Purdue sought DOC-related discovery, including documents from the DOC. In response, the State claimed that the DOC did not have policies concerning opioid medications because the DOC does not prescribe opioids to inmates:

With respect to Corrections, there – there are no prescription claims for opioids there. ... [O]n the just prescriptions standpoint, I mean, it’s our understanding that there just aren’t any, they don’t administer opioids to prisoners I think for the very simple reason that they don’t want to give imprisoned individuals mind-altering narcotics.

Ex. A, Transcript of April 10, 2018 Meet and Confer at 29:15-30:1-3. Nevertheless, Purdue pursued the requested discovery, and on May 15, 2018 issued a deposition notice to the State for testimony on the DOC’s standards, practices, and procedures as they relate to pain treatment and

¹ See, <http://doc.ok.gov/health-services> (last accessed 10/4/2018)

opioids. Ex. B. Following service of Purdue's deposition notice, the State had had almost *five months* in which to prepare its corporate representative.

On September 5, 2018, the State presented Clint Castleberry, the Director of the DOC's Health Services, for a deposition on the noticed topic, to which the State had no objection. Yet Mr. Castleberry was not adequately prepared to testify on the topic. Mr. Castleberry spent "six to eight" hours preparing for his deposition (Ex. C, September 5, 2018 Deposition Transcript of Clint Castleberry at 83:22-84:2), but he acknowledged that he did not prepare himself by spending substantive time with the DOC's Chief Medical Officer or the DOC's Pharmacist—two individuals he repeatedly noted would be the sources of information related to opioids and pain treatment that he did not have.² Mr. Castleberry testified that he asked the Chief Medical Officer "[j]ust question[s] [about] how medications were on the formulary, what his role was in the pharmacy and therapeutics committee." *Id.* at 24:20-22. As for discussions with the DOC's pharmacist, perhaps the most informed individual on the DOC's prescription opioid policies, Mr. Castleberry testified his conversation with her in preparation was "minutes" long. *Id.* at 24:2-6.

² See, Ex. C, at 27:9-17; 37:3-13; 39:25-40:8; 48:4-9; 53:19-23; 56:20-57:1; 58:23-25; 87:4-10; 110:3-9; 124:21-125:5; 134:24-135:8; 136:8-20; 154:3-16; 169:24-170:7; and 260:3-261:25.

This lack of preparation rendered the deposition almost fruitless.³ At the outset, although the Special Discovery Master has determined, at the State's urging, that the relevant time period in this case dates back to 1996, the witness was unable to testify as to any DOC policies prior to 2018, much less those in existence over two decades ago:

Q. Well, when you were preparing for this deposition what did you use as the relevant time period?

A. I used our most recent information, formulary and policies and procedures.

Q. And that was just this year. Right?

A. Correct.

Q. Nothing prior to 2018?

A. Not to my recollection.

Q. So in your preparation you did not endeavor to find out any information prior to January 1st, 2018. Correct?

A: Yes.

³ The deposition was not completely fruitless in that it revealed that the State's prior claim that the DOC does not prescribe opioids was demonstrably false:

Q. So if somebody were to say that opioids are not prescribed or administered in Department of Corrections' facilities, that would be categorically wrong, wouldn't it?

A. Correct.

Q. [T]here's no policy or procedure that you're aware of, and that's what you're going to testify, that says we don't allow prisoners to have opioid prescriptions because they're mind altering narcotics, is there?

A. No, there is not.

Q. In all of your discussions and talking that would be categorically false, that statement?

A. Correct.

Ex. C, at 168:1-23.

Q. If you wanted to go prior to 2018 you certainly could have. Right?

A. Yes.

Q. So if I wanted to know anything about standards, policies, procedures prior to 2018 with respect to the diagnosis and treatment of pain, you would not be prepared to talk about that, would you?

A. No, I wouldn't.

Ex. C, at 74:23-75:6; 75:25-76:6. Nor did the witness review any DOC drug formularies prior to 2018 that contain opioid medications:

Q. Did you review the formularies prior to the most recent formulary in connection with your preparation today?

A. No.

Ex. C, at 34:16-19. As a result, the witness had no knowledge of key prescription opioids whatsoever:

Q. Do you have any idea whatsoever whether there was -- Oxycontin was ever on the formulary for the Department of Corrections?

A. Do not know.

Q. Never asked anyone about that?

A. No.

Ex. C, at 53:13-18.

After several breaks, the State attempted to rehabilitate the witness on re-direct. Contrary to his earlier testimony, Mr. Castleberry suggested that he was in fact prepared to testify as to the DOC's prior operating procedures. *Id.* at 253:4-7. Upon re-cross, however, it was established that Mr. Castleberry was only prepared to testify as to whether earlier policies *existed*, not as to what they were. He once again repeated that he was not prepared to testify as to anything related to the topic prior to 2018:

Q. But are you prepared to testify for each of those policies what they were during the relevant period of time other than the most recent?

A. No.

Ex. C, at 255:25-256:3. It turns out that, rather than educate himself on pre-2018 policies, Mr. Castleberry made an email request to the DOC's "policies and procedures" unit for prior policies, received them as attachments in an email, and then, *without even reviewing the policies*, forwarded them to the State's attorneys:

Q. So tell me what you did to educate yourself about policies and procedures, let's start with 1995. What were the policies and procedures then and how are they different with the present?

A. The request that I made to our policies and procedures unit was as far back as they could within the existing policies and procedures pertaining to the subject heading and get anything as far back to Adam that existed. Those were collected, cursorily reviewed in terms of whether they existed or not and then e-mailed to the attorneys.

Q. Were those brought here today?

A. The historical, no, just the most current ones.

Q. Those were provided to your attorneys?

A. The historical versions of procedures, yes, a listing of them and the attachments.

Q. And so you did a cursory review of all of those?

A. In terms of they existed and how far back they could go were included in each of the e-mails.

Q. Okay. So with respect to those your testimony is for each of those you asked to go back to 1995 or 1996 and reviewed all of the iterations?

A. Did not review every iteration, no. My request was do we -- do we have these policies, if we have these policies please forward them to me. Looked at the e-mail to see if there were attachments if they could be produced from the procedures and then forward them onto the attorneys.

Ex. C, at 253:22-255:18.⁴

Beyond his failure to educate himself on prior policies, Mr. Castleberry's testimony was deficient in every other substantive category of the deposition topic. For example, Mr. Castleberry's cursory discussions with the DOC Chief Medical Officer and Pharmacist did not educate Mr. Castleberry on a prime subject of the deposition:

Q. So if you wanted to find out what opioid alternative medicines, medications meant or might have meant, you -- you would have talked to the chief medical officer about that. Right?

A. Potentially, yes.

Q. And/or the pharmacist. Right?

A. Potentially, yes.

Q. And you didn't do that?

A. No.

Q. So therefore you wouldn't be the right person for me to ask questions about opioid alternative medications because you're not familiar with that term. Fair?

A: Not beyond the two examples I gave you.

Ex. C, at 81:19-82:12.

The witness did not educate himself on opioid medications that appear on the DOC's formulary, and repeatedly pointed to other DOC personnel as having the relevant knowledge called for by the deposition topic:

Q. If you wanted to know about policies and procedures and standards regarding the use of fentanyl, you're not the most knowledgeable person about that, are you?

A. Correct.

⁴ Although Mr. Castleberry testified that he forwarded prior DOC policies to attorneys for the State in advance of the deposition, those prior policies were not produced to the Defendants prior to the deposition.

Q. Who would -- who do you think would actually know some of those answers?

A. The chief medical officer and the agency pharmacist.

Ex. C, at 124:21-125:5.

Indeed, the witness did not know anything specific about opioid use at the DOC at all:

Q. Similar to the current opioids of which you don't know if any and how many opioid prescriptions were written, you have no information about the volume, scope or reasons for any opioid prescription written by a healthcare provider in the Department of Corrections within the last ten years, do you?

A. No.

Q. That's information that's obtainable if you were asked to do that?

A. Yes, to an extent.

Ex. C, at 176:1-12.

Ultimately, this case is about the use of prescription opioid medication. The deposition topic required a deponent familiar with the DOC's policies on prescription opioid medication. But Mr. Castleberry, by his own admission, knew nothing about prescription opioid medication:

Q. But as you sit here today you don't know anything about what opioids were prescribed, do you?

A. Outside of any that are listed in the formulary, other than we have the ability to prescribe them, no.

Q. Even, even the ones in the formulary, can you tell me anything about the frequency or the purpose for the prescriptions or the indications for which they were prescribed?

A. No.

Q. Can you even tell me that any of them were prescribed?

A. No.

Q. So, you would be speculating if you told me one or 10,000 or 500 because you have no idea as to whether opioids were prescribed or were not prescribed. Right?

A. Correct.

Ex. C, at 172:17-173:14.

Shortly after Mr. Castleberry's deposition, counsel for Purdue sent a letter to the State cataloging the many glaring deficiencies in Mr. Castleberry's preparation and testimony. *See*, Ex. D, September 14, 2018 letter from Cheffo to State's Counsel. In its response, the State brushed off the detailed examples of Mr. Castleberry's lack of preparation identified by Purdue, and primarily chose to attack an unrelated Purdue witness rather than defend Mr. Castleberry's testimony. *See*, Ex. E, September 17, 2018 letter from Leonoudakis to Cheffo. In the lone passage in the State's letter addressing Mr. Castleberry's preparation, the State cites only Mr. Castleberry's statement that he was prepared to testify as to the mere *existence* of prior DOC policies. But as noted, *supra*, Mr. Castleberry subsequently clarified that while he was aware the policies existed, he did not review them, and was therefore not prepared to testify about their substance. Ex. C, at 253:22-255:18. The State ignored that testimony in its letter. However, in a display of audacity, the State went on to chide *Purdue's counsel* for somehow choosing not to ask questions *about the very topics the witness repeatedly declared he was unfit to testify on*. Ex. E, at p.2.

ARGUMENT

Oklahoma's discovery code requires designated corporate representatives to testify "as to matters known or reasonably available to the organization." 12 Okla. Stat. § 3230(C)(5). The recipient of a deposition notice seeking corporate testimony has "an affirmative duty" to designate a knowledgeable representative, which includes an "obligat[ion] to make a conscientious good-faith endeavor to designate the persons having knowledge of the matters sought ... and to prepare those persons in order that they can answer fully, completely, unevasively, the questions posed." *ZCT Sys. Grp., Inc. v. Flightsafety Int'l*, 2010 WL 1541687, at *2 (N.D. Okla. Apr. 19, 2010).⁵

⁵ While Oklahoma courts have not clearly defined the requirements for such corporate testimony, Oklahoma Courts "may look to discovery procedures in the federal rules when construing similar

Further, “[i]f the organization fails to produce a designee with sufficient knowledge, it is required to produce an additional designee with adequate knowledge.” *Id.* And even if a party, in good faith, *thought* its designee would satisfy a deposition notice, “it ha[s] a duty to substitute another person once the deficiency of its [corporate representative] designation became apparent during the course of the deposition.” *Marker v. Union Fid. Life Ins. Co.*, 125 F.R.D. 121, 126 (M.D.N.C. 1989). “An inadequate [corporate representative] designation amounts to a refusal or failure to answer a deposition question.” *Id.* at 126; *see also*, 12 Okla. Stat. §3237(A)(2) (“If a deponent fails to answer a question propounded or submitted...the discovering party may move for an order compelling an answer.”)

The transcript of Mr. Castleberry’s deposition is clear and conclusive. He repeatedly could not answer basic questions about the subject of the deposition. He repeatedly noted that he could have educated himself on the topic but failed to do so. The information needed to address the deposition topic fully was available to Mr. Castleberry, either in documents Mr. Castleberry could have reviewed or through discussions with the DOC Chief Medical Officer and the Pharmacist. He did not take advantage of those resources. When the State was made aware of the obvious deficiencies in Mr. Castleberry’s preparation, it chose to blame the defense rather than meet its duty to remedy his lack of education on the subject. It is clear that the State has chosen to abdicate its affirmative duty to provide educated corporate representative testimony and comply with the Oklahoma discovery rules.

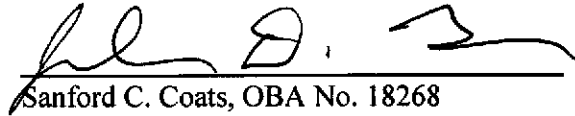
language in the Oklahoma Discovery Code.” *Crest Infiniti, II, LP v. Swinton*, 174 P.3d 996, 999 and n.4 (Okla. Oct. 10, 2007) (recognizing parallels between Oklahoma Discovery Code 12 Okla. Stat. § 3230(C)(5) and Fed R. Civ. P. 30(b)(6)).

CONCLUSION

The discovery sought is relevant and important to Purdue's defense and the State should be compelled to designate a new corporate representative who is properly educated and prepared on the deposition topic.

Date: October 4, 2018

Respectfully submitted,



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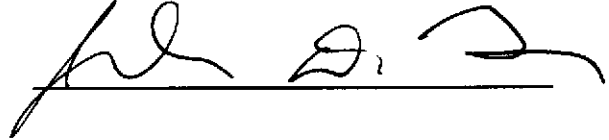
*Counsel for Purdue Pharma L.P.,
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CERTIFICATE OF SERVICE

I hereby certify that on this 4th day of October 2018, I caused a true and correct copy of the following:

PURDUE'S MOTION TO COMPEL WITNESS TESTIMONY

to be served via email upon the counsel of record listed on the attached Service List.

A handwritten signature in black ink, appearing to be 'P. D. Z.', is written over a horizontal line.

CERTIFICATE OF COMPLIANCE WITH 12 OKLA. STAT. § 3237(A)(2)

I hereby certify that counsel for Purdue has in good faith conferred with counsel for the State in an effort to secure the information that is the subject of this motion without court action. The parties were unable to reach a resolution.

A handwritten signature in black ink, appearing to be 'P. D. Z.', is written over a horizontal line.

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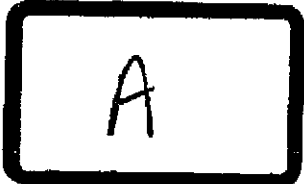
IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex	§
rel., MIKE HUNTER,	§
ATTORNEY GENERAL OF	§
OKLAHOMA,	§ Case No. CJ-2017-816
	§ Judge Thad Balkman
Plaintiff,	§
	§
v.	§ Special Master:
	§ William Hetherington
PURDUE PHARMA L.P., et	§
al.,	§
	§
Defendants.	§

DISCOVERY CONFERENCE BETWEEN THE PARTIES
(Via Telecommunications)
April 10, 2018

DISCOVERY CONFERENCE BETWEEN THE PARTIES, taken
in the above-styled and numbered cause on
April 10, 2018, from 3:05 p.m. to 3:54 p.m., reported
by machine shorthand by JOSEPH D. HENDRICK, CSR in and
for the State of Texas, and the following telephonic
proceedings were had, to-wit:

Job No. 2863506
Pages 1 - 39



1 three.

2 For Corrections, we do have some updated
3 information. And let me just say we're going to
4 provide you all of the information related to this.
5 We're not standing on any objections related to, for
6 instance, any redefinitions of terms that were used.
7 If there's information that's responsive to your
8 requests related to those three categories of documents
9 or information, we are going to produce it. Okay. So
10 that -- there was nothing intentional about not
11 including that in our original discussion. We were
12 just trying to understand the scope of your request,
13 which I think that we achieved that on our last meet
14 and confer.

15 [REDACTED]
16 [REDACTED]. Now,
17 there could be some situations where there are
18 inpatient -- you know, there's an inpatient, you know,
19 provision of an opioid medication, it's not a
20 prescription per se, and we are looking at those
21 records and anything related to that to see if there's
22 anything there we can produce. As far as addiction
23 treatment is concerned, another thing we are looking
24 into to see how that's handled and we are going to
25 provide any information there as well, [REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] But if there's

anything else that's provided in a different setting
but through Corrections, we're going to provide it.

Then for the workers' compensation
situation, I mentioned to you that there is an Oklahoma
kind of quasi-public entity that we don't represent.
It's called CompSource. And CompSource is essentially
a previous -- a previously state affiliated insurance
mutual and we do not represent CompSource and if
you-all want any information there, you'll have to
subpoena them. If we wanted any information, we would
have to subpoena them as well, is my understanding.
The only CompSource related Oklahoma agency is the
Oklahoma Workers' Compensation Commission, which is
simply a non-judicial dispute entity that handles any
workers' compensation disputes related to employees.
But as far as the processing of any claims for workers'
compensation, the state -- the state doesn't handle
that; a third party does. So -- and OHCA does not
handle it.

Lastly, on retired employees, the only

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA, ex rel., MIKE
HUNTER, ATTORNEY GENERAL OF
OKLAHOMA,

Plaintiff,

v.

PURDUE PHARMA L.P.; PURDUE
PHARMA, INC.; THE PURDUE
FREDERICK COMPANY; TEVA
PHARMACEUTICALS USA, INC.;
CEPHALON, INC.; JOHNSON &
JOHNSON; JANSSEN
PHARMACEUTICALS, INC.; ORTHO-
McNEIL-JANSSEN
PHARMACEUTICALS, INC., n/k/a
JANSSEN PHARMACEUTICALS, INC.;
JANSSEN PHARMACEUTICA, INC.,
n/k/a JANSSEN PHARMACEUTICALS,
INC.; ALLERGAN, PLC, f/k/a ACTAVIS
PLC, f/k/a ACTAVIS, INC., f/k/a
WATSON PHARMACEUTICALS, INC.;
WATSON LABORATORIES, INC.;
ACTAVIS LLC; and ACTAVIS PHARMA,
INC., f/k/a WATSON PHARMA, INC.,

Defendants.

Case No. CJ-2017-816

Honorable Thad Balkman

Special Discovery Master:
William C. Hetherington, Jr.

**NOTICE TO TAKE VIDEOTAPED DEPOSITION OF
CORPORATE REPRESENTATIVE PURSUANT TO
SECTION 3230(C)(5) OF THE DISCOVERY CODE**

To: **Corporate Representative
State of Oklahoma**

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Please take notice that, pursuant to OKLA. STAT. TIT. 12 § 3230(C), Defendants Purdue Pharma L.P., Purdue Pharma, Inc., and the Purdue Frederick Company (collectively, "Purdue") will take the deposition upon oral examination of one or more corporate representative(s) of Plaintiff the State of Oklahoma (the "State") on the matters described on **Exhibit A** on **June 20, 2018, starting at 9:00 AM**, at the offices of Crowe & Dunlevy, P.C., 324 N. Robinson Avenue, Suite 100, Oklahoma City, Oklahoma 73102.

This deposition is to be used as evidence in the trial of the above action, and the deposition will be taken before an officer authorized by law to administer oaths. It will be recorded by stenographic means and will be videotaped, and it will continue from day to day until completed.

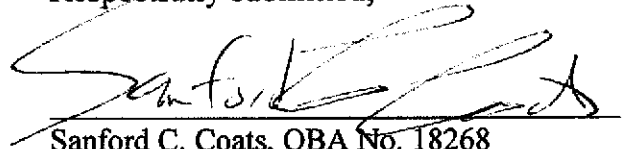
Pursuant to OKLA. STAT. TIT. 12, § 3230(C)(5), the State is hereby notified of its obligation to designate one or more officers, directors, managing agents, or other persons who consent to testify on the State's behalf about all matters embraced in the "Description of Matters on Which Examination is Requested" that is attached as **Exhibit A**.

PLEASE TAKE FURTHER NOTICE that each such officer, director, managing agent, or other person produced by the State to testify under OKLA. STAT. TIT. 12, § 3230(C)(5) has an affirmative duty to have first reviewed all documents, reports, and other matters known or

reasonably available to the State, along with speaking to all potential witnesses known or reasonably available to the State, in order to provide informed and binding answers at the deposition.

DATED: May 15, 2018.

Respectfully submitted,



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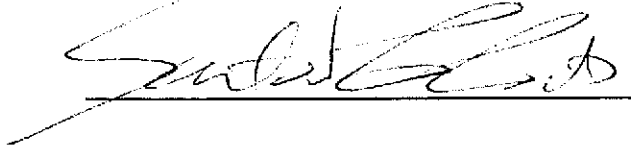
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CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of May 2018, I caused a true and correct copy of the following:

NOTICE TO TAKE VIDEOTAPED DEPOSITION OF CORPORATE REPRESENTATIVE PURSUANT TO SECTION 3230(C)(5) OF THE DISCOVERY CODE

to be served via email upon the counsel of record listed on the attached Service List.

A handwritten signature in black ink, appearing to be "S. J. [unclear]", is written over a horizontal line.

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EXHIBIT A

DESCRIPTION OF MATTERS ON WHICH EXAMINATION IS REQUESTED

1. The standards, practices, and procedures during the Relevant Time Period for the diagnosis and treatment of pain and for the use of opioid medications and opioid alternative medications for persons in the care and custody of the Oklahoma Department of Corrections.¹

¹ Unless otherwise defined herein, capitalized terms shall have the meanings assigned to them in Purdue's January 12, 2018 discovery requests to the State.

IN THE DISTRICT COURT OF CLEVELAND COUNTY
FOR THE STATE OF OKLAHOMA

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STATE OF OKLAHOMA, ex rel.)
MIKE HUNTER, ATTORNEY GENERAL)
OF OKLAHOMA,)
)
Plaintiff,)
)
VS.) Case No. CJ-2017-816
)
PURDUE PHARMA, L.P.; PURDUE)
PHARMA, INC.; THE PURDUE)
FREDERICK COMPANY; TEVA)
PHARMACEUTICALS USA, INC.;)
CEPHALON, INC.; JOHNSON &)
JOHNSON; JANSSEN)
PHARMACEUTICALS, INC.; ORTHO-)
McNEIL-JANSSEN PHARMACEUTICALS,)
INC., n/k/a JANSSEN)
PHARMACEUTICALS, INC.; JANSSEN)
PHARMACEUTICALS, INC., n/k/a)
JANSSEN PHARMACEUTICALS, INC.;)
ALLERGAN, PLC, f/k/a WATSON)
PHARMACEUTICALS, INC.; WATSON)
LABORATORIES, INC.; ACTAVIS LLC;)
and ACTAVIS PHARMA, INC., f/k/a)
WATSON PHARMA, INC.,)
)
Defendants.)
)

VIDEOTAPED CORPORATE REPRESENTATIVE DEPOSITION OF
CLINT CASTLEBERRY
TAKEN ON BEHALF OF THE DEFENDANTS
IN OKLAHOMA CITY, OKLAHOMA
ON SEPTEMBER 5, 2018

REPORTED BY: DAVID BUCK, CSR

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	The Videographer: Bruce Rodgers

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3	IT IS HEREBY STIPULATED AND AGREED by
4	and among the attorneys for the respective parties
5	hereto that the deposition of CLINT CASTLEBERRY may be
6	taken on behalf of the Defendants on the 5th of
7	August, 2018, in Oklahoma City, Oklahoma, by David
8	Buck, Certified Shorthand Reporter for the State of
9	Oklahoma, taken pursuant to Notice.
10	IT IS FURTHER STIPULATED AND AGREED by
11	and among the attorneys for the respective parties
12	hereto that all objections, except as to the form
13	of the question and the responsiveness of the answer,
14	are reserved until the time of trial, at which time
15	they may be made with the same force and effect as if
16	made at the time of the taking of this deposition.
17	*****
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1 THE VIDEOGRAPHER: Good morning. We're going on
2 the record at 8:57 a.m. Please note that the
3 microphones are sensitive and may pick up whispering,
4 private conversations and cellular interference.
5 Please turn off all cellphones or place them away from
6 the microphones so they do not interfere with the
7 deposition. Audio and video recordings will continue
8 to take place unless the parties agree to go off the
9 record. This is media unit number one, video
10 deposition of Clint Castleberry taken on behalf of the
11 defendants in the matter of State of Oklahoma versus
12 Purdue Pharma, L.P., et al filed in the District Court
13 of Cleveland County, Case Number CJ-2017-816. The
14 deposition is being held at Whitten & Burrage located
15 at 512 North Broadway, Suite 300, Oklahoma City,
16 Oklahoma. My name is Bruce Rodgers with the firm D &
17 R Reporting. The court reporter is David Buck from
18 the firm D & R Reporting. I'm not authorized to
19 administer the oath, I'm not related to any party in
20 this action nor am I financially interested in the
21 outcome.
22 Counsel and all present in the room and
23 everyone attending remotely will now state their
24 appearances and affiliations for the record.
25 MR. LEONOUKAKIS: Ross Leonoudakis from Nix

Page 7

1 Patterson & Roach on behalf of the state.
2 MS. MINIETTA: Michele Minietta, Department of
3 Corrections.
4 MR. MERKLEY: Nick Merkley, GableGotwals, for the
5 Teva, Cephalon defendants.
6 MR. KINNEY: David Kinney with the Odom & Sparks
7 Law Firm for the Johnson & Johnson defendants.
8 MR. TAM: Jonathan Tam from Dechert for Purdue.
9 MR. CHEFFO: Mark Cheffo from Dechert for Purdue.
10 THE VIDEOGRAPHER: Will the reporter please swear
11 in the witness?
12 CLINT CASTLEBERRY,
13 after having been first duly sworn at 8:59 a.m.
14 deposes and says in reply to the questions propounded
15 as follows, to wit:
16 * * * * *
17 DIRECT EXAMINATION
18 BY MR. CHEFFO:
19 Q. Good morning, sir. Will you please state
20 your name for the record?
21 A. Clint Castleberry.
22 Q. And are you employed?
23 A. Yes.
24 Q. Where are you employed?
25 A. Oklahoma Department of Corrections.

Page 8

1 Q. You understand you're under oath today?
2 A. Yes.
3 Q. I'm sure your counsel had an opportunity to
4 give you some ground rules, but if there's anything I
5 ask you that you don't understand today, will you
6 please just let me know and I'll try and rephrase it?
7 A. Sure.
8 Q. And if you need a break for some time I just
9 ask that you answer the question that's pending and
10 let us know and we'll take a break. Fair enough?
11 A. Okay.
12 Q. What -- how long have you worked at the
13 Department of Corrections?
14 A. Eighteen years.
15 Q. And what's your current role?
16 A. I'm the director of health services.
17 Q. Can you just give us a little bit of a
18 narrative if you don't mind your -- your kind of
19 history at the Department of Corrections
20 professionally in terms of when you started, what your
21 roles were and your general responsibilities and take
22 us up through today?
23 A. Sure. I started with the agency in November
24 of 1999 as a psychological clinician at our assess --
25 assessment and reception center in Lexington,

Page 9

1 Oklahoma. I was there for approximately a year and a
2 half, two years and moved to our programs division
3 which had oversight for treatment programs,
4 educational, vocational services and grants for the
5 agency, worked as the individual who was over
6 coordinating the grants that worked with our substance
7 abuse treatment programs. Moved up the ranks there
8 until I was the I think the title was chief
9 administrator of program services for seven or eight
10 years probably and then moved over to the director of
11 health services role in July 2015, I believe.
12 Q. What is your role as the director of health
13 services?
14 A. The administrative oversight for our medical
15 and mental health units within the agency.
16 Q. When you say within the agency, does that
17 cover all correctional institutions within the State
18 of Oklahoma?
19 A. Yes and no. Private prisons where we house
20 a certain percentage of our population have their own
21 contracts and contract requirements. We have some
22 oversight but not direct oversight of their medical
23 and mental health services.
24 Q. Okay. What -- what portion of the inmate
25 population are housed in private versus public

3 (Pages 6 - 9)

Page 10

1 institutions?
2 A. I couldn't tell you today without a count
3 sheet.
4 Q. Could you give me an estimate?
5 MR. LEONOUKAKIS: Objection.
6 THE WITNESS: Four thousand to 5,000 inmates.
7 Q. (By Mr. Cheffo) In private?
8 A. Yes.
9 Q. And how many in public?
10 A. Twenty-two to 23,000 roughly.
11 Q. And you have direct responsibility as the
12 department -- the director of health services for
13 the -- all the inmates who are in the public and you
14 have some responsibility for the private?
15 A. Yes.
16 MR. LEONOUKAKIS: Objection.
17 Q. (By Mr. Cheffo) Can you tell us what the
18 nature of your responsibility is with respect to the
19 private inmates, for the inmates housed in private
20 facilities?
21 A. In terms of their medical care, there are
22 contracts that the agency's region three develops that
23 includes all the services that private prisons are
24 required by that contract to provide. In terms of the
25 medical care that is completely contracted out, the

Page 11

1 mental healthcare is completely contracted out but
2 there are references within those contracts as to
3 which of our operating procedures they are exempted
4 from.
5 Q. What about formularies, do you use the same
6 formularies?
7 A. I don't know.
8 Q. Do you know what a formulary is?
9 A. Yes.
10 Q. What is it?
11 A. A formulary is the listing of drugs that can
12 be prescribed by a provider.
13 Q. Are they limited to -- when you say provided
14 are you talking about a healthcare provider?
15 A. Yes.
16 Q. So if something is on the formulary does
17 that limit the ability of the doctor in his or her
18 discretion to prescribe a medicine?
19 A. No.
20 Q. How does it work?
21 A. Within the agency we have a pharmaceutical
22 and therapeutics group which manages the formulary.
23 It's headed by our chief medical officer. They
24 determine what's on the pharmacy -- or on the
25 formulary, excuse me.

Page 12

1 Q. Do you have any involvement in that process?
2 A. I do not.
3 Q. Who is the chief medical officer?
4 A. Dr. Joel McCurdy.
5 Q. How long has Dr. McCurdy been with the
6 Department of Corrections?
7 A. I don't know.
8 Q. Has it been more than two or three years?
9 A. Yes.
10 Q. And prior to joining the Department of
11 Corrections can you tell us about your educational
12 background?
13 A. I have a master's of applied psychology.
14 Q. Where did you get that?
15 A. Southwestern Oklahoma State University.
16 Q. And where did you go to undergrad?
17 A. Southwestern.
18 Q. And what was your degree in?
19 A. Bachelor of Science.
20 Q. And prior to November 1999 when you were
21 employed by the Department of Corrections as a
22 clinician, did you have other employment?
23 A. Yes.
24 Q. What did you do?
25 A. I worked at Wal-Mart.

Page 13

1 Q. After your master's in between the
2 Department of Corrections you worked at Wal-Mart?
3 A. While I was working on my master's while I
4 was in college I worked there.
5 Q. And then after you received your master's
6 was your -- was your first job with the Department of
7 Corrections?
8 A. Yes.
9 Q. And you've been there ever since?
10 A. Yes.
11 Q. Who do you report to?
12 A. The director of the agency.
13 Q. And when you say the agency, it's the
14 Department of Corrections?
15 A. Department of Corrections.
16 Q. And who does he report to or she report to?
17 A. He reports to the board of corrections.
18 Q. And who is the director, the current
19 director?
20 A. Joe Allbaugh.
21 Q. And how long has Mr. Allbaugh been the
22 director?
23 A. Under three years.
24 Q. And who was the director before
25 Mr. Allbaugh?

Page 14

1 A. Patent. I can't remember his first name.
2 Q. Mr. Patent?
3 A. Uh-huh.
4 Q. Was he there the entire time that you were
5 there at least other than Mr. Allbaugh?
6 A. I'm not sure I understand the question.
7 Q. Sure. I'm trying to figure out, you
8 probably know who the directors were from the time
9 that you were at since 1999. I'm going --
10 A. I got you.
11 Q. -- to try to maybe short circuit it. Maybe
12 you can just tell us, from 1999 until the present who
13 have the directors been?
14 A. I believe when I started with the agency
15 Mr. Sapple was the director, then Mr. Ward, Justin
16 Jones, Patent and Allbaugh.
17 Q. Are these political appointments?
18 A. I have no idea.
19 Q. And has Mr. -- excuse me, has Dr. McCurdy
20 been the CMO, chief medical officer, since you've been
21 there in 1999?
22 A. No, not since 1999.
23 Q. Do you remember who it was before him?
24 A. Immediately before him it was Dr. Don
25 Suttmiller.

Page 15

1 Q. And how long was he there?
2 A. Don't know.
3 Q. And who was before Dr. Suttmiller?
4 A. Dr. Mike Jackson.
5 Q. And before him?
6 A. I don't know.
7 Q. Is the -- is the -- the Department of Health
8 services for the Department of Corrections adequately
9 funded?
10 MR. LEONOUKAKIS: Objection.
11 THE WITNESS: I'm not sure how to answer that
12 question.
13 Q. (By Mr. Cheffo) You know what I mean by that.
14 Right?
15 MR. LEONOUKAKIS: Objection.
16 THE WITNESS: Can you rephrase the question?
17 Q. (By Mr. Cheffo) Sure. Does it have adequate
18 funding to meet the needs that you believe are
19 appropriate to provide services to inmates?
20 A. Yes.
21 Q. So it has the full funding that you believe
22 it needs in order to function as a fully operational
23 and appropriate health service organization?
24 MR. LEONOUKAKIS: Objection.
25 THE WITNESS: With the funding we have we meet

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1 the healthcare needs of the population that we serve.
2 Q. (By Mr. Cheffo) So, is it your -- your view
3 that it's adequately funded?
4 MR. LEONOUKAKIS: Object to this being outside
5 the scope of the topic.
6 You can answer in your personal capacity if
7 you know the answer.
8 THE WITNESS: Certainly when you look at, just my
9 opinion, when you look at what we request each year
10 versus what we are funded it is rarely the amount that
11 we request.
12 Q. (By Mr. Cheffo) Am I correct that within the
13 last years one of the heads of the Department of
14 Corrections actually asked for a billion dollars more
15 than you received?
16 MR. LEONOUKAKIS: Objection.
17 THE WITNESS: When it comes to the total scope of
18 the budget --
19 Q. (By Mr. Cheffo) And I understand you're
20 saying you requested more. I'm just asking your
21 opinion if you can tell me your personal view. Is
22 it -- is it adequately funded in your view as in -- as
23 the director of health services and an 18 year
24 employee, does the health services department of the
25 Department of Corrections for the State of Oklahoma

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1 have all of the money and resources it needs to
2 provide adequate healthcare services to the inmates in
3 Oklahoma?
4 MR. LEONOUKAKIS: Objection, outside the scope.
5 You can answer if you know in your personal
6 capacity.
7 THE WITNESS: I don't know that the agency in
8 general is funded the way that it should be funded in
9 my personal view.
10 Q. (By Mr. Cheffo) And what about the healthcare
11 services component?
12 MR. LEONOUKAKIS: Same objection.
13 THE WITNESS: From my personal view I would say
14 it is a challenge with the funding that we are given
15 to operate.
16 Q. (By Mr. Cheffo) Is it underfunded?
17 MR. LEONOUKAKIS: Objection.
18 You can answer in your personal capacity.
19 THE WITNESS: In some areas, yes.
20 Q. (By Mr. Cheffo) What about is it underfunded
21 in terms of drug treatment?
22 MR. LEONOUKAKIS: Same objection.
23 THE WITNESS: I don't have oversight for drug
24 treatment.
25 Q. (By Mr. Cheffo) You were a psych -- clinician

Page 18

1 in psychology?
2 A. Uh-huh.
3 Q. And you started there?
4 A. Yes.
5 Q. Did you work with patients, inmates who were
6 patients?
7 A. As a psych clinician in the assessment and
8 reception center my job was to screen inmates for the
9 next step in the corrections process.
10 Q. Do you believe that the Department of
11 Corrections provides adequate drug treatment programs
12 and therapy to inmates currently housed in the
13 Department of Corrections facilities in the State of
14 Oklahoma?
15 MR. LEONOUKAKIS: Objection.
16 You can answer.
17 THE WITNESS: I don't have any oversight for the
18 number of treatment programs and the capacity of the
19 programs that we currently have in existence.
20 Q. (By Mr. Cheffo) So you have no opinion?
21 A. No.
22 MR. LEONOUKAKIS: Objection.
23 THE WITNESS: I do not have an opinion.
24 Q. (By Mr. Cheffo) Who is responsible for those
25 programs?

Page 19

1 A. Nate Brown is the individual who is the
2 chief administrator of program services.
3 Q. And what is -- what is he responsible for?
4 A. He has oversight for all substance abuse,
5 educational, vocational programs that are operated in
6 the agency, volunteer services and grants.
7 Q. Okay. So, what -- what are your -- what are
8 your specific roles as the director of health services
9 that you've had since 2015?
10 A. The administrative oversight for our
11 functional operation as a division for medical and
12 mental health services within the agency.
13 Q. And what does it mean administrative
14 oversight?
15 A. I supervise the chief medical officer and
16 the chief mental health officer and then I have
17 oversight for our budgetary goals.
18 Q. The chief medical officer reports to you?
19 A. The chief medical administratively reports
20 to me.
21 Q. And the chief mental health officer reports
22 to you?
23 A. Administratively, yes.
24 Q. And have either one of those individuals
25 come to you and said that their funding was not

Page 20

1 adequate to meet the needs of their programs?
2 MR. LEONOUKAKIS: Objection.
3 You can answer.
4 THE WITNESS: No.
5 Q. (By Mr. Cheffo) What did you do to prepare
6 for the deposition today?
7 A. Met with --
8 MR. LEONOUKAKIS: I'll just caution you you can
9 tell him about meetings but not go into the substance
10 of any meetings you had with counsel. You can answer
11 the question.
12 THE WITNESS: I had discussions with Ross,
13 discussions with our general counsel and attorneys
14 within the agency.
15 Q. (By Mr. Cheffo) Okay. And I agree, I'm not
16 asking you to tell me any conversations you had with
17 lawyers, but what lawyers did you meet with other than
18 Ross?
19 A. I believe there was an initial meeting with
20 multiple state agencies that occurred at the AG's
21 office with Abby Dillsaver I think was her last name.
22 I don't know who all the attorneys were that were with
23 the AG's office.
24 Q. Was that in preparation for this deposition?
25 A. Not this specific deposition, no, I guess

Page 21

1 not.
2 Q. Okay. So in connection with preparing for
3 this deposition, what did you do?
4 A. Met with Ross.
5 Q. Anyone else?
6 A. I had conversations with our general counsel
7 so that they were aware of what was going on since we
8 were -- since I was being deposed and have asked some
9 clarification questions to our chief medical officer
10 and pharmacist.
11 Q. Who is the pharmacist?
12 A. Robin Murphy.
13 Q. And when were you first asked to appear for
14 this deposition?
15 A. When it was scheduled this time?
16 Q. Or even initially if you recall?
17 A. I have no idea.
18 Q. Did you review any documents in connection
19 with the preparation?
20 A. Outside of the ones in front of me, no.
21 Q. And you said you spoke with your -- Ross,
22 your -- your lawyer, the doctor I guess, Murphy, the
23 pharmacist, general counsel and the chief medical
24 officer. Correct?
25 A. Uh-huh.

Page 22

1 Q. Anyone else?
2 A. Not that I can recall.
3 Q. And -- and where did you get the documents
4 that you reviewed?
5 A. They are from our policies and procedures
6 website on the DOC web page.
7 Q. And did you -- did you physically go and
8 pull them or did -- did someone give them to you?
9 A. A combination of the two.
10 Q. Did you -- did you do any independent
11 searches?
12 A. Well, I have full access to all of the
13 policies and procedures within the agency as all
14 employees do.
15 Q. What I'm asking you though is in connection
16 with this specific deposition did you specifically
17 conduct any document searches in order to help prepare
18 yourself for this deposition?
19 A. Only of our own policies and procedures --
20 Q. Which --
21 A. -- which I have in front of me.
22 Q. Only the documents in front of you. Yes?
23 A. Yes.
24 Q. Sorry, you need to do that on the record.
25 A. Got it.

Page 23

1 Q. I'm not trying to harass you.
2 (Deposition Exhibit Number 1 marked for
3 identification purposes and made part of
4 the record.)
5 Q. (By Mr. Cheffo) Let me show you what we've
6 marked as Exhibit I and ask you if you've seen this
7 document before. I'll tell you this is the Notice of
8 Deposition for you to be here today.
9 A. No.
10 Q. You were not shown that?
11 A. No.
12 Q. Do you know what the scope of your testimony
13 is?
14 A. Yes.
15 Q. Have you seen that before?
16 A. I've heard this before, yes.
17 Q. Not seen it?
18 A. Not to my recollection.
19 Q. You said you had conversations with I assume
20 is it Dr. Murphy, Robin Murphy, is she a doctor of
21 pharmacy?
22 A. I believe she's a PharmD.
23 Q. Okay. So, what was the nature of your
24 conversation with Dr. Murphy?
25 A. Just clarification of processes on pharmacy,

Page 24

1 ops and controlled substance ops or MSRM.
2 Q. [REDACTED]
3 [REDACTED]
4 [REDACTED]
5 Q. [REDACTED]
6 [REDACTED]
7 Q. And you don't remember the general subject
8 matter of what you wanted to ask her about?
9 MR. LEONOUidakis: Objection.
10 THE WITNESS: No.
11 Q. [REDACTED]
12 [REDACTED]
13 [REDACTED]
14 [REDACTED]
15 [REDACTED]
16 [REDACTED]
17 [REDACTED]
18 [REDACTED]
19 [REDACTED]
20 [REDACTED]
21 [REDACTED]
22 [REDACTED]
23 Q. And what did he tell you?
24 A. The process of what's really in policy.
25 Q. I certainly have no objection to you looking

Page 25

1 at the documents but it would be helpful if you just
2 tell us --
3 A. Sure.
4 Q. -- what they are --
5 A. Sorry.
6 Q. -- so I can refer to it.
7 A. I'm looking at the pharmacy operations
8 policy. Now I lost it.
9 Q. What is the date? Is there a date on it?
10 A. Effective date 01/17 of '18. Looking at
11 Roman numeral IV, the oversight of pharmacy services
12 and pharmacy operations, B, the pharmacy and
13 therapeutics committee.
14 Q. Okay. So what specifically did you talk
15 about with him?
16 A. Just those items that are enumerated under
17 B, that the committee approves and adopts the policy
18 and procedures to promote the safe and effective use
19 of the drugs that the inmates of ODOC, who the members
20 were.
21 Q. And he told you all of that information?
22 A. Yes. Just reiterated what was in the policy
23 and how often they meet, which is quarterly on Number
24 4.
25 Q. Anything else -- sorry, go ahead.

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1 A. And Number 5, if there was a process for
2 considering drugs that were on the formulary.
3 Q. Anything else?
4 A. No.
5 Q. Did -- do you know whether opioid analgesic
6 medicines are on the current formulary?
7 A. Yes.
8 Q. Which ones are?
9 A. I'm not sure I can give you an exhaustive
10 list off the top of my head, but primarily morphine
11 and Norco.
12 Q. And was that the case last year?
13 A. I don't know.
14 Q. Did you make any efforts to find out what
15 was on any of the formularies prior to the most recent
16 formulary?
17 A. No.
18 Q. How would -- how would you have found that
19 out if you wanted to know?
20 A. Looking at the pharmacy op again, Roman
21 numeral III D.
22 Q. I think it will be easier, I'm going to let
23 you answer your question, but I have a copy of that.
24 I'm just going to mark this. You can -- I think it's
25 the same thing. You can look at it. We'll mark this

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1 as Exhibit 2.
2 (Deposition Exhibit Number 2 marked for
3 identification purposes and made part of
4 the record.)
5 Q. (By Mr. Cheffo) Does that appear to be the
6 same document?
7 A. Sure is the same effective date. I believe
8 it is.
9 Q. [REDACTED]
10 [REDACTED]
11 [REDACTED]
12 [REDACTED]
13 [REDACTED]
14 [REDACTED]
15 [REDACTED]
16 [REDACTED]
17 [REDACTED]
18 Q. Do you know the years that are involved in
19 this lawsuit?
20 MR. LEONOUidakis: Objection.
21 THE WITNESS: No.
22 Q. (By Mr. Cheffo) Do you understand what the
23 claims are in this lawsuit?
24 MR. LEONOUidakis: Objection.
25 THE WITNESS: Not outside of the specific

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1 question that's posed here, no.
2 Q. (By Mr. Cheffo) Have you ever read the
3 Complaint?
4 A. No.
5 Q. I take it you have no information about any
6 of the defendants or what they were alleged to have
7 done?
8 MR. LEONOUidakis: Objection.
9 THE WITNESS: No.
10 Q. (By Mr. Cheffo) Am I correct that you don't
11 even know who the defendants are?
12 MR. LEONOUidakis: Objection.
13 You can answer if you know.
14 THE WITNESS: Other than the entities that you
15 all represent that you introduced yourselves as, no,
16 if it's beyond that scope.
17 Q. (By Mr. Cheffo) Is the -- strike that.
18 Are the formularies that were written over
19 or revised, are they accessible on the Internet?
20 A. We post our current formulary on the
21 Internet. I don't know how far back they can go with
22 formularies that have been amended.
23 Q. But you believe that if you wanted to find
24 out what the formulary was in existence in two or
25 three or five years, that would be something that

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1 Dr. Murphy would have?
2 MR. LEONOUidakis: Objection.
3 You can answer.
4 THE WITNESS: I believe to some extent, yes.
5 Q. (By Mr. Cheffo) Have you retained any
6 documents that you've been working with in connection
7 with your job function?
8 MR. LEONOUidakis: Objection.
9 Q. (By Mr. Cheffo) Have you been told to retain
10 any documents?
11 MR. LEONOUidakis: Objection.
12 You can answer.
13 THE WITNESS: I recall a conversation with
14 general counsel about retaining documents, but whether
15 or not it was pertaining to this, without the order in
16 front of me I don't recall.
17 Q. (By Mr. Cheffo) Have you retained documents
18 or segregated any documents?
19 MR. LEONOUidakis: Objection.
20 You can answer.
21 THE WITNESS: We've not disposed of any
22 documents, if that's your question.
23 Q. (By Mr. Cheffo) You've not deleted any
24 e-mails?
25 A. Not related to this topic, no.

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1 Q. Related to healthcare system or opioids or
2 your work function?
3 MR. LEONOUKAKIS: Objection.
4 THE WITNESS: Certainly there are e-mails that we
5 delete that are just day to day operational but not
6 anything specific to opioids or --
7 Q. (By Mr. Cheffo) You just told my I think that
8 you don't know what this lawsuit is about. Right?
9 MR. LEONOUKAKIS: Objection.
10 THE WITNESS: Well, I know this lawsuit is about
11 opioids in general, yes.
12 Q. (By Mr. Cheffo) But the specifics of the
13 claims you're not familiar with, are you?
14 A. I'm not familiar with the claims in their
15 totality, no.
16 Q. So what types of information do you believe
17 you are required to retain?
18 MR. LEONOUKAKIS: Objection, outside the scope of
19 the noticed deposition.
20 You can answer in your personal capacity if
21 you know.
22 THE WITNESS: I believe assuming that the
23 retention was in relation to this, we were to retain
24 any information that was relevant to opioid medication
25 and opioid alternative medications.

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1 Q. (By Mr. Cheffo) Okay. So any, any
2 information or documents or e-mails about opioids or
3 opioid medication, it's your testimony that you've
4 retained all that?
5 MR. LEONOUKAKIS: I just want to object and
6 caution the witness not to disclose communications
7 you've had with your lawyers, general counsel or
8 otherwise about -- about these questions.
9 You can -- you can answer the question about
10 a topic but don't disclose communications.
11 MR. CHEFFO: Yeah. He can read back the question
12 if you want to hear it again.
13 THE WITNESS: Please.
14 MR. CHEFFO: Okay. Didn't ask for any of that
15 stuff, but go ahead.
16 (The record was read as directed.
17 "Q. So any, any information or documents or
18 e-mails about opioids or opioid medication, it's your
19 testimony that you've retained all that?")
20 THE WITNESS: To the best of my ability, yes.
21 Q. (By Mr. Cheffo) Now, while we're on Exhibit
22 2, that's the document that we were just talking
23 about, what is this document?
24 A. It's the operational policy for pharmacy
25 operations.

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1 Q. And is this something that is updated on a
2 regular basis?
3 A. Yes.
4 Q. Is it fair to say that if we looked at Page
5 2, the effective date of this policy, 01/17/2018,
6 there would have been a prior similar policy that may
7 have been updated to some extent?
8 A. Correct.
9 Q. This wouldn't be the first time you ever had
10 a policy on this, this issue, would it?
11 A. Correct.
12 Q. And as with the formulary, would there be a
13 place that is maintained within the Department of
14 Corrections that would show changes from one effective
15 policy to the next?
16 A. Yes.
17 Q. And where would that be maintained?
18 A. That would be in policy and procedures.
19 Q. Did you review any of the prior policies and
20 procedures?
21 A. No.
22 Q. Did you believe that that was part of the
23 Deposition Notice which calls for the standards,
24 practices and procedures during the relevant time
25 period for the diagnosis and treatment of pain and for

Page 33

1 the use of opioid medications and opioid alternative
2 medications for persons in the care, custody of the
3 Oklahoma Department of Corrections?
4 MR. LEONOUKAKIS: Objection.
5 You can answer the question.
6 THE WITNESS: It's my belief that what are our
7 current operational policies are are what we're bound
8 to to operate under.
9 Q. (By Mr. Cheffo) I understand. But they do
10 change from time to time?
11 A. They can. They are reviewed annually. That
12 does not necessarily mean that any of them is changed.
13 Q. Do you -- did you review any policies prior
14 to this year or the most recent versions in order to
15 determine what the policies were and if there were any
16 changes?
17 A. Yes.
18 Q. What did you review?
19 A. All of the medical policies and procedures
20 are on a rolling annual review. As part of that I am
21 a stakeholder along with other entities within the
22 agency.
23 Q. When you say a stakeholder, does that mean
24 that you actually participate in the review process
25 when a new policy either comes out or a policy is

Page 34

1 ratified?

2 A. Yes for health services, no for every policy

3 in the agency.

4 Q. Okay. What are some of the policies for

5 health services that you review?

6 A. The ones that are here.

7 Q. So this, this policy that we're talking

8 about, Exhibit 2, is one of the health services

9 policies?

10 A. Correct.

11 Q. So, and it also has information here about

12 the formulary. Correct?

13 A. Correct.

14 Q. That's listed at Page 3. Do you see that?

15 A. Yes.

16 Q. [REDACTED]

17 [REDACTED]

18 [REDACTED]

19 [REDACTED]

20 Q. And I think you told us you were aware

21 generally of some of the opioid analgesics that are on

22 the current formulary?

23 A. Yes.

24 Q. And which were those?

25 A. Morphine and Norco.

Page 35

1 Q. Okay. And can you tell us any -- can you

2 tell us first whether there were -- those opioid

3 analgesics were on prior formularies?

4 A. I don't know.

5 Q. Do you know whether other form -- other

6 opioid analgesics were on prior formularies?

7 A. I don't know.

8 Q. And with respect to Exhibit 2, how far back

9 do the prior versions go?

10 MR. LEONOUidakis: Objection.

11 Q. (By Mr. Cheffo) Do you understand my

12 question?

13 A. Yes.

14 I don't know. That would be a policy and

15 procedures question.

16 Q. What would you -- you've been at the com --

17 at the department for 18 years. Approximately how

18 long do you think you'd expect to find it?

19 MR. LEONOUidakis: Objection.

20 THE WITNESS: During my role as the director of

21 health services there's been one.

22 Q. (By Mr. Cheffo) Okay. So you would expect --

23 well, not only has there been one but is it maintained

24 in a computer somewhere?

25 A. Yes, back to some point in time.

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1 Q. So what I'm just trying to find out is

2 assuming your supervisor said I'd like to know what

3 the policy said back in, you know, 2009 with respect

4 to this policy, where would you go to try and find

5 that?

6 A. Policies and procedures.

7 Q. Is that a department?

8 A. It is a department within the agency.

9 Q. And who is the person you would speak to?

10 A. Any number of people in procedures could

11 find that for me.

12 Q. Who, who would be the person you would call

13 up?

14 A. Penny Lewis is the person who was over

15 procedures for the agency.

16 Q. And she would have the prior versions of

17 both Exhibit 2 and the formularies and other

18 informations regarding policies and procedures. Is

19 that right?

20 A. She --

21 MR. LEONOUidakis: Objection.

22 THE WITNESS: She would not have formulary.

23 Q. (By Mr. Cheffo) Who would have formulary?

24 A. I believe Robin Murphy would.

25 Q. Okay. So, policies and procedures would be

Page 37

1 treated separately than formulary?

2 A. Yes.

3 Q. [REDACTED]

4 [REDACTED]

5 [REDACTED]

6 [REDACTED]

7 [REDACTED]

8 [REDACTED]

9 [REDACTED]

10 [REDACTED]

11 [REDACTED]

12 [REDACTED]

13 [REDACTED]

14 Q. Is that published somewhere, do you know?

15 A. I don't believe so.

16 Q. Does the Department of Corrections use any

17 private companies for pharmacies?

18 A. We use Diamond Pharmacies, who is our

19 supplier of medications.

20 Q. Is that -- that's the company who actually

21 provides prescription medicines to the Department of

22 Corrections?

23 A. Correct.

24 Q. With respect to the setting of the

25 formularies, there's the P and T committee that you

Page 38

1 told us about.
2 A. Uh-huh.
3 Q. Are they solely responsible for setting the
4 formularies are do you engage some outside
5 consultants?
6 A. I believe Diamond itself has a role in the P
7 and T committee.
8 Q. And -- and what's the basis of that belief?
9 A. I think in conversation I had with Dr.
10 McCurdy.
11 Q. And do you know what the role is?
12 A. No.
13 Q. Do you know how many members are on the P
14 and T committee?
15 A. No.
16 Q. Are they all doctors?
17 MR. LEONOUKAKIS: Objection.
18 THE WITNESS: In the op itself the committee
19 consists of medical providers and qualified healthcare
20 professionals.
21 Q. (By Mr. Cheffo) Have you ever sat on the P
22 and T committee?
23 A. No.
24 Q. Has the CMO sat on the P and T committee?
25 MR. LEONOUKAKIS: Objection.

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1 THE WITNESS: In policy the members of the P and
2 T committee are appointed by the chief medical officer
3 or designee, but I don't know off the top of my head,
4 no, if he himself has.
5 Q. (By Mr. Cheffo) And you understand when I say
6 CMO today I'm talking about the chief medical officer?
7 A. Correct.
8 Q. What is the role of the P and T committee?
9 A. In the policy itself, III C, the pharmacy
10 and therapeutics committee are a group of healthcare
11 professionals employed by DOC and appointed by DOC's
12 chief medical officer, CMO, for the general purpose of
13 evaluating, educating and advising the medical
14 services administration regarding all aspects of
15 medication use within DOC.
16 Q. Do they have meetings?
17 A. Yes.
18 Q. Do they keep records of those meetings?
19 A. I don't know.
20 Q. Are there any minutes?
21 A. I don't know.
22 Q. Is there something that you looked at in
23 connection with this deposition?
24 A. No.
25 Q. [REDACTED]

Page 40

1 [REDACTED]
2 [REDACTED]
3 [REDACTED]
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]
9 Q. Prior to preparing to this -- for this
10 deposition had you ever had occasion to look at
11 medicines that were on the formulary?
12 MR. LEONOUKAKIS: Objection.
13 THE WITNESS: Yes.
14 Q. (By Mr. Cheffo) In what context?
15 A. Primarily checking to see what the latest
16 version of the formulary was that was published on the
17 website.
18 Q. And do you know whether Oxycontin was ever
19 on the formulary?
20 A. I know it's not on the current formulary.
21 Q. Okay. My question was a little different.
22 Do you know whether it ever was?
23 A. No.
24 Q. Do you know whether any opioid analgesics
25 other than those that are currently on there were on

Page 41

1 there at some point previously?
2 A. I don't know.
3 Q. The way we would find that out is to
4 actually look at the prior formularies that are
5 maintained by the policies and procedures folks.
6 Right?
7 A. Policies and procedures don't maintain the
8 formularies.
9 Q. I'm sorry, you told me that.
10 Other than -- other than the formularies,
11 you would go to the pharm -- to the director of
12 pharmacy and you would ask her where the prior
13 versions of the formulary were?
14 A. Correct.
15 Q. Thanks for correcting me on that.
16 Now, what -- strike that.
17 If a -- if a patient who is an inmate or
18 subject to the jurisdiction of the Department of
19 Corrections is prescribed a medicine by a healthcare
20 provider outside the formulary, what happens?
21 A. Can you ask the question one more time?
22 Q. Sure. If a healthcare provider prescribes a
23 patient medicine that he or she believes is
24 appropriate in his or her medical judgment and it's
25 not on the current formulary, what's the process and

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1 procedure?

2 MR. LEONOUKAKIS: Objection.

3 You can answer.

4 THE WITNESS: I believe in general terms that it
5 depends on how the inmate was outside of our custody
6 to a small extent. But if they are seen by an outside
7 provider and they are prescribed something that is not
8 on formulary, at the point in time they come back into
9 our jurisdiction one of our providers reviews their
10 medical condition and what they are prescribed and
11 they can maintain the duration of that prescription
12 since it's already been filled by an outside provider
13 or they can alter that prescription to something
14 different.

15 Q. (By Mr. Cheffo) It's not the Department of
16 Corrections view that all opioid analgesics should be
17 barred from use by inmates, is it?

18 A. I'm not a medical provider.

19 Q. It wouldn't be on the formulary, would it,
20 if you didn't think it was appropriate to have opioid
21 analgesics?

22 MR. LEONOUKAKIS: Objection.

23 THE WITNESS: Certainly whatever is on the
24 formulary the P and T committee has recommended for
25 our medical providers to prescribe.

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1 Q. (By Mr. Cheffo) And they also determine that
2 they're safe and effective when appropriately
3 prescribed. Isn't that the point of the formulary?

4 MR. LEONOUKAKIS: Objection.

5 THE WITNESS: The formulary takes into account
6 what medications we can prescribe that are utilized to
7 treat different conditions and that are cost effective
8 to do so.

9 Q. (By Mr. Cheffo) What if a patient is on --
10 strike that.

11 What if an in might -- inmate had been
12 prescribed a certain opioid analgesic for chronic pain
13 prior to incarceration, would that inmate still have
14 an ability to maintain his or her prescription?

15 MR. LEONOUKAKIS: Objection.

16 THE WITNESS: There are processes and policy in
17 the pharmacy op that talk about how a provider can
18 request non-formulary meds to be considered, but it's
19 evaluated on a case by case basis by a medical
20 professional.

21 Q. (By Mr. Cheffo) Why -- you did intake.
22 Right?

23 A. Yes.

24 Q. If someone is on a medicine, right --

25 A. Uh-huh.

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1 Q. -- could be a chronic pain medicine, it
2 could be a heart medicine, blood pressure, right, they
3 come in, they're incarcerated and they are on a
4 medicine. Right? What happens in terms of continuing
5 their healthcare?

6 A. So, from the intake process when they come
7 into our system they're evaluated by a triage nurse.
8 That triage nurse takes a listing of medications that
9 they report that they're on or any physical
10 medications that are received with them from the
11 county jail. At that point in time they're scheduled
12 to see a medical provider normally within 24 hours
13 unless in the nurse's professional opinion it needs to
14 be sooner. The exact medications that you come in on
15 from the county jail are disposed of and new
16 prescriptions are written. They can be for the same
17 type of medication or they can be for something
18 completely different based on the medical provider's
19 professional opinion.

20 Q. So even if they had a full prescription that
21 would be disposed of?

22 A. Correct.

23 Q. And I saw some procedures here regarding
24 disposal. Is one of them to pour water on them in the
25 sink or to pour them in a toilet?

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1 MR. LEONOUKAKIS: Objection.

2 THE WITNESS: I'm looking at the controlled drug
3 procedures.

4 Q. (By Mr. Cheffo) Can you tell us what document
5 you're talking about?

6 A. I'm looking at controlled drug -- or
7 ODOC-00001733. Under wastage, wasted dose, partial or
8 full, must be recorded by a qualified healthcare
9 professional on a spiral bound controlled drug record
10 with a signature witness by a separate ODOC employee
11 such as -- or e.g., ODOC Pharmacy Director,
12 correctional officer. Wastage doses may be disposed
13 by running water in sinks or toilets, and the
14 placement in sharps containers are not permitted.

15 Q. You read that pretty quickly. Let me just
16 ask you. So it says any wasted dose, partial or full,
17 must be recorded by a qualified healthcare
18 professional on a spiral bound controlled drug records
19 with a signature witness by a private ODOC employee,
20 and it says e.g., ODOC Pharmacy Director, correctional
21 officer. Wasted dose may be disposed by running water
22 in sink or toilets. The placement in sharps
23 containers is not permitted. Right?

24 A. Correct.

25 Q. So that means you could put it into the sink

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1 and run water over it or flush it down the toilet.
2 Right?
3 MR. LEONOUKAKIS: Objection.
4 THE WITNESS: This is the MSRM that's specific to
5 the controlled drugs. So it's --
6 Q. (By Mr. Cheffo) That would be opioids, right,
7 and other controlled substances?
8 MR. LEONOUKAKIS: Objection.
9 THE WITNESS: Correct.
10 Q. (By Mr. Cheffo) So, for controlled substances
11 like opioids and other controlled substances, a policy
12 and procedure is to -- with wastage is to put them in
13 the sink, run water over them or put them down the
14 toilet. Correct?
15 A. In the same document --
16 Q. I'm sorry, is that correct?
17 MR. LEONOUKAKIS: Objection.
18 THE WITNESS: Can you repeat the question?
19 MR. CHEFFO: Sure. Let's read it back.
20 (The record was read as directed.
21 "Q. So, for controlled substances like opioids
22 and other controlled substances, a policy and
23 procedure is to -- with wastage is to put them in the
24 sink, run water over them or put them down the toilet.
25 Correct?")

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1 THE WITNESS: Yes. And in addition, under Roman
2 numeral X, destruction of expired or unused controlled
3 drugs, other than wastage of partial or full, refused,
4 contained dosage controlled drugs -- I'm sorry, other
5 than the wastage of partial or full, refused,
6 contaminated doses, controlled drugs by running water,
7 sink or toilet only - placement in sharps container
8 not permitted), the destruction of controlled drugs on
9 site at the facility is not permitted. All controlled
10 drugs must be destroyed -- all controlled drugs to be
11 destroyed must be reported on reverse distributorship
12 forms and sent to the address specified on the form.
13 The initial copy will be supplied to each medical unit
14 by the contract pharmacy provided -- provider with
15 subsequent copies obtained from the reverse
16 distributorship and will be the responsibility of CHSA
17 to keep the forms available on the unit at all times.
18 Q. (By Mr. Cheffo) Okay. So, it can either be
19 poured in the toilet or in the sink or in certain
20 circumstances it could be taken off site?
21 MR. LEONOUKAKIS: Objection.
22 You can answer.
23 THE WITNESS: The reverse distributorship is the
24 setup through Diamond so that we return those meds for
25 destruction through them.

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1 Q. (By Mr. Cheffo) So which ones gets returned
2 and which ones gets poured down the sink?
3 A. I don't know.
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]
9 [REDACTED]
10 Q. Does the Department of Corrections recognize
11 chronic pain as a legitimate disease endpoint --
12 MR. LEONOUKAKIS: Object.
13 Q. (By Mr. Cheffo) -- or medical problem?
14 MR. LEONOUKAKIS: Objection.
15 THE WITNESS: I don't know.
16 Q. (By Mr. Cheffo) Does the Department of
17 Corrections inform its view about formulary medicines
18 by any other policies or procedures that are
19 applicable to other state agencies?
20 MR. LEONOUKAKIS: Objection, outside the scope.
21 You can answer.
22 THE WITNESS: I don't know.
23 Q. (By Mr. Cheffo) Do you know what SoonerCare
24 is?
25 A. Yes.

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1 Q. What is it?
2 A. It's the state's Medicaid program.
3 Q. And what population does that program apply
4 to?
5 MR. LEONOUKAKIS: Objection, outside the scope.
6 You can answer in your person -- personal
7 knowledge.
8 THE WITNESS: I believe they have criteria as to
9 who they can serve. You have to be over a certain
10 age, have some defined disabilities. Beyond that I'm
11 not real sure.
12 Q. (By Mr. Cheffo) And that's a state program.
13 Correct?
14 MR. LEONOUKAKIS: Objection.
15 THE WITNESS: I don't know.
16 (An off the record discussion was had.)
17 Q. (By Mr. Cheffo) Let me refer you to -- to
18 Exhibit 2, please. So, on -- on the second page,
19 1749, there's a -- on the first top of the page it
20 says D, formulary.
21 Do you see that?
22 A. Yes.
23 Q. And it says, a listing of drugs approved by
24 the P&T committee that are considered safe and
25 therapeutically effective.

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1 Do you see that?
2 A. Yes.
3 Q. And -- and that's your understanding that if
4 it's on the formulary those are drugs that have been
5 determined by the P and T committee to be safe and
6 therapeutically effective as defined in the policy of
7 the DOC. Is that right?
8 A. Yes.
9 Q. So if we were to see morphine -- and, in
10 fact, I think you told us morphine is one of the
11 approved formulary medicines. Right?
12 A. Yes.
13 Q. So that would mean that there was a
14 determination that morphine is considered safe and
15 therapeutically effective by the P and T committee?
16 MR. LEONOUKAKIS: Objection.
17 THE WITNESS: Yes, but with the same type of
18 controls in place to make sure that it's not
19 potentially abused by the population. It's not a keep
20 on person or carry on person medication.
21 Q. (By Mr. Cheffo) Sure. There -- there could
22 be some restrictions about how it's dispensed or how
23 an inmate may be able to use it, but the idea is if
24 it's on the formulary there's been a determination
25 that morphine is considered safe and therapeutically

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1 effective?
2 MR. LEONOUKAKIS: Objection.
3 Q. (By Mr. Cheffo) Isn't that what it means to
4 be on the formulary?
5 A. By definition, yes.
6 Q. If you look at the next page, 1750, please,
7 it's stock medications noncontrolled. What does that
8 mean?
9 A. Medications that are both prescription, over
10 the counter drugs that have been approved by the P and
11 T committee for initiation of drug therapy, for
12 maintaining continuity of care unit -- or continuity
13 of care until the inmate receives prescription
14 medications from a designated pharmacy, service
15 provider or the administration of the medical services
16 unit as a part of the diagnosis or treatment of an
17 inmate. They are -- the stock medications are non
18 patient specific meds.
19 Q. Can you give us some examples?
20 A. Certainly morphine we do have the ability to
21 order non patient specific along with aspirin,
22 Tylenol, things that can be dispensed by a nurse for a
23 very short period of time that may have multiple uses
24 than just one patient.
25 Q. Is the idea to have these stock medications

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1 on hand in case you need them even though it's not
2 specifically called for by a patient like aspirin,
3 like --
4 A. Correct.
5 Q. -- other things, morphine?
6 A. Correct.
7 Q. Are there protocols about how to prescribe
8 controlled substances and any restrictions on the
9 length of use?
10 MR. LEONOUKAKIS: Objection.
11 THE WITNESS: No.
12 Q. (By Mr. Cheffo) That's totally within the
13 discretion of the healthcare provider?
14 A. Yes.
15 Q. So, once an inmate -- let me strike that.
16 Do you call them patients or inmates?
17 A. Inmates.
18 Q. Okay. Once an inmate is evaluated by a
19 healthcare provider and he or she makes a
20 determination, the only guidepost or restrictions are
21 his or her medical judgment as opposed to any
22 restrictions or guidelines specifically with respect
23 to controlled substances. Is that right?
24 MR. LEONOUKAKIS: Objection.
25 THE WITNESS: Unless if it's specifically defined

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1 in policy.
2 Q. (By Mr. Cheffo) And are you aware if it's
3 specifically defined in policy about any restrictions
4 on controlled substances?
5 A. Not off the top of my head.
6 Q. And -- strike that.
7 Okay. And what about O, controlled
8 drought -- drug stock for controlled
9 substances/narcotics?
10 A. The same example that we talked about in the
11 one above. Doses are administered in multiple
12 inmates.
13 Q. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
19 Q. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
24 Q. You would expect that those decisions
25 wouldn't be done willy nilly, right, they would be

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1 done based on some considered information?
2 MR. LEONOUKAKIS: Objection.
3 THE WITNESS: Correct.
4 Q. (By Mr. Cheffo) So, it wouldn't be one day
5 someone just says I don't like the name of that drug,
6 we're taking it off the formulary, you would expect
7 that there would be some information provided to the P
8 and T committee and the P and T committee would look
9 at it and make -- each member would make his or her
10 own independent judgment about the formulary. Is that
11 your expectation?
12 MR. LEONOUKAKIS: Objection.
13 THE WITNESS: Correct, I believe that's the
14 function of the committee.
15 Q. (By Mr. Cheffo) And, in fact, on 15 -- 1751
16 it says under pharmacy, the P and T committee, the P
17 and T committee will approve the adoption of policies
18 and procedures that promote the safe and effective use
19 of drugs for inmates of ODOC. Right? I'm on B, IV B.
20 A. Number 1?
21 Q. Yes, sir.
22 A. Yes.
23 Q. And that's consistent with your
24 understanding?
25 A. Yes.

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1 Q. And if you flip to the next page, this is
2 under the oversight of pharmacy services and pharm --
3 pharmacy operations section. Do you see that? I'm
4 counting over from 1751 under IV.
5 A. Yes.
6 Q. It carries over to the next page. Correct?
7 Yes?
8 A. Yes.
9 Q. And there are -- under B the heading is
10 pharmacy and therapeutics committee. Right?
11 A. Yes.
12 Q. And that's what we call the P and T
13 committee. Right?
14 A. Yes.
15 Q. And -- and the six points below that refer
16 to the roles and responsibilities of the P and T
17 committee. Is that right?
18 A. Correct.
19 MR. LEONOUKAKIS: Objection.
20 Q. (By Mr. Cheffo) And under six it says, the
21 committee's tasks specifically include. And they're
22 referring to the P and T committee. Right?
23 A. Correct.
24 Q. And there's tasks A through H. Right?
25 A. Yes.

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1 Q. And E says, objectively evaluating
2 scientific/clinical criteria regarding drugs proposed
3 for inclusion in the formulary.
4 Do you see that?
5 A. Yes.
6 Q. So, one of the P and T committee's jobs in
7 determining whether a proposed medicine should be in
8 the formulary is to evaluate the scientific and
9 clinical criteria regarding that drug. Isn't that
10 what it says in 6 E?
11 A. Yes, that is what it says.
12 Q. And it's also the responsibility of the P
13 and T committee to recommend removal/addition of drugs
14 from the formulary under F. Right?
15 A. Correct.
16 Q. And G says promoting educational programs
17 for the safe and appropriate use of drugs.
18 Do you see that?
19 A. Yes.
20 [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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1 [REDACTED]
2 Q. And then H says periodically evaluating
3 ADEs.
4 Do you know what ADEs are? Does it mean
5 adverse drug events?
6 A. I don't know.
7 Q. Okay. And C on 1752 talks about pharmacy
8 services provider. Do you see that?
9 A. Yes.
10 Q. Right below that.
11 A. Yes.
12 Q. Is that current pharmacy services provider
13 Diamond Pharmacies?
14 A. Yes.
15 Q. And do you know how long Diamond Pharmacies
16 has been the pharmacy services provider?
17 A. They've been the pharmacy provider as long
18 as I've been in my position, but I don't know if that
19 was -- I'm not sure when their actual contract went
20 into place. It predates me.
21 Q. Have you heard the term off label usage?
22 A. No.
23 Q. If you flip to 1760 in Exhibit 2, Exhibit 2,
24 the document we've been talking about, this is one of
25 the documents you brought with you today and one of

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1 the documents that you reviewed in preparation for
2 your deposition. Is that right?
3 A. Correct.
4 Q. Under B, reports, at the top of the page.
5 Do you see that, sir?
6 A. Yes.
7 Q. If you go down to two. Are you with me?
8 A. Yes.
9 Q. It says, statistical reports will be
10 prepared by the designated pharmacy services provider
11 and are reviewed monthly by the facility CHSA, ODOC
12 medical services through the director of pharmacy
13 services and any administrator designated by the chief
14 medical officer or the director of health services.
15 Do you see that?
16 A. Yes.
17 Q. And then it talks about reports include drug
18 utilization analysis, usage patterns, medical errors
19 and ADRs and it goes on?
20 A. Yes.
21 Q. Did you review any of those reports?
22 A. No.
23 [REDACTED]
[REDACTED]
[REDACTED]

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1 Q. Is there a protocol for treating inmates who
2 have substance abuse?
3 MR. LEONOUidakis: Objection.
4 THE WITNESS: Not in the medical policies.
5 Q. (By Mr. Cheffo) Is there a Department of
6 Corrections protocol?
7 MR. LEONOUidakis: Same objection.
8 THE WITNESS: Substance abuse treatment is
9 handled under our programs division in terms of what
10 policies and procedures they have in place for how and
11 who they treat in substance abuse programs. I'm not
12 incredibly familiar with those.
13 Q. (By Mr. Cheffo) Do you know if methadone is
14 used?
15 A. Methadone is only used for pregnant females
16 who are received into our custody actively receiving
17 methadone.
18 Q. What if someone is on methadone before they
19 become incarcerated, what happens to them and they're
20 not a pregnant female?
21 MR. LEONOUidakis: Objection.
22 You can answer.
23 THE WITNESS: They are discontinued on it.
24 Q. (By Mr. Cheffo) Are they given something
25 else?

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1 A. In many instances we may not even know that
2 they're on methadone.
3 Q. Wasn't my question. If they -- you may know
4 because they may have very significant withdrawal
5 symptoms. Right?
6 MR. LEONOUidakis: Objection.
7 THE WITNESS: Only if they were received from
8 county jail immediately upon sentencing. We --
9 Q. (By Mr. Cheffo) Sir, corrections officers
10 sometimes look inside cells. Right?
11 A. Yes.
12 Q. You -- you -- you've been working in a
13 corrections facility for a long time, you are familiar
14 not even as an expert, just as a human that there are
15 things called withdrawal symptoms. Right?
16 A. Yes.
17 Q. And you know that they can be severe in some
18 people?
19 A. Yes.
20 Q. So, and methadone you know is used to
21 prevent withdrawal symptoms?
22 A. Yes.
23 Q. That's why you allow it for pregnant women.
24 Right?
25 MR. LEONOUidakis: Objection.

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1 THE WITNESS: We allow it for pregnant females
2 because they were already prescribed it at the point
3 in time they were received and the adverse potential
4 results to the fetus if they were to be abruptly
5 discontinued.
6 Q. (By Mr. Cheffo) So, when an inmate who is not
7 a pregnant female comes in with a prescription of
8 methadone and indicates that he is on methadone, your
9 testimony is that he does not receive the methadone?
10 MR. LEONOUidakis: Objection.
11 Q. (By Mr. Cheffo) Is that right?
12 A. To my knowledge we've not received any one
13 at the assessment reception center other than pregnant
14 females that we have knowledge of that were actively
15 on methadone immediately prior to their reception.
16 Q. If they were would they receive methadone?
17 MR. LEONOUidakis: Objection.
18 THE WITNESS: I don't know.
19 Q. (By Mr. Cheffo) If they didn't receive
20 methadone what alternative medicines, if any, would
21 they receive?
22 MR. LEONOUidakis: Objection.
23 THE WITNESS: I don't know. We do have a -- I
24 don't know.
25 Q. (By Mr. Cheffo) Is there any medicines that

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1 are provided in order to assist inmates who have abuse
2 or dependence or addiction problems?
3 MR. LEONOUKAKIS: Objection.
4 You can answer.
5 THE WITNESS: If you mean medicated -- medication
6 assisted treatment, no.
7 Q. (By Mr. Cheffo) You're -- you're familiar
8 with that term. Right? It's called MAT?
9 A. Yes.
10 Q. What does it mean?
11 A. Medicated assisted treatment.
12 Q. And generally for laypeople how would you
13 describe that?
14 A. That there is some medication that is used
15 to assist with withdrawal symptoms from an addiction.
16 Q. Are there policies and procedures that
17 you've seen regarding correctional institutions that
18 talk about recommending the use for a medication to
19 treat -- assist the treatment?
20 MR. LEONOUKAKIS: Objection.
21 THE WITNESS: I've not seen any specific agency's
22 policy around it, no.
23 Q. (By Mr. Cheffo) Are you aware of whether the
24 Department of Corrections' a member of any
25 organizations or that basically have as its members

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1 other Department of Corrections that set policies and
2 procedures?
3 MR. LEONOUKAKIS: Objection.
4 THE WITNESS: Can you rephrase the question?
5 Q. (By Mr. Cheffo) Sure.
6 Are you aware of whether medically assisted
7 treatment is a generally accepted medical concept?
8 MR. LEONOUKAKIS: Objection.
9 THE WITNESS: I don't know.
10 Q. (By Mr. Cheffo) But it's your testimony that
11 the Department of Corrections does not permit
12 medically assisted treatment except in the case of
13 pregnant females who are receiving methadone prior to
14 incarceration. Is that right?
15 MR. LEONOUKAKIS: Objection, misstates the
16 testimony.
17 THE WITNESS: Say it again, please.
18 Q. (By Mr. Cheffo) Sure.
19 I'll ask you. Who receives, if anyone,
20 medically assisted treatment in the Department of
21 Corrections facilities?
22 A. Only pregnant females who are received into
23 our custody who are actively receiving methadone at
24 the point in time they are received into DOC custody.
25 Q. Do you know what naloxone is?

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1 A. Yes.
2 Q. Does the Department of Corrections maintain
3 naloxone in its facilities?
4 A. Yes.
5 Q. Is it used in connection with overdoses by
6 inmates?
7 MR. LEONOUKAKIS: Objection.
8 You can answer the question.
9 THE WITNESS: I need to look at -- there is a
10 policy, medical emergency response, which is 140118 --
11 well, and I guess the number you're looking for is
12 1720. And under B, emergency supplies, at a minimum
13 the following emergency medications will be available
14 in the medical unit at every facility. These
15 medications may only be used at the direction of
16 medical provider. Narcan injectable and naloxone kit,
17 Narcan and nasal along with several other meds. In
18 addition to that there is an MSRSM, or Medical Service
19 Resource Manual, which is 1729 which details the use
20 of naloxone, which is under one, purpose and overview,
21 treatment guideline deals with the treatment of opioid
22 overdoses and the administration of opioid
23 antagonists.
24 Q. (By Mr. Cheffo) So it's -- strike that.
25 So these, these two documents is, one -- are

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1 they both -- how do you refer to them, are they
2 policies, are they procedures?
3 A. The first one I referenced, 1720, is a
4 policy or procedure. The second one is an MSRSM, which
5 is a Medical Service Resource Manual, that operate as
6 attachments or additional reference material to the
7 policies.
8 Q. I was just going to ask you that. So just
9 can you give me a little more clarity what -- what the
10 difference is between these two, the policies and
11 procedures, because I've seen MSRSMs and I've seen
12 policy and procedures?
13 A. The MSRSMs are designed to provide a little
14 bit more direction to nursing staff and medical
15 providers specifically.
16 Q. So are they -- they're -- they're a more
17 specific guidance that's meant to be consistent with
18 the policies and procedures. Is that fair?
19 A. Correct.
20 Q. And obviously you have a policy or the
21 Department of Corrections has a policy and procedure
22 and a MSRSM because it's contemplated that naloxone is
23 used in the confines of the Department of Corrections.
24 Correct?
25 MR. LEONOUKAKIS: Objection.

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1 THE WITNESS: Yes.
2 Q. (By Mr. Cheffo) Are -- are illicit drugs
3 found in the Department of Corrections' prisons in
4 Oklahoma like they probably are in every other
5 correctional facility in the country?
6 MR. LEONOUKAKIS: Objection.
7 THE WITNESS: Yes.
8 Q. (By Mr. Cheffo) That would include both
9 illegal medicines -- strike that.
10 That would include both illegal substances
11 like methamphetamines or crack cocaine or illicit
12 fentanyl. Right?
13 MR. LEONOUKAKIS: Objection, outside the scope of
14 the topic.
15 You can answer in your personal capacity.
16 THE WITNESS: Certainly contraband gets into
17 facilities. In terms of an all encompassing amount
18 and of what I don't know.
19 Q. (By Mr. Cheffo) And I -- and contraband could
20 include products that -- substances that are illegal
21 for everyone like heroin. Right?
22 MR. LEONOUKAKIS: Same objection.
23 THE WITNESS: Yes.
24 Q. (By Mr. Cheffo) And contraband could also
25 include things like medicines that are legal to a

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1 person who is appropriately prescribed them but
2 they're illegal if they are diverted or stolen or
3 provided to somebody in jail unlawfully?
4 MR. LEONOUKAKIS: Same objection.
5 Q. (By Mr. Cheffo) Right?
6 A. Yes.
7 Q. And both of those happen in the prisons of
8 Oklahoma notwithstanding the best efforts to try to
9 reduce the amount of contraband. Fair?
10 MR. LEONOUKAKIS: Same objection.
11 THE WITNESS: Yes.
12 MR. LEONOUKAKIS: Need a break or are you okay?
13 We've been going for about an hour and 15 minutes.
14 MR. CHEFFO: Yeah, let's just finish. I just
15 have a few questions and then we'll take a break.
16 MR. LEONOUKAKIS: All right.
17 Q. (By Mr. Cheffo) Is there a place where the
18 use of Narcan would be recorded?
19 A. Possibly.
20 Q. From what you just read, right, it could
21 only be used at the direction of a healthcare provider
22 I think you read?
23 MR. LEONOUKAKIS: Objection.
24 (A brief pause.)
25 THE WITNESS: Ask the question one more time,

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1 please.
2 Q. (By Mr. Cheffo) Sure.
3 I'm just trying to understand if -- if it's
4 administered to an inmate is there going to be a
5 record of it somewhere, Narcan?
6 A. Yes.
7 Q. And -- and if you wanted to find out when,
8 where, how it was administered, where would you go to
9 look?
10 A. I believe the administration -- in the MSRM,
11 1731, overdose prevention program report back form is
12 completed by the CHSA if naloxone is used, damaged or
13 expired and the form is sent to the Oklahoma
14 Department of Mental Health and Substance Abuse
15 Services at the e-mail that's provided and to the
16 director of pharmacy.
17 Q. Okay. One last question then we'll take a
18 break.
19 To the extent that I wanted to know the
20 specifics about programs that are used to assist or
21 are geared for patients, inmates who have addiction or
22 abuse problems, are you the person most knowledgeable
23 or is there someone else that you think is most
24 knowledgeable about those topics?
25 MR. LEONOUKAKIS: Objection.

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1 You can answer.
2 THE WITNESS: Substance abuse treatment programs
3 is a separate division that is not under my purview,
4 so it's not me.
5 Q. (By Mr. Cheffo) And that is?
6 A. Nate Brown is the chief administrator of
7 programs or the administrator over programs.
8 MR. CHEFFO: Okay. We've been going a little
9 while, why don't we take a break.
10 THE VIDEOGRAPHER: This marks the end of Video
11 Media Number 1. The time is 10:19.
12 (A recess was here had 10:19 to 10:27.)
13 THE VIDEOGRAPHER: Beginning Media Number 2. The
14 time is 10:27.
15 Q. (By Mr. Cheffo) We're back on the record.
16 You, you understand you're under oath still?
17 A. Yes.
18 Q. You testified about Nate Brown. What is his
19 title?
20 A. I believe he's the chief administrator of
21 programs.
22 Q. And you indicated that you have no
23 information about programs?
24 MR. LEONOUKAKIS: Objection.
25 THE WITNESS: I have no oversight for programs.

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1 Q. (By Mr. Cheffo) Okay. Do you have
2 information about programs?
3 MR. LEONOUKAKIS: Objection.
4 THE WITNESS: Not anything in depth, no, other
5 than we operate them.
6 Q. (By Mr. Cheffo) What did you do prior to this
7 job?
8 A. I was the chief administrator of programs.
9 Q. How long ago was that?
10 A. Three years and some change.
11 Q. So when you had -- when you were the chief
12 administrator of programs did you have a lot of
13 knowledge about programs?
14 MR. LEONOUKAKIS: Objection.
15 THE WITNESS: I had knowledge of the operations
16 as they were when I was there.
17 Q. (By Mr. Cheffo) You had the same role that
18 Nate Brown has now. Right?
19 A. Correct.
20 Q. And when I asked you about questions about
21 programs for abuse and addiction you said Nate Brown
22 would be the person that I should go to.
23 A. Correct.
24 Q. Right? And you held that same role prior to
25 2015.

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1 A. Correct.
2 Q. Right? Let's talk about prior to 2015.
3 A. Okay.
4 Q. And when you held the role.
5 A. Okay.
6 Q. Tell us about the programs that were in
7 place for treating inmates who had abuse and
8 addiction.
9 A. There were substance abuse programs that
10 existed at multiple security levels, majority of which
11 were contracted through the Department of Mental
12 Health and Substance Abuse Services to provide
13 substance abuse treatment through cognitive
14 restructuring, manualized type treatment programs to
15 select offender population.
16 Q. Did any of them involve medically assisted
17 treatment?
18 A. No.
19 Q. Was buprenorphine used?
20 A. Not to my knowledge, no.
21 Q. Was methadone used?
22 A. Not to my knowledge, no.
23 Q. Who were the outside agencies that you
24 contracted with or outside entities?
25 A. The contract itself was with the Department

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1 of Mental Health and Substance Abuse Services with an
2 interagency agreement. They selected the agencies.
3 Q. What exactly did they do?
4 MR. LEONOUKAKIS: Objection.
5 Q. (By Mr. Cheffo) What -- what -- what was the
6 type of services that were provided to inmates as a
7 result of these contracts? I'd like to understand
8 some specifics.
9 MR. LEONOUKAKIS: I'm going to just object to
10 this line of questioning as outside the scope of the
11 topic.
12 You can answer in your personal capacity.
13 THE WITNESS: Historically when I was over
14 program services the interagency agreement with the
15 Department of Mental Health was for them to provide a
16 contractor at facilities to provide intake assessments
17 of people that had been -- had been selected for the
18 treatment programs and provide the treatment
19 programming itself, which was primarily group
20 services, a couple of individual type services and
21 treatment planning.
22 Q. (By Mr. Cheffo) In your tenure as -- in that
23 role did you learn of inmates who had no prior abuse
24 or addiction issues until they became inmates?
25 MR. LEONOUKAKIS: Same objection.

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1 THE WITNESS: I don't understand that question.
2 Q. (By Mr. Cheffo) Someone could come into be
3 incarcerated and have a prior history of abuse and
4 addiction. Correct?
5 A. Yes.
6 Q. And what I'm asking you, are there
7 situations where someone did not have that prior
8 history and through incarceration and access to
9 contraband developed an addiction or abuse issue?
10 MR. LEONOUKAKIS: Same objection.
11 THE WITNESS: I have no idea.
12 Q. (By Mr. Cheffo) Who, who would know that?
13 A. I don't know that the agency keeps records
14 in that way.
15 Q. Well, if someone was in -- who would have
16 records about an inmate's profile and medical history
17 with respect to addiction?
18 MR. LEONOUKAKIS: Same objection.
19 THE WITNESS: If the inmate reports a history of
20 substance abuse or addiction to a medical staff person
21 at intake or at any point in time while they're
22 incarcerated it would be documented in the electronic
23 health record.
24 Q. (By Mr. Cheffo) And is there a certain code
25 that would be assigned?

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1 MR. LEONOUKAKIS: Same objection.
2 THE WITNESS: I don't know.
3 Q. (By Mr. Cheffo) Would you look back at
4 Exhibit 1, which is the Notice? The first portion of
5 it says, the standards, practices and procedures
6 during the relevant time period.
7 Do you see that?
8 A. Uh-huh.
9 Q. What is the relevant time period?
10 MR. LEONOUKAKIS: Objection.
11 THE WITNESS: Today and back, back to some point
12 in time.
13 Q. (By Mr. Cheffo) Well, when you were preparing
14 for this deposition what did you use as the relevant
15 time period?
16 A. I used our most recent information,
17 formulary and policies and procedures.
18 Q. And that was just this year. Right?
19 A. Correct.
20 Q. Nothing prior to 2018?
21 MR. LEONOUKAKIS: Objection.
22 THE WITNESS: Not to my recollection.
23 [REDACTED]
[REDACTED]
[REDACTED]

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1 MR. LEONOUKAKIS: Objection.
2 [REDACTED]
3 [REDACTED]
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 Q. (By Mr. Cheffo) Did you ever ask anyone what
8 the relevant time period should be that you should
9 actually look at to prepare for the deposition?
10 MR. LEONOUKAKIS: Objection. Just caution the
11 witness not to disclose any communications he had with
12 counsel.
13 MR. CHEFFO: Yeah, let me strike that. I don't
14 want to ask you any counsel.
15 Q. (By Mr. Cheffo) Other than any conversations
16 that you may have had with lawyers, did you have a
17 discussion with anyone about whether you should
18 actually look for information prior to January 1,
19 2018?
20 A. No.
21 Q. And irrespective of any conversations, you
22 didn't do it in any event. Correct?
23 MR. LEONOUKAKIS: Objection.
24 THE WITNESS: No.
25 [REDACTED]

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1 [REDACTED]
2 [REDACTED]
3 [REDACTED]
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 Q. (By Mr. Cheffo) So, what are the standards,
8 practices and procedures between January 1, 2018 and
9 the present for the diagnosis and treatment of pain?
10 MR. LEONOUKAKIS: Objection.
11 You can answer.
12 THE WITNESS: The diagnosis and treatment of pain
13 is left up to the medical abilities of our medical
14 providers in facilities.
15 Q. (By Mr. Cheffo) So is there any standard
16 practice or procedure regarding the diagnosis and
17 treatment of pain?
18 A. Not to my knowledge.
19 Q. They have -- the healthcare providers have
20 free rein consistent with their medical and ethical
21 obligations with respect to the diagnosis and
22 treatment of pain. Is that your testimony?
23 MR. LEONOUKAKIS: Objection, misstates the
24 testimony.
25 THE WITNESS: The medical providers within

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1 their -- the scope of their license or in practice and
2 within the confines of the existing policies and
3 procedures and the direction of the chief medical
4 officer provide services to the inmate population.
5 Q. (By Mr. Cheffo) Okay. That's what I'm trying
6 to find out. You said policies and procedures and
7 that's what this says. Right? Standards, policies
8 and procedures during January 1 to -- 2018 to the
9 present regarding the diagnosis of treatment of pain.
10 Are there any written policies, procedures or
11 standards regarding the diagnosis and treatment of
12 pain?
13 A. To my knowledge, no.
14 Q. Are there any unwritten policies, procedures
15 or standards regarding the diagnosis and treatment of
16 pain?
17 MR. LEONOUKAKIS: Objection.
18 THE WITNESS: The only two policies that I know
19 that might loosely, excuse me, detail that, 2823,
20 palliative care program, specifically Roman numeral
21 II, palliative care procedures, A, Number 2 where it
22 says inmates will be placed in the infirmary when they
23 require medical or comfort services which exceed the
24 capacity of other housing or medical units.
25 Q. (By Mr. Cheffo) Can you tell us what document

1 you're referring to?
 2 A. 2823.
 3 Q. Okay, 2823. And --
 4 A. Do you need the name of it?
 5 Q. I think I might have it. But we'll just
 6 mark that whole collection of documents as Exhibit 3
 7 just so we don't lose track of it.
 8 (Deposition Exhibit Number 3 marked for
 9 identification purposes and made part of
 10 the record.)
 11 MR. CHEFFO: I can mark them individually. You
 12 don't have objection to that. Right?
 13 MR. LEONOUidakis: No, no, I think I'd rather do
 14 them individually, easier to refer.
 15 MR. CHEFFO: I'm going to go through them
 16 individually and I'll remark them. I just want to
 17 mark as a collection of documents that he brought with
 18 him as Exhibit 3, but I will go through them. If I
 19 forget you'll remind me.
 20 Q. (By Mr. Cheffo) So do you understand what
 21 we're doing here? I don't want to confuse you. We're
 22 going to mark that entire stack as Exhibit 3 and then
 23 when I go through specifics I'll remark them. Okay?
 24 A. Works for me.
 25 Q. Now, so that talks about you said palliative

1 care. Is that for people who have end stage disease
 2 or -- or cancer?
 3 A. The ability for palliative care programs
 4 appropriate when its med -- medically determined that
 5 the inmate has a prognosis of six months or less to
 6 live. Healthcare provider informs the inmate of his
 7 or her prognosis and treatment options including the
 8 palliative care program.
 9 Q. So other than that dealing with end of life
 10 care, are you aware of any other standards, policies
 11 or procedures?
 12 A. Convalescent and infirmary care of inmates
 13 which starts with 1965 where it talks about infirmary.
 14 Infirmary is a specific separate area that provides
 15 medical care for a period of 24 hours or more. The
 16 infirmary will be operated for the purpose of
 17 providing skilled nursing care, custodial nursing care
 18 and specialized housing to inmates and those who do
 19 not require hospitalization as deemed by the medical
 20 authority.
 21 Q. What's the date of that document?
 22 A. 07/14/16.
 23 Q. Now, are you aware of any standards,
 24 policies and procedures for the use of opioid
 25 medicines?

1 MR. LEONOUidakis: Objection.
 2 THE WITNESS: Outside of the pharmacy op which
 3 references just the formulary in general.
 4 Q. (By Mr. Cheffo) What about standards,
 5 policies, procedures regarding opioid alternative
 6 medications for persons in the care and custody of the
 7 Oklahoma Department of Corrections?
 8 A. Can you define what opioid alternative
 9 medication is?
 10 Q. It's listed on Exhibit 1.
 11 MR. LEONOUidakis: Objection.
 12 Q. (By Mr. Cheffo) Right here. Well, no, let me
 13 be clear, sir. I don't know if there's a definition,
 14 but that's -- I took that term from Exhibit A. Right?
 15 A. Okay.
 16 Q. So when you were preparing for this
 17 deposition you endeavored to understand and find
 18 information about opioid alternative medications.
 19 Right?
 20 MR. LEONOUidakis: Objection, form.
 21 THE WITNESS: Inasmuch as they related or used
 22 the same term within our agency policies and
 23 procedures.
 24 Q. (By Mr. Cheffo) Right. So, so you did have
 25 an understanding of what it meant. Right?

1 A. No.
 2 Q. Did you ask the chief medical officer?
 3 A. No.
 4 Q. Did you ask the pharmacist?
 5 A. No.
 6 Q. Did you ask any nonlawyer?
 7 A. No.
 8 Q. So you as you sit here today don't really
 9 understand what opioid alternative medications are?
 10 MR. LEONOUidakis: Objection.
 11 THE WITNESS: Only inasmuch as if you are
 12 referring to naloxone or methadone in terms of how
 13 those treat overdoses.
 14 Q. (By Mr. Cheffo) Well, are those alternatives
 15 or are those treatments for overdoses?
 16 A. Naloxone is treatment for overdoses.
 17 Methadone is a medicated assisted treatment for
 18 someone who is addicted.
 19 Q. [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

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1 [REDACTED]
2 [REDACTED]
3 [REDACTED]
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]
9 [REDACTED]
10 [REDACTED]
11 [REDACTED]
12 [REDACTED]
13 Q. (By Mr. Cheffo) The examples you gave me were
14 naloxone. Right?
15 A. Yes.
16 Q. Is that an alternative or a treatment?
17 A. Naloxone is a treatment for overdose.
18 Q. So would you consider it to be an opioid
19 alternative medication?
20 A. Probably not.
21 Q. Okay. Did you -- do you have any other
22 examples of what you would consider to be an opioid
23 alternative medication?
24 A. I believe that would be the methadone.
25 Q. Anything else?

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1 A. No.
2 Q. And what did you do to understand the
3 policies and standards and procedures regarding the
4 use of methadone?
5 A. Reviewed the current policies that exist
6 within our agency's website related to health
7 services.
8 Q. That's it?
9 A. Yes.
10 Q. Did you speak to anyone about that?
11 MR. LEONOUKAKIS: Objection.
12 THE WITNESS: Outside of the casual conversations
13 with the pharmacist and Dr. McCurdy concerning P and
14 T.
15 Q. (By Mr. Cheffo) That, that specific topic
16 didn't come up, did it?
17 A. No.
18 Q. And -- and beyond what the current policies
19 are, you don't know of any policies prior to that
20 regarding opioid alternative medications. Right?
21 A. Correct.
22 Q. [REDACTED]
23 [REDACTED]
24 [REDACTED]
25 [REDACTED]

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1 [REDACTED]
2 [REDACTED]
3 Q. What -- can you please tell me more
4 specifics about what your roles and responsibilities
5 were in your -- in your position prior to your current
6 position, the job that Nate, Mr. Nate Brown has?
7 A. Had administrative oversight for the
8 agency's program services, which are substance abuse
9 treatment, educational, vocational services, volunteer
10 services, at one time victim services and at one time
11 the grants division.
12 Q. Is -- tell me if I got this wrong, but is --
13 I think we talked earlier about if you wanted to know
14 about certain policies and programs and you wanted to
15 find out some historic information you would go to
16 somebody in program services. Is that right?
17 A. If you want to know something historic about
18 procedures you would go to procedures.
19 Q. Okay. That's different than program
20 services?
21 A. That's different than programs. Policies
22 and procedures is Penny Lewis.
23 Q. Okay. Does the Department of Corrections
24 maintain an org chart that lists out various people
25 and what their roles and responsibilities are?

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1 A. Yes.
2 Q. Who, who would you go if you wanted that?
3 A. Human resources.
4 Q. Is it updated pretty frequently?
5 A. As far as I know, yes.
6 Q. Do you know what a PDMP is?
7 A. No.
8 Q. A monitor -- a monitoring database that
9 physicians or healthcare providers can look at to
10 determine if someone has a prescription medicine.
11 A. I have heard of that.
12 Q. Maybe called something else?
13 A. Yeah.
14 Q. OARRS, have you ever heard of that?
15 A. Not the exact term but I have heard of
16 prescription monitoring database.
17 Q. You're not an expert in it but you're
18 generally familiar with what it is?
19 A. I've heard of it.
20 MR. LEONOUKAKIS: Objection.
21 Q. (By Mr. Cheffo) When -- when an inmate is
22 first received there's an intake you said?
23 A. Correct.
24 Q. And that includes probably many things
25 including an assessment of psychological and physical

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1 health?
2 A. Correct.
3 Q. And is there a form that's filled out?
4 MR. LEONOUKAKIS: Objection.
5 THE WITNESS: There are many forms that are
6 filled out.
7 Q. (By Mr. Cheffo) Well, with respect to mental
8 and physical health and medications, let's talk
9 specifically about that. Is the inmate asked to fill
10 out a form?
11 A. Yes.
12 Q. Something that says tell me all of your
13 problems, your medical history, any medicines that
14 you're on, things like that?
15 A. I would say they fill it out or if they're
16 reporting it to a staff member and the staff member is
17 documenting their information, one of the two or a
18 combination of both.
19 Q. And not unlike an initial visit that someone
20 might have with their doctor. Right?
21 A. Correct.
22 Q. And then that is maintained in the files of
23 the DOC. Right?
24 A. Yes.
25 Q. And the Department of Corrections and its

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1 healthcare providers have access to this physician
2 database. Is that right?
3 A. I don't know.
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]
9 [REDACTED]
10 [REDACTED]
11 MR. CHEFFO: Let's mark this as four, please.
12 (Deposition Exhibit Number 4 marked for
13 identification purposes and made part of
14 the record.)
15 Q. (By Mr. Cheffo) So, do you see this document
16 we've marked as Exhibit 4?
17 A. Yes.
18 Q. This is off the Department of Corrections'
19 website. Correct?
20 A. It looks like it.
21 Q. And it talks about accreditation? It
22 says --
23 A. Yes.
24 Q. -- Oklahoma accreditation?
25 A. Yes.

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1 Q. And in the middle of the page, and you can
2 read as much as you need to, but I'm going to direct
3 your attention just to the middle, it says the
4 Department of Corrections -- I'm over here, sir.
5 (Indicating.)
6 A. Okay.
7 Q. The Department of Corrections has continued
8 its quest for excellent by maintaining its
9 accreditation of its major institutions, probation and
10 parole, field services and community correction
11 center. Today the following facilities and programs
12 are accredited.
13 Do you see that?
14 A. Uh-huh.
15 Q. And it lists a number of facilities that
16 I -- and programs that I take it are all with -- under
17 the umbrella of the Department of Corrections. Is
18 that right?
19 A. This appears to be a list of DOC facilities.
20 Q. Okay. It says, on the DOC website it says
21 today the following facilities and programs are
22 accredited.
23 A. Yes, it does say that.
24 Q. And your -- your testimony is that this
25 doesn't look like programs, this looks like

Page 89

1 facilities?
2 A. These are facility names.
3 Q. Okay. And were you aware that the
4 department was accredited by any organizations or
5 institutions?
6 MR. LEONOUKAKIS: Objection.
7 THE WITNESS: I know the agency has been
8 accredited by ACA.
9 Q. (By Mr. Cheffo) What is ACA?
10 A. The American Correctional Association.
11 Q. And does the American Correctional
12 Association have certain guidelines and best
13 practices?
14 MR. LEONOUKAKIS: Objection.
15 THE WITNESS: Yes.
16 Q. (By Mr. Cheffo) Are you aware of what the ACA
17 guidelines are with respect to the prescription or
18 administration of opioids in correctional facilities?
19 A. Not verbatim off the top of my head, no.
20 Q. Are you generally aware?
21 A. I believe ACA stands that they are
22 supported -- supportive of medication assisted
23 therapy.
24 Q. That is something that the Department of
25 Corrections in Oklahoma does not subscribe to. Is

Page 90

1 that right?

2 MR. LEONOUKAKIS: Objection.

3 THE WITNESS: Correct.

4 Q. (By Mr. Cheffo) So the American Correctional

5 Association of which the department of Oklahoma is

6 proud to be a part of recommends the use of medically

7 assisted treatment but the Oklahoma Department of

8 Corrections does not use medically assisted treatment.

9 Is that right?

10 MR. LEONOUKAKIS: Objection.

11 THE WITNESS: Other than with those pregnant

12 females that we discussed earlier, that's correct.

13 Q. (By Mr. Cheffo) Right. But -- and you

14 understand that the American Correctional

15 Association's recommendations and guidelines with

16 respect to medically assisted treatment are broader

17 than just for women who are pregnant who are

18 dependent. Right?

19 MR. LEONOUKAKIS: Objection.

20 THE WITNESS: It's my understanding the ACA

21 standards are broad, general and considered best

22 practice for corrections in a wide birth.

23 Q. (By Mr. Cheffo) And with respect to medically

24 assisted treatment, they're not followed by Oklahoma.

25 Correct?

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1 MR. LEONOUKAKIS: Objection.

2 THE WITNESS: Other than as I stated that I know

3 that they are supportive of it. I'm not sure what

4 their -- if they have a detailed bullet point list of

5 all that makes up their medication assisted treatment

6 recommendations.

7 Q. (By Mr. Cheffo) Does Oklahoma follow any of

8 them outside of pregnant women?

9 MR. LEONOUKAKIS: Objection.

10 THE WITNESS: The only ones that we treat are

11 pregnant females who are received on methadone at the

12 point in time.

13 Q. (By Mr. Cheffo) So the answer is no?

14 MR. LEONOUKAKIS: Objection.

15 THE WITNESS: No.

16 Q. (By Mr. Cheffo) Are there other guidelines or

17 recommendations from the American Correctional

18 Association with respect to the use of opioids or

19 treatment of dependent or addicted inmates that the

20 Department of Corrections of Oklahoma does not follow?

21 A. State it again, please.

22 Q. Sure.

23 We talked about medically assisted treatment

24 as being a recommendation from the American

25 Correctional Association. Correct?

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1 A. Correct.

2 Q. Are there other recommendations with respect

3 to either the administration or use of opioids or the

4 treatment of inmates who are addicted or dependent

5 on -- on substances that the State of Oklahoma

6 Department of Corrections does not follow?

7 MR. LEONOUKAKIS: Objection, outside the scope.

8 You can answer in your personal capacity if

9 you're aware.

10 THE WITNESS: I don't -- I don't know.

11 Q. (By Mr. Cheffo) Have you seen any data

12 regarding the benefits of medically assisted

13 treatment?

14 MR. LEONOUKAKIS: Objection.

15 THE WITNESS: Unless there were -- I don't

16 recall.

17 Q. (By Mr. Cheffo) In your 18 years some of what

18 you were involved with, right, was you were an intake

19 person doing clinical work. Right?

20 A. Correct.

21 Q. Then you were at program services, you were

22 looking at grants and substance abuse treatment --

23 A. Correct.

24 Q. -- issues. Right?

25 Then you were the chief of the

Page 93

1 administration of program services. Right?

2 A. Correct.

3 Q. In many of those roles you touched upon

4 individuals who had or issues involving addiction and

5 substance abuse. Fair?

6 A. Fair.

7 Q. And did you ever seek a grant or a -- or

8 funding for medically assisted treatment?

9 MR. LEONOUKAKIS: Objection, outside the scope.

10 THE WITNESS: No.

11 MR. LEONOUKAKIS: You can answer in your personal

12 capacity.

13 Q. (By Mr. Cheffo) Did you ever make that

14 recommendation?

15 MR. LEONOUKAKIS: Same objection.

16 THE WITNESS: Going back that far it is certainly

17 possible that there were grant announcements that may

18 have been around medication assisted treatment, but in

19 my capacity at the time that would be outside of the

20 scope of something that I could do just as the chief

21 administrator of programs.

22 Q. (By Mr. Cheffo) Okay. Do you believe that

23 medically assisted treatment is a beneficial program?

24 MR. LEONOUKAKIS: Objection, outside the scope.

25 You can answer in your personal capacity, if

Page 94

1 you know.

2 THE WITNESS: I think treatment in general can be

3 beneficial to people.

4 Q. (By Mr. Cheffo) What about medically assisted

5 treatment?

6 MR. LEONOUDAKIS: Same objection.

7 THE WITNESS: It certainly is possible.

8 Q. (By Mr. Cheffo) Do you believe that it's

9 something that should be implemented at the Department

10 of Corrections?

11 MR. LEONOUDAKIS: Same objection.

12 THE WITNESS: No.

13 Q. (By Mr. Cheffo) Why not?

14 MR. LEONOUDAKIS: Same objection, outside the

15 scope.

16 You can answer in your personal capacity.

17 THE WITNESS: Given the management, management

18 concerns of how -- how it would be controlled, how it

19 would be administered, the oversighting of it,

20 delivery of it, it would create some new

21 administrative wrinkles.

22 Q. (By Mr. Cheffo) Well, putting aside

23 administrative, if it could be handled administrative

24 do you agree that it would be beneficial for the

25 patient population?

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1 MR. LEONOUDAKIS: Same objection.

2 Q. (By Mr. Cheffo) The inmate population?

3 A. I don't know that I have a feel for what

4 percentage or number of inmates in the population

5 would meet that criteria for treatment.

6 Q. If even one benefited from it would it be

7 beneficial?

8 MR. LEONOUDAKIS: Same objection.

9 THE WITNESS: Sure.

10 MR. CHEFFO: Mark this as Exhibit 5.

11 (Deposition Exhibit Number 5 marked for

12 identification purposes and made part of

13 the record.)

14 Q. (By Mr. Cheffo) I haven't had a chance to go

15 through all your documents but I believe it's probably

16 in your collection. You'll tell me if -- one, if you

17 could tell me what that document is and if you've seen

18 it before.

19 A. It's a policy for inmate medical, mental

20 health and dental care.

21 Q. Did you review that in connection in

22 preparation for your deposition?

23 A. It's not one specifically in my stack today,

24 but I have seen this policy before.

25 Q. Did you review it in preparation for your

Page 96

1 deposition?

2 A. No.

3 Q. You would agree with me that it's a --

4 strike that.

5 What is this?

6 A. It's a health services policy for inmate

7 medical, mental health and dental care.

8 Q. And this is an overall policy regarding

9 inmate medical, mental health and dental care. Is

10 that right?

11 MR. LEONOUDAKIS: Objection.

12 THE WITNESS: It is the policy for inmate

13 medical, mental health and dental care.

14 Q. (By Mr. Cheffo) If you look at Page 3 you'll

15 note that there's page numbers on the top?

16 A. Yes.

17 Q. Do you see pharmaceutical services there?

18 A. Yes.

19 Q. And it says, appropriate management of

20 pharmaceutical services will be available to all

21 inmates.

22 Do you see that?

23 A. Yes.

24 Q. And it says, facilities, on Number 3, will

25 provide secure storage and daily inventory of all

Page 97

1 controlled substances, syringes and needles.

2 Do you see that?

3 A. Yes.

4 Q. How is that done?

5 A. In the pharmacy policy, pharmacy operations,

6 which is 140130, it details the medication

7 administration record, which is the document where

8 inmate medications administered and issued by DOC,

9 QHCPs are recorded. The medication administration

10 record may either be a hard copy or an electronic

11 health record format. And then the daily inventory

12 process under E, Roman numeral IV E, general

13 procedures and practices, contracted pharmacy service

14 provider, procedures are outlined in the MSRM

15 140130-01 entitled pharmacy services which delineates

16 the exact steps involved in medication management.

17 Q. Okay.

18 A. Procedures regarding along in there.

19 Q. Okay. I'll represent to you I -- my

20 understanding is that it was pulled off the Department

21 of Corrections' website and we see it's got an

22 effective date of 03/07/17?

23 A. Yes.

24 Q. Would it be a fair assumption that if it's

25 on the current website this is the most recent

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1 document?
2 A. Yes.
3 Q. It would be the policy and procedure to put
4 the most recent one on if there was something that was
5 after this. Correct?
6 A. Correct.
7 Q. And you're not aware of any policy or
8 procedure -- this, this policy or procedure being
9 revised or updated after 03/07 of 2017?
10 A. To my knowledge this is the most current
11 one.
12 Q. Now, if you look on Section 5, healthcare
13 records, and I'm on Page 3 again.
14 A. Yes.
15 Q. It says health assessments. A health
16 assessments is completed on each inmate upon reception
17 into the system periodically as required by the
18 inmate's health status and age and as appropriate upon
19 transfer between facilities.
20 Do you see that?
21 A. Yes.
22 Q. Is the health assessment that's referred to
23 here the same type of intake assessment that you
24 testified about earlier?
25 A. It includes those, yes.

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1 Q. And in addition to that there's other entry
2 points where a health assessment can be done?
3 A. Correct.
4 Q. And that's all maintained as part of the
5 patient's -- excuse me, as part of the inmate's
6 healthcare records?
7 A. Correct.
8 Q. So if we wanted to find out whether an
9 inmate who had an abuse problem, a drug abuse problem
10 was prescribed a medicine, lawfully prescribed a
11 medicine that they became dependent on, one way we
12 could do it is to actually look at their healthcare
13 records to find out what their history was. Is that
14 right?
15 A. Are you talking about while they're
16 incarcerated?
17 Q. Sure. If we -- if we wanted to find out
18 someone's history, an incarcerated person, one of the
19 things that we could look at was their healthcare
20 records to the extent that they recorded information
21 on intake or somewhere else that would be in there.
22 Right?
23 A. Correct.
24 Q. In other words, their healthcare history
25 doesn't start the day that they get into prison.

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1 Right?
2 A. Presumably, yes. Right.
3 Q. They're asked questions about their history.
4 Right?
5 A. Right.
6 Q. Whether they have any issues with
7 dependence?
8 A. Correct.
9 Q. What medicines they were prescribed. Right?
10 A. Correct.
11 Q. If they -- if they indicated yes, they have
12 a dependence you would expect to see some followup
13 questioning by the healthcare provider, right, when
14 did that start, what drugs were you abusing, were they
15 illegal, things like that. Right?
16 A. Correct.
17 Q. And that would all be maintained in the
18 healthcare records of those, those prisoners?
19 A. To the extent those questions are asked and
20 they are reported, yes.
21 Q. Outside of the correctional facility do you
22 think that medically assisted treatment is a positive
23 thing for people who have substance abuse issues?
24 MR. LEONOUidakis: Objection, outside the scope.
25 You can answer in your personal capacity if

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1 you can.
2 THE WITNESS: Personally I think it could be
3 beneficial.
4 Q. (By Mr. Cheffo) If you knew of someone who
5 had a substance abuse problem you would agree that
6 everything you know about it from your history and
7 your work and what you've read and the recommendations
8 of the organizations of which the Department of
9 Corrections are a member of that medically assisted
10 treatment can both assist the person with removing
11 themselves from a medicine and also increase their
12 prognosis about relapse. Isn't that right?
13 MR. LEONOUidakis: Same objection.
14 THE WITNESS: From a personal opinion I think it
15 can be beneficial. I think, again, personally I would
16 have some concerns whether or not the person would
17 become dependent on the medication that is assisting
18 them and if there are any addiction potential to that.
19 Q. (By Mr. Cheffo) Would you rely on a medical
20 professional to make that determination?
21 A. Sure.
22 Q. Do you see under -- I'm going back to
23 Section V B, there's healthcare records. I'm in 3717
24 document. I think it's Exhibit 5 in front of you.
25 A. Which one again?

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1 Q. I'm on the third page, V B. Do you see
2 that?
3 A. Yes.
4 Q. Healthcare records. The Oklahoma Department
5 of Corrections will maintain comprehensive
6 confidential healthcare records regarding all
7 healthcare services provided to inmates. Right?
8 A. Correct.
9 Q. That's a requirement?
10 A. Yes.
11 Q. And that's complied with?
12 A. Yes.
13 Q. If you wanted to find out information and
14 you were authorized to do that, have an inmate's
15 medical healthcare information, how would you go about
16 doing that?
17 A. For every inmate currently incarcerated or
18 historically incarcerated there is a healthcare record
19 on them. There's a point in time when they were not
20 electronic and a point in time when they were
21 converted to electronic. It depends what information
22 we are looking for in the healthcare record.
23 Q. But -- but let's just talk about the basic
24 IT.
25 A. Okay.

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1 Q. If you wanted to find that information at
2 what point would they be paper?
3 MR. LEONOUidakis: Objection.
4 THE WITNESS: I believe we converted to an
5 electronic health record in 2010 as an agency.
6 Q. (By Mr. Cheffo) And when you converted in
7 2010 did you go back and digitize records prior to
8 2010 or was it basically just forward looking?
9 A. There is an ongoing process whereby old
10 active paper files, individuals who are still in our
11 custody and were in custody when they had a paper file
12 that are being scanned into the existing system.
13 Q. So if an inmate had a 20 year sentence and
14 was in prison let's say in '95, my math is not great,
15 '95, you get the point, and they were still
16 incarcerated, there would be an effort to put those
17 records in a digital format?
18 A. Correct.
19 Q. But after 2010 --
20 A. Everybody --
21 Q. No, that's all right. After 2010 your
22 expectation would be anybody who was in the system,
23 those would all be digital?
24 A. Correct.
25 Q. And is there a group or group of people who

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1 that maintain those types of records?
2 A. Our --
3 Q. So, in other words, if you wanted to find
4 out John Smith's medical record from 2014, who would
5 you go to?
6 A. I'd go to the chief medical officer or one
7 of his staff would tell me. They'd be able to answer
8 questions specifically about any inmate's health
9 record.
10 Q. Who -- is it only the -- strike that.
11 Are there only certain people that are able
12 to access health records of inmates?
13 A. Yes.
14 Q. Is that only medical staff?
15 A. Medical and mental health staff.
16 Q. Is there a separate database that that's all
17 on?
18 MR. LEONOUidakis: Objection, it's outside the
19 scope of the topic.
20 You can answer in your personal capacity.
21 THE WITNESS: I believe the electronic health
22 records are stored on servers through OU Health
23 Science Center.
24 Q. (By Mr. Cheffo) Is there a person who you
25 would start with as kind of an IT person to find out

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1 more nuts and bolts about how you would access or
2 download or get a database if you wanted it?
3 A. Yes.
4 MR. LEONOUidakis: Same objection.
5 Q. (By Mr. Cheffo) Who is that?
6 A. Judy Brinkley, who is one of our nurse
7 managers, who provides oversight in-house for our
8 electronic health record and for the contractor.
9 Q. Do you have any idea about what was
10 collected and produced in this litigation?
11 A. In its totality?
12 Q. At all.
13 MR. LEONOUidakis: Objection.
14 THE WITNESS: No.
15 Q. (By Mr. Cheffo) So whether it's in totality
16 or even one page, you have no idea. Is that right?
17 A. Outside of what I furnished here, no.
18 Q. And those were documents that you either
19 pulled off the website or your lawyer gave you?
20 A. Yes.
21 Q. Were you asked to provide any, any
22 documents?
23 MR. LEONOUidakis: Objection. Caution the witness
24 not to disclose any communications he had with
25 counsel. So if anybody other than your counsel asked

1 you to --

2 MR. CHEFFO: Yeah, with that, no cause for that

3 but I'm sensitive to the issue.

4 Q. (By Mr. Cheffo) I don't want you to tell me

5 any conversations, but did you provide documents or

6 give access to any of your documents in connection

7 with this litigation?

8 A. The only documents I've provided have been

9 to my attorney.

10 Q. Were they documents other than --

11 A. Other than --

12 Q. -- what's produced here?

13 A. -- policies and procedures, no.

14 Q. So no one -- do you operate, do you use a

15 computer in your office?

16 A. Yes.

17 Q. Are you aware of whether any of your

18 documents were collected?

19 MR. LEONOUKAKIS: Objection. This is outside the

20 scope of the topic.

21 You can answer in your personal capacity.

22 I'd just caution the witness not to disclose any

23 communications you had with your counsel.

24 THE WITNESS: If -- if there were any documents,

25 e-mails that were obtained I believe central IT would

1 do that behind the scenes.

2 Q. (By Mr. Cheffo) So you don't know one way or

3 the other?

4 A. So I wouldn't have knowledge if they went

5 into my e-mail and extracted them.

6 Q. And I -- I would just say there's an ongoing

7 you should just be guided, any question I asked you,

8 as I think I've said, I never want you to tell me

9 about conversations you've had with your lawyers. So,

10 if you would need to do that in order to answer you

11 should just tell me and your lawyer that you can't do

12 that because it's based on a conversation. That's not

13 my intention. Okay?

14 A. Okay.

15 (Deposition Exhibit Number 6 marked for

16 identification purposes and made part of

17 the record.)

18 Q. (By Mr. Cheffo) I've marked this document,

19 sir, as Exhibit 6. When you've had a chance to look

20 at it would you tell us what that is?

21 A. This is the MSRM for controlled drug

22 procedures.

23 Q. Is that a document that you reviewed in

24 preparation for the deposition?

25 A. Yes.

1 Q. Is that one of the documents that you have

2 before you?

3 A. I think so. Yes.

4 Q. And the person who either promulgated or

5 signed this document is Dr. Joel McCurdy. Do you see

6 that? It's on the first page, sir.

7 A. Yes.

8 Q. Just for the record, when I see in this case

9 Joel McCurdy, M.D. --

10 A. Uh-huh.

11 Q. -- chief medical officer, is that the

12 equivalent of Dr. McCurdy signing this document as

13 promulgating it?

14 A. That's -- the signature block on policies

15 and procedures are the signature block on MSRMs where

16 it says signature on file means that it has gone

17 through its final review process. On the last page

18 under action directs who is responsible for it whether

19 it's the compliance with the procedure itself or any

20 reviews or revisions. So, the signature block means,

21 yes, he has completed all those requirements and his

22 signature is on file as approving.

23 Q. Okay. And thank you. So I've seen that on

24 the bottom of some of these policies it will say

25 action and it talks about the person who is ultimately

1 responsible. That means that the kind of buck stops

2 with them with respect to that policy?

3 A. Correct.

4 Q. What -- what's the purpose of this, this

5 policy in general terms?

6 MR. LEONOUKAKIS: Objection.

7 THE WITNESS: As it states, it defines the

8 process for control and accountability of controlled

9 drugs distributed and administered by medical service

10 providers to offenders in the Oklahoma Department of

11 Corrections.

12 Q. (By Mr. Cheffo) Okay. If you look at the

13 second page of this, 1734.

14 A. Uh-huh.

15 Q. It talks about stock controlled, I'm on the

16 very bottom.

17 A. Yes.

18 Q. It's under ordering, stock controlled

19 pharmaceuticals will be ordered on the controlled drug

20 stock order schedules 3-5 only.

21 Do you see that?

22 A. Yes.

23 Q. And Schedule II controlled pharmaceuticals

24 for starter stock must be ordered by a DEA 222 form

25 specific for that DOC facility address.

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1 Do you see that?
2 A. Yes.
3 [REDACTED]
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]
9 [REDACTED]
10 Q. Can you turn to 1737?
11 A. Okay.
12 Q. It's Page 5. There's a section here, nine,
13 it talks about theft or loss of controlled substances.
14 Do you see that?
15 A. Yes.
16 Q. Are you aware of any circumstances of theft
17 or lost of controlled substances?
18 A. Specific instances, no. But in general it's
19 in policy because it does occasionally occur where
20 staff divert medications and the process is in place
21 so that we can initiate an investigation.
22 Q. What does it mean staff divert medications?
23 A. It means that qualified staff who have
24 access to dispense those medications through the
25 logbook when they check it out, instead of wasting or

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1 disposing of a med or administering the med they could
2 potentially divert that and alter the logbook.
3 Q. And by diverting that means either taking it
4 themselves or giving it to an inmate or selling it or
5 doing something unlawful. Right?
6 A. It just means it did not wind up where it
7 was supposed to go.
8 Q. Well, divert is a -- is not a policy that's
9 condoned by the Department of Corrections, is it?
10 A. No, it's not.
11 Q. Divert either means take, steal, sell, do
12 something that's illegal. Right?
13 A. It means not administering it as the way
14 that it was supposed to be administered.
15 Q. And if someone diverts -- sorry.
16 A. Go ahead.
17 Q. If -- if one of the -- the DOC employees
18 diverts a scheduled medicine, there can be and often
19 would be serious ramifications for that person.
20 Right?
21 A. Correct.
22 Q. And there have been situations where that's
23 occurred?
24 A. Correct.
25 Q. And there are records of those?

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1 A. Records of --
2 Q. Of diversion?
3 A. Yes.
4 Q. And one of the things -- in this case you
5 would file a serious incident report. Right?
6 A. Correct.
7 Q. Because it would be a serious incident?
8 A. Correct.
9 Q. If you'd please look to 1739. There's also
10 a recordkeeping requirement. It says, by Oklahoma law
11 all records for controlled substances, see listing
12 below, must be kept for a period of five years. These
13 records should be filled -- I'm sorry, filed and
14 maintained by the facility CHSA in a secure location
15 with limited access.
16 Do you see that?
17 A. Yes.
18 Q. What is the facility CHSA?
19 A. The Correctional Health Service
20 Administrator.
21 Q. And to your knowledge is the Department of
22 Corrections in compliance with this regulation?
23 A. Yes.
24 Q. Do they keep records more than five years?
25 A. I don't know.

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1 Q. If there's policies that something be kept
2 for five or three or so years, are they routinely
3 purged?
4 A. To my knowledge, yes, based on the
5 destruction schedule.
6 Q. And do you know whether any policies or
7 destruct -- destruction schedules have been suspended
8 or altered as a result of this litigation?
9 A. I believe you asked me that question earlier
10 and it seems as though now after our initial meeting
11 at the AG's office that our general counsel set out
12 instructions to not destroy any records related to
13 this which was sent out to all facility CHSAs and
14 medical providers. The directive was given.
15 Q. Okay.
16 (Deposition Exhibit Number 7 marked for
17 identification purposes and made part of
18 the record.)
19 Q. (By Mr. Cheffo) Are you familiar with this
20 document?
21 A. It's the formulary.
22 Q. Just to be clear, when you say it's the
23 formulary, this is the list of medicines that are
24 approved by your P and T committee to be on the
25 formulary for the Oklahoma Department of Corrections?

29 (Pages 110 - 113)

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1 A. As of March 2018.
2 Q. And the individuals who were part of the P
3 and T committee who make the decisions include
4 individuals designated by the chief medical officer?
5 A. Correct.
6 Q. And also there's participation by Diamond
7 Pharmacy Services?
8 A. I believe that is correct.
9 Q. Are any pharmaceutical companies part of the
10 P and T decisions?
11 A. No. Not -- not to my knowledge.
12 Q. Have you ever been aware that anyone
13 associated with any pharmaceutical company has ever
14 sat or been part of decisions made by the P and T
15 committee?
16 MR. LEONOUKAKIS: Objection.
17 You can answer --
18 THE WITNESS: Not to my knowledge. I think it
19 would be in the procedure if that was intended or
20 allowed.
21 Q. (By Mr. Cheffo) And there's nothing in the
22 procedure currently that would allow that, would it?
23 A. Nothing.
24 Q. And in your preparation did you find out how
25 often the formulary is modified?

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1 A. In review of the policy, the pharmacy
2 operations policy where it talks about oversight of
3 pharmacy services and pharmacy operations, the
4 committee meets quarterly. So there is potential that
5 it can be modified quarterly.
6 Q. If you look on page -- the second page,
7 which is 1765, you see that it indicates that this is
8 the March 2018 version. Right?
9 A. Correct.
10 Q. And am I correct that this also tells us
11 that we don't know when the proper -- so we don't know
12 what date the prior one was or how long it was in
13 existence, we know that the changes are that it added
14 tramadol and it didn't delete anything?
15 A. Correct.
16 Q. But you don't know how long the prior one
17 was in existence or any changes that may have occurred
18 with respect to the formularies other than this one.
19 Is that right?
20 A. Correct.
21 Q. And these medicines are all listed in some
22 type of grouping. Is that right?
23 MR. LEONOUKAKIS: Objection.
24 THE WITNESS: It appears that way.
25 Q. (By Mr. Cheffo) The first one is anti

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1 migraine. Right? And they're grouped a bunch of anti
2 migraine medicines. Right?
3 A. They grouped a lot of medicines. I couldn't
4 tell you if those are anti migraine medications or
5 not.
6 Q. If they say anti migraine above them would
7 you assume that they're anti migraine?
8 A. I would assume that they are.
9 Q. You have no reason to believe that this is a
10 wholly inaccurate document, do you?
11 A. No.
12 Q. You have faith in this, don't you?
13 A. Yes.
14 Q. Because this is done at the direction of
15 your CMO?
16 A. Correct.
17 Q. Who reports to you. Right?
18 A. Correct.
19 Q. And if you thought there was anything wrong
20 with this process you would be talking to your CMO.
21 Right?
22 A. Correct.
23 Q. Now, the next one is narcotic analgesics,
24 right, and anti-pyretics.
25 Do you see that?

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1 A. Yes.
2 Q. And there is a number of narcotic analgesics
3 listed here, at least a number of dosage types. Do
4 you see that?
5 A. Correct.
6 Q. And morphine?
7 A. Yes.
8 Q. Yes? Is that a controlled substance?
9 A. I believe so, yes.
10 Q. Am I correct that you have really no idea or
11 no information about any policies or procedures with
12 respect to how morphine is or should be administered
13 or prescribed?
14 A. Correct.
15 Q. And you don't know how often it's used, do
16 you?
17 A. No.
18 Q. You don't know under what circumstances it's
19 used?
20 A. Other than what we discussed under
21 palliative care or infirmary care, no.
22 Q. If -- if patients -- strike that.
23 If inmates receive morphine, for example, do
24 they receive any type of package information or
25 labeling?

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1 MR. LEONOUKAKIS: Objection.
2 THE WITNESS: I don't know.
3 Q. (By Mr. Cheffo) Who would know that?
4 A. The chief medical officer.
5 Q. Do they receive any, any warnings or
6 information about risks when they're prescribed
7 morphine?
8 MR. LEONOUKAKIS: Objection.
9 THE WITNESS: I don't know.
10 Q. (By Mr. Cheffo) There's no policy about that?
11 (A brief pause.)
12 A. Can you repeat the question again, please?
13 Q. Is there a policy about advising inmates
14 about the risks of prescription medicines including
15 narcotic analgesics?
16 A. Not that I'm aware of using that language
17 specifically.
18 Q. Are you aware of anything, any policy,
19 procedure or practice about providing any types of
20 information or warnings of risks in connection with
21 the administration of narcotic analgesics?
22 A. No.
23 Q. There's also a list here on -- there's also
24 a list -- strike that.
25 It's also listed as it says Hydrocod. Is --

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1 do you understand to be hydrocodone?
2 A. Yes.
3 Q. And that's also a narcotic analgesic.
4 Right?
5 A. Yes.
6 Q. That's a scheduled medicine?
7 A. Yes.
8 Q. That's approved for use in the prisons?
9 A. Yes.
10 Q. As is morphine?
11 A. Yes.
12 Q. Do those medicines have the risk of
13 addiction?
14 MR. LEONOUKAKIS: Objection.
15 THE WITNESS: Yes.
16 MR. LEONOUKAKIS: You can answer if you can.
17 THE WITNESS: Yes.
18 Q. (By Mr. Cheffo) Do they have the risk of
19 abuse?
20 MR. LEONOUKAKIS: Objection.
21 THE WITNESS: Yes.
22 Q. (By Mr. Cheffo) It's fair to say they
23 wouldn't be on this if -- if the P and T committee
24 didn't believe that they provided some benefit to
25 inmates who were prescribed them. Right?

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1 A. Yes.
2 Q. That's what the point of the formulary is.
3 Right?
4 A. Correct.
5 Q. Are you aware of any policy or practice that
6 limits the amount of initial dose of opioid analgesics
7 that a healthcare provider can provide to an inmate?
8 A. No.
9 Q. Are you aware that other prison systems have
10 policies and procedures limiting the initial dose of
11 narcotic analgesics?
12 MR. LEONOUKAKIS: Objection, outside the scope.
13 You can answer in your personal capacity.
14 THE WITNESS: No.
15 Q. (By Mr. Cheffo) Are you aware of whether
16 there's any of those regulations with respect to other
17 governmental organizations?
18 MR. LEONOUKAKIS: Same objection.
19 THE WITNESS: No.
20 Q. (By Mr. Cheffo) So, is it fair to say that
21 you don't know what information is provided to a
22 patient, whether there's any limitations on the amount
23 of initial prescriptions or refill prescriptions or
24 for what purposes patients are prescribed, inmates are
25 prescribed narcotic analgesics in the correctional

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1 institutions?
2 MR. LEONOUKAKIS: Objection, misstates the
3 testimony.
4 If you understand that you can answer it.
5 MR. CHEFFO: Can you read it back?
6 (The record was read as directed.
7 "Q. So, is it fair to say that you don't know
8 what information is provided to a patient, whether
9 there's any limitations on the amount of initial
10 prescriptions or refill prescriptions or for what
11 purposes patients are prescribed, inmates are
12 prescribed narcotic analgesics in the correctional
13 institutions?")
14 MR. LEONOUKAKIS: Same objection.
15 THE WITNESS: The only part of that that I'm
16 aware of that we primarily use those medications for
17 are for palliative care or potentially short term
18 post-op.
19 Q. (By Mr. Cheffo) Okay. And with respect to
20 any information about what the protocol is or how
21 they're prescribed or why, do you have any information
22 about that?
23 A. No.
24 Q. You just know that they are permitted for
25 use for palliative and end of life care. Is that

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1 right?

2 MR. LEONOUKAKIS: Objection.

3 THE WITNESS: For those and -- I term that in

4 that that is the most common way that I hear them

5 discussed is for palliative care, end of life care or

6 again, postoperative care or short term to treat some

7 condition.

8 Q. (By Mr. Cheffo) Okay. And whether they are

9 prescribed for other purposes, you just don't know?

10 A. Don't know.

11 Q. Are there other medicines other than opioids

12 that have a heightened sense of security in terms of

13 the way that the Department of Corrections treats them

14 to avoid diversion or abuse?

15 MR. LEONOUKAKIS: Objection, outside the scope.

16 You can answer if you know.

17 THE WITNESS: It would just be those that are

18 listed as scheduled substances that are under the

19 controlled drug procedure MSRM.

20 Q. (By Mr. Cheffo) Are there specific drugs

21 listed?

22 A. There are not specific drugs, they're just

23 scheduled, so anything that would fall under those

24 categories.

25 Q. You have the formulary in front of you. Can

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1 you identify any others?

2 MR. LEONOUKAKIS: Objection, outside the scope.

3 You can answer if you know.

4 THE WITNESS: I don't know.

5 Q. (By Mr. Cheffo) You don't know?

6 A. Don't know.

7 Q. Now, if you look at Page 1792.

8 A. Okay.

9 Q. Do you see that it says unclassified?

10 A. Yes.

11 Q. And if you flip the page and if you -- it's

12 in alphabetical order. Do you see fentanyl?

13 A. Yes.

14 Q. Fentanyl is an opioid analgesic, isn't it?

15 A. Yes.

16 Q. So why isn't it listed in the opioid

17 analgesic section?

18 MR. LEONOUKAKIS: Objection.

19 THE WITNESS: I don't know. I don't know.

20 Q. (By Mr. Cheffo) So if it's listed as

21 unclassified, does that mean that all of the

22 procedures and policies with respect to opioid

23 analgesics or scheduled medicines are not applicable

24 to fentanyl?

25 MR. LEONOUKAKIS: Objection.

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1 THE WITNESS: I don't know.

2 Q. (By Mr. Cheffo) You agree it is an opioid

3 medication. Right?

4 A. Yes.

5 Q. And as part of your preparation for this

6 deposition did you ask about any policies or practices

7 or procedures for the use of fentanyl for prisoners in

8 the facilities?

9 A. No, not fentanyl specifically.

10 Q. Do you know what Phentamine is?

11 MR. LEONOUKAKIS: Objection, outside the scope.

12 You can answer if you know personally.

13 THE WITNESS: No.

14 Q. (By Mr. Cheffo) Is it an animal -- is it also

15 used as an animal tranquilizer?

16 MR. LEONOUKAKIS: Objection, same objection.

17 THE WITNESS: If you say so.

18 Q. (By Mr. Cheffo) You just don't know one way

19 or the other?

20 A. Just don't know.

21 Q. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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1 MR. LEONOUKAKIS: Objection.

2 Q. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

6 Q. As you sit here today do you have any idea

7 why fentanyl is on the same list as Castor Oil and BD

8 Syringe/luer Tip Cap and Magnesium Oxide?

9 MR. LEONOUKAKIS: Objection, outside the scope.

10 Answer if you know personally.

11 THE WITNESS: I don't know.

12 MR. CHEFFO: Let's mark this next document.

13 (Deposition Exhibit Number 8 marked for

14 identification purposes and made part of

15 the record.)

16 Q. (By Mr. Cheffo) This is marked as Exhibit 8.

17 This is another formulary. No. This is the August

18 2018?

19 A. Correct.

20 Q. So this, this is a few months after the one

21 we were just talking about. Right?

22 A. Correct.

23 Q. And if we want to know what the changes are

24 we would look on the second page?

25 A. Correct.

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1 Q. Do you know from looking at the second page
2 whether any opioid analgesics were added or deleted?
3 A. I do not.
4 Q. Does that mean you don't see any?
5 A. I don't know.
6 Q. Can you tell from looking at them?
7 A. I don't pretend to know every name of opioid
8 analgesics.
9 Q. But do you recognize any?
10 A. No.
11 Q. And if you turn to the first page, this is
12 number one, it's the A, analgesic and inflammatory
13 agents?
14 A. Yes.
15 Q. Like the one we talked about, the March
16 version, hydrocodone and morphine are listed. Right?
17 A. Yes.
18 Q. I was just looking to see if there's a
19 section for unclassified in this version. Do you see
20 one? Actually I'm told it's Page 27, sir.
21 A. Yes.
22 Q. And again, fentanyl is listed. Do you see
23 that?
24 A. Yes.
25 Q. Am I correct you'd have the same answer,

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1 that you don't know why it's there, what unclassified
2 means?
3 A. Correct.
4 Q. And the same would be true for ketamine,
5 which you don't know what it is. Right?
6 A. Correct.
7 Q. Okay.
8 MR. CHEFFO: We've been going for a little bit.
9 Want to take a few minute break?
10 THE VIDEOGRAPHER: Going off the record. This
11 ends Media Number 2. The time is 11:42.
12 (A recess was here had 11:42 to 11:55.)
13 THE VIDEOGRAPHER: Back on the record, beginning
14 Media Number 3. The time is 11:55.
15 Q. (By Mr. Cheffo) So, I thought I -- I heard
16 you testify earlier, correct me if I misheard it or
17 misremembered it, that your understanding is opioids
18 are used for palliative care. Did you also -- also
19 say postsurgical?
20 A. I said I believe that they can be used for
21 that, yes.
22 Q. Do you know if they are?
23 A. No.
24 Q. Do you -- are you aware of any policies or
25 procedures with respect to the use of opioids and

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1 acute pain?
2 A. I don't believe there's -- to my knowledge
3 there's nothing in our policies that discuss acute
4 pain specifically.
5 Q. What about chronic pain?
6 A. Either.
7 Q. If there is a statewide policy regarding the
8 administration of opioids and use of opioids, would
9 that bind the Department of Corrections?
10 MR. LEONOUKAKIS: Objection.
11 Answer if you know.
12 THE WITNESS: To my knowledge we're bound by
13 what's in state law and statute and the policies and
14 procedures that are promulgated for the agency.
15 Q. (By Mr. Cheffo) What about other agencies
16 like the Department of Health or -- strike. Or like
17 the Department of Health?
18 MR. LEONOUKAKIS: Objection.
19 THE WITNESS: To my knowledge only if it is
20 specified in state law.
21 Q. (By Mr. Cheffo) Are there different
22 procedures for inmates with respect to the
23 administration of medicines than there are for people
24 who are not inmates?
25 MR. LEONOUKAKIS: Objection.

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1 THE WITNESS: I don't know. Certainly there are
2 our own policies and procedures which are specific to
3 those that are incarcerated in the Department of
4 Corrections. I can't speak to outside of that.
5 Q. (By Mr. Cheffo) What are -- what are those?
6 A. In agency operations they're everything
7 that's detailed under the 14, the 14 section are all
8 of the health services and medical and mental health
9 policies.
10 Q. Who is in charge of administering those?
11 A. What do you mean by administering?
12 Q. Who is ultimately responsible for the
13 administration of those policies?
14 A. All policies in effect have to be signed by
15 the director of the agency.
16 (Deposition Exhibit Number 9 marked for
17 identification purposes and made part of
18 the record.)
19 Q. (By Mr. Cheffo) Let me show you what we've
20 marked as Exhibit 9. Do you see these Oklahoma opioid
21 prescribing guidelines?
22 A. Yes.
23 Q. Have you ever seen this before? Did you
24 look at these in preparation for your deposition?
25 A. No.

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1 Q. Do you know who promulgates this document?
2 MR. LEONOUKAKIS: Objection.
3 THE WITNESS: No.
4 Q. (By Mr. Cheffo) Doesn't it say on the second
5 page?
6 MR. LEONOUKAKIS: Objection, outside the scope.
7 THE WITNESS: Which part are you referring to?
8 Q. (By Mr. Cheffo) Right down here, sir,
9 Oklahoma State Department of Health at the bottom
10 right.
11 A. Yes.
12 Q. This is from the Oklahoma State Department
13 of Health, isn't it?
14 MR. LEONOUKAKIS: Objection.
15 THE WITNESS: I assume.
16 Q. (By Mr. Cheffo) Isn't that what it says?
17 A. It is a document that has their insignia on
18 it, the Oklahoma State Department of Health.
19 Q. I'll represent to you we took it off the
20 website.
21 And it says Oklahoma opioid prescribing
22 guidelines. Do you see that on the first page?
23 A. Yes.
24 Q. And it says opioid treatment for acute pain.
25 Do you see that?

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1 A. Yes.
2 Q. It says, avoid prescribing opioids to
3 patients currently taking benzodiazepines, I'm in
4 Number 4, or other opioids -- and/or other opioids.
5 Do you see that?
6 A. Yes.
7 Q. Is that a policy or procedure of the
8 Department of Corrections?
9 MR. LEONOUKAKIS: Objection, outside the scope.
10 If you want to take time to read this before
11 you answer questions, go for it.
12 Q. (By Mr. Cheffo) Let me ask you just a general
13 question. You can -- you can read the whole thing if
14 you'd like. Are -- can you testify here that any of
15 these guidelines are or are not standards, practices
16 or procedures that are employed or adopted by the
17 Oklahoma Department of Corrections?
18 (A brief pause.)
19 A. The question again, please.
20 MR. CHEFFO: Can you read it back, please?
21 (The record was read as directed.)
22 "Q. Let me ask you just a general question. You
23 can -- you can read the whole thing if you'd like.
24 Are -- can you testify here that any of these
25 guidelines are or are not standards, practices or

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1 procedures that are employed or adopted by the
2 Oklahoma Department of Corrections?")
3 THE WITNESS: At the top where it says these are
4 general guidelines and they don't replace clinical
5 judgment and appropriate care of patients, I believe
6 the clinical judgment is what our providers use in
7 adopting may be a tent -- intent of some of these,
8 majority of these written in their care of our patient
9 population.
10 MR. CHEFFO: Move to strike.
11 Q. (By Mr. Cheffo) My question is, do you know,
12 can you testify from your knowledge and preparation as
13 to whether any of these are or are not incorporated
14 into policies, procedures or standards of the
15 Department of Corrections?
16 MR. LEONOUKAKIS: Objection.
17 THE WITNESS: No.
18 MR. LEONOUKAKIS: Asked and answered.
19 Q. (By Mr. Cheffo) So you just read the entire
20 document and you can't tell us, right, which of these
21 are part of the policies or procedures and which are
22 not because you're not familiar with the policies and
23 procedures.
24 MR. LEONOUKAKIS: Objection --
25 Q. (By Mr. Cheffo) Is that fair?

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1 MR. LEONOUKAKIS: -- misstates -- misstates his
2 testimony.
3 THE WITNESS: I'm familiar with the policies and
4 procedures that make up the health services division
5 for our agency, but I don't believe that these
6 specifics, specific regurgitation of this information
7 or references to the State Department of Health are
8 carried in any of our existing policies.
9 Q. (By Mr. Cheffo) So, which standards, policies
10 and procedures are there that the Department of
11 Corrections maintains for the diagnosis and treatment
12 of pain other than palliative care?
13 A. Other than palliative care there is not a
14 specific policy or MSRM that I'm aware of that is
15 specifically for pain management.
16 Q. So to the extent any of these
17 recommendations or guidelines talk about pain
18 management, they would not be in the Department of
19 Corrections' policies or procedures or standards
20 because you don't have any. Is that right?
21 MR. LEONOUKAKIS: Objection.
22 THE WITNESS: Correct.
23 Q. (By Mr. Cheffo) And are you aware of the
24 standards, practices, procedures for the use of opioid
25 medications other than for end of life or palliative

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1 care?

2 A. Outside of what's documented in the pharmacy

3 op and controlled substances, which really makes a

4 distinction based on schedule, not type of medication,

5 that's as far as I know that it goes in the policy.

6 Q. So to the extent any of these guidelines

7 from the Oklahoma State Department of Health talk

8 about the standards or practices or procedures for the

9 use of opioid medications, they are not part of any

10 policy or procedure at the Department of Corrections

11 because you don't have any?

12 MR. LEONOUKAKIS: Objection, misstates the

13 testimony.

14 THE WITNESS: As it relates to an actual policy

15 around opioid prescribing, no, we do not have a policy

16 around opioid prescribing.

17 Q. (By Mr. Cheffo) So, do you see on opioid

18 treatment for acute pain on the first page, sir?

19 A. Yes.

20 Q. It says by Ok -- I take it that the

21 healthcare providers who work for the Department of

22 Corrections are required to follow Oklahoma law?

23 A. Correct.

24 Q. [REDACTED]

[REDACTED]

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1 procedure, guideline that opioids should not be

2 prescribed to patients taking benzodiazepines?

3 MR. LEONOUKAKIS: Objection.

4 THE WITNESS: I do not. Although, again, the

5 prescribing practices goes back to the clinical

6 judgment of our providers when it comes to what

7 they're prescribing and the interactions.

8 Q. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

21 Q. (By Mr. Cheffo) The CMO reports to you.

22 Right?

23 A. Correct.

24 Q. You had complete access to them I suppose.

25 Right?

Page 135

1 [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

9 Q. You're not aware of any policy that says the

10 healthcare providers who prescribe opioids actually

11 have to follow Oklahoma law?

12 MR. LEONOUKAKIS: Objection, misstates testimony.

13 (A brief pause.)

14 Q. (By Mr. Cheffo) Let me withdraw the question.

15 Let me just ask you this. Are you -- do you have any

16 information about any policies or procedures that

17 healthcare providers who work for the DOC undertake

18 with respect to checking the Oklahoma prescription

19 monitoring program?

20 A. No.

21 Q. And so you don't know whether they do it

22 every 180 days or whether they don't do it or whether

23 they do it more frequently or less frequently. Right?

24 A. Right.

25 Q. Do you know whether there is a policy or

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1 A. Sure.

2 Q. And if he was asked to testify he could have

3 testified. Right?

4 MR. LEONOUKAKIS: Objection.

5 THE WITNESS: I suppose.

6 Q. (By Mr. Cheffo) Is there any policy that long

7 acting or extended release opioids should not be

8 prescribed for acute pain?

9 A. Not to my knowledge.

10 Q. And then for chronic pain, do you see that,

11 sir, opioid treatment for chronic pain?

12 A. Yes.

13 Q. There's no dispute that there is such a

14 thing called chronic pain, isn't there?

15 MR. LEONOUKAKIS: Objection.

16 THE WITNESS: Yes.

17 Q. (By Mr. Cheffo) Yes, you agree with me or --

18 A. Yes, there is such a thing as chronic pain.

19 Q. Thank you.

20 And under four it says, the health care

21 provider should screen for risk of abuse or addiction

22 before initiating opioid treatment.

23 Do you see that?

24 A. Yes.

25 Q. Is that -- is that a policy or procedure of

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1 the Department of Corrections?
2 A. No. I believe it's a function of our
3 providers as they review an inmate's intake and
4 healthcare history as documented in the electronic
5 health record.
6 Q. So is it your testimony they do that, they
7 screen for risk of abuse or addiction before
8 initiating therapy?
9 A. I believe so.
10 Q. Do you have a basis for that?
11 A. The electronic health record can track what
12 medications someone is on electronically and that can
13 be reviewed for interactions.
14 Q. Because I think -- and forgive me if I asked
15 a confusing. But I think this Number 4 says the
16 health care provider should screen for risk or abuse
17 before making, before initiating opioid treatment.
18 So my question is, is there a policy or
19 procedure that you're aware of that -- that
20 essentially codifies that guideline?
21 A. No.
22 Q. And you don't know one way or the other
23 whether that happens or not?
24 A. No.
25 Q. Number 7 says, a written treatment plan

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1 should be established that includes measurable goals
2 for reduction of pain and improvement of function.
3 Do you see that?
4 A. Yes.
5 Q. And you're not aware of any policy that
6 would incorporate that recommendation, are you?
7 A. No, I'm not.
8 Q. And you don't know whether that happens or
9 not, do you?
10 A. No.
11 Q. Do you think the CMO is -- is it part within
12 his scope of responsibilities to be generally aware of
13 guidelines and procedures promulgated by the Oklahoma
14 Department of Health?
15 MR. LEONOUKAKIS: Objection, outside the scope.
16 Answer in your personal capacity.
17 THE WITNESS: It's his responsibility to be up on
18 best clinical practices in general of medicine.
19 Q. (By Mr. Cheffo) You supervise him. Right?
20 A. Administratively, yes.
21 Q. And from an administrative supervision
22 perspective, would it be your expectation that the
23 chief medical officer for the Department of
24 Corrections would be aware of Oklahoma department of
25 state guidelines and recommendations?

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1 MR. LEONOUKAKIS: Objection, same objection.
2 THE WITNESS: To the extent that they apply to
3 the population treated in our custody, yes.
4 Q. (By Mr. Cheffo) And you know from what we
5 looked at the formulary that some population that are
6 treated have access to opioid analgesics including
7 morphine, fentanyl and hydrocodone?
8 MR. LEONOUKAKIS: Objection.
9 THE WITNESS: They're listed in the formulary, so
10 yes, they can be prescribed.
11 Q. (By Mr. Cheffo) So this document that talks
12 about opioid -- Oklahoma opioid prescribing guidelines
13 would apply to at least some population of the
14 individuals in custody in the Department of
15 Corrections. Right?
16 MR. LEONOUKAKIS: Objection.
17 THE WITNESS: Well, at the top of this it says
18 they're not intended as standards of care or as a
19 template for legislation. They're recommendations.
20 Q. (By Mr. Cheffo) I understand that.
21 A. So --
22 Q. But they -- these guidelines would apply.
23 They're not -- they're not requirements. Right?
24 MR. LEONOUKAKIS: Objection.
25 Q. (By Mr. Cheffo) They're guidelines. Yes?

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1 A. Recommendations, yes.
2 Q. Okay. These recommendations would encompass
3 individuals within the control of the Department of
4 Corrections. Right?
5 MR. LEONOUKAKIS: Objection.
6 THE WITNESS: Possibly.
7 Q. (By Mr. Cheffo) You -- you're aware that
8 there are some patients who are receiving opioid
9 medicines in the custody of the Department of
10 Corrections, aren't you?
11 A. Correct.
12 Q. Now, if you look at 15 -- actually before we
13 get that, 12, it says opioid treatment should be
14 tapered or gradually discontinued if adverse effects
15 outweigh benefits or if aberrant, dangerous, or
16 illegal behaviors are demonstrated.
17 Do you see that?
18 A. Yes.
19 Q. Are you aware of any policies or procedures
20 regarding the tapering of opioid medicines from
21 individuals who have a dependence?
22 A. Yes. OP-140123, chemically dependent
23 inmates, medical detoxification and tapered
24 withdrawals will be in accordance with the orders from
25 a treating psychiatrist slash physician.

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1 Q. Okay. And do you have a -- do you know what
 2 tapering is?
 3 MR. LEONOUKAKIS: Objection.
 4 THE WITNESS: My understanding that's where they
 5 gradually decrease the amount of medication.
 6 Q. (By Mr. Cheffo) And is that a policy of the
 7 Department of Corrections to taper dependent inmates?
 8 A. As written.
 9 Q. And as -- as -- as the healthcare provider
 10 determines is appropriate. Right?
 11 A. Correct.
 12 Q. You leave that decision to the doctor?
 13 A. Correct.
 14 Q. And then 15, healthcare provider should
 15 offer a range of evidence based treatment and it says
 16 usually medication assisted treatment with
 17 buprenorphine, buprenorphine or methadone in
 18 combination with behavioral therapies for patients
 19 with opioid use disorder.
 20 Do you see that?
 21 A. Yes.
 22 Q. Is that something that the Department of
 23 Corrections provides?
 24 MR. LEONOUKAKIS: Objection.
 25 THE WITNESS: Only to the extent we discussed

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1 earlier with pregnant females who are received already
 2 on methadone treatment.
 3 Q. (By Mr. Cheffo) Other than pregnant females,
 4 is this guideline put in place in the Department of
 5 Corrections?
 6 MR. LEONOUKAKIS: Objection.
 7 THE WITNESS: It is not.
 8 Q. (By Mr. Cheffo) Do you have -- does the
 9 Department of Corrections have any interaction with
 10 the Oklahoma Department of Mental Health?
 11 A. Yes.
 12 Q. In what way?
 13 A. Currently we have con -- historically we've
 14 had contracts in place with the Department of Mental
 15 Health proper. We also have some contracts in place
 16 through agencies that are certified by the Department
 17 of Mental Health and Substance Abuse Services to
 18 provide counseling groups.
 19 Q. So does department -- the Oklahoma
 20 Department of Mental Health actually provide mental
 21 health services to inmates?
 22 A. We make a distinction between mental health
 23 services and addiction services.
 24 Q. Can you please tell me what those are?
 25 A. So, we have our own in-house and mental

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1 health staff who are psychiatrists, psychologists and
 2 master's level clinicians. They provide services to
 3 the mentally ill in our population. If the mentally
 4 ill are deemed stable enough through a classification
 5 process where they can participate in programming or
 6 group services, then that's where they would receive
 7 treatment for addictions in a group. If they are not
 8 stable enough it's part of the overall treatment plan
 9 that our mental health staff deal with them on a more
 10 individualized or smaller group basis.
 11 Q. Okay, thanks. So let me just see if I got
 12 that. You have your -- the Department of Corrections
 13 has its own mental health staff of professionals and
 14 to the extent that someone is deemed an appropriate
 15 candidate they could receive addiction services in a
 16 group and that would be administered by the Oklahoma
 17 Department of Mental Health. Is that right?
 18 A. Correct.
 19 Q. And the Oklahoma Department of Mental
 20 Health, do they have the oversight and responsibility
 21 for the administration of the programs for those
 22 inmates who are qualified to participate in those
 23 addiction programs?
 24 MR. LEONOUKAKIS: Object to this, outside the
 25 scope of the topic.

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1 You can answer in your personal capacity if
 2 you know.
 3 THE WITNESS: In terms of -- of oversight,
 4 there's policies and procedures under programs that
 5 dictate average length and content of programming. So
 6 in terms of that agency they are contracted to provide
 7 a prescribed set of services, group counseling, cog
 8 behavior and nature, manual driven. The --
 9 Q. (By Mr. Cheffo) I'm sorry --
 10 A. Go ahead.
 11 Q. No, I was going to -- did you -- did you
 12 review those in preparation for the deposition?
 13 MR. LEONOUKAKIS: Same objection.
 14 THE WITNESS: No, because it's outside of health
 15 services. It's a programs issue.
 16 Q. (By Mr. Cheffo) If I want to understand the
 17 specifics would you be the right person to talk to?
 18 A. Specifics of?
 19 Q. Of the programming done by the Department of
 20 Mental Health for inmates?
 21 MR. LEONOUKAKIS: Same objection.
 22 THE WITNESS: Historically that was a role I
 23 played with the agency. In terms of what they
 24 currently do, what programs are, what those contracts
 25 look like, no, I have no oversight over that anymore.

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1 Q. (By Mr. Cheffo) Do they come into the -- into
2 the prisons and perform those functions typically?
3 A. Yes.
4 Q. And the prisoners are in a secure facility.
5 Correct?
6 A. Yes.
7 Q. And the people and entities who decide
8 whether those prisoners can participate, that's done
9 by the Department of Corrections. Correct?
10 MR. LEONOUKAKIS: Same objection, outside the
11 scope of the topic.
12 You can answer in your personal capacity.
13 THE WITNESS: The Department of Corrections at
14 the point of intake develops a -- what we call a case
15 plan which is designed to list certain programmatic
16 needs of which substance abuse treatment can be one
17 of. There is more additional assessment done by the
18 Department of Mental Health staff at the point in time
19 the inmate is eligible to go into a treatment program.
20 Q. (By Mr. Cheffo) Who runs those programs once
21 a -- once a patient -- excuse me, once an inmate let's
22 assume he goes to a specific room or location in the
23 prison with a group of other folks and there is a
24 mental health professional from the Department of
25 Mental Health conducting a session. Is -- is that

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1 session conducted within the protocols and
2 programmatic scheduling of the Department of Mental
3 Health or the Department of Corrections or a
4 combination?
5 MR. LEONOUKAKIS: Same objection, outside the
6 scope of the noticed topic.
7 You can answer if you know.
8 THE WITNESS: I'm not sure what you mean by the
9 scope of the Department of Mental Health.
10 Q. (By Mr. Cheffo) The program.
11 A. Yes.
12 Q. Right? There's a program?
13 A. Yes.
14 Q. Who -- whose program is it, is it theirs or
15 yours?
16 A. The agency Department of Corrections views
17 it as ours. It's our programming contracted those
18 services out.
19 Q. Do you regulate the content and the
20 methodology and the content of it --
21 MR. LEONOUKAKIS: Same objection.
22 THE WITNESS: To an extent, yes.
23 Q. (By Mr. Cheffo) Do they have any input?
24 A. Yes.
25 Q. The Department of Mental Health?

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1 A. Yes.
2 Q. So --
3 A. Or they did historically again.
4 Q. Okay. If you look at this document that
5 we've marked here, this two page Department of Mental
6 Health.
7 A. Uh-huh.
8 Q. Amongst the many, many signatories, if you
9 look under the second row, the first in the green,
10 what is that organization?
11 A. It's the Oklahoma Department of Mental
12 Health and Substance Abuse Services.
13 Q. That's the same organization that
14 administers the program in the Department of
15 Corrections for dependent or addicted inmates.
16 Correct?
17 MR. LEONOUKAKIS: Objection.
18 THE WITNESS: Some of the programs, yes.
19 Q. (By Mr. Cheffo) And you would agree that
20 they've endorsed these guidelines?
21 MR. LEONOUKAKIS: Objection.
22 THE WITNESS: They've certainly -- their agency
23 stamp is on the document, yes.
24 Q. (By Mr. Cheffo) What do you think that means?
25 MR. LEONOUKAKIS: Objection.

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1 THE WITNESS: I'd assume that that means that
2 they endorsed it.
3 Q. (By Mr. Cheffo) And can you tell some of the
4 other organizations here that have endorsed these
5 guidelines?
6 A. State Department of Health.
7 MR. LEONOUKAKIS: Objection.
8 THE WITNESS: Everything listed there, State
9 Medical Association, Oklahoma Bureau of Narcotics, the
10 Hospital Association, I'm not sure what the next one
11 is, Board of Pharmacy, Oklahoma Medical Board,
12 Pharmacy Association, the next one is small enough I
13 can't read it, Department of Mental Health, Board of
14 Dentistry, Pain Physicians, Veterinary Medical
15 Examiners, Oklahoma Health Authority, Oklahoma
16 Osteopathic Association, APA, College of Emergency
17 Physicians, not sure what the next one is, American
18 College of Osteopathic Family Physicians, Oklahoma
19 Pharmacists Helping Pharmacists, PPOK, Oklahoma Pain
20 and Wellness Center and AONP, whatever that is.
21 Q. (By Mr. Cheffo) In addition there's also
22 listed below that the Oklahoma Society of
23 Interventional Pain Physicians and Oklahoma Board of
24 Nursing. Right?
25 A. Yes.

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1 Q. Is an issue of drug dependence amongst the
2 inmate population a significant issue in Oklahoma?
3 MR. LEONOUKAKIS: Objection, outside the scope.
4 THE WITNESS: Certainly inmates have dependence
5 issues. As to what percentage of the inmates I
6 couldn't tell you.
7 Q. (By Mr. Cheffo) Has that been the case since
8 you've first joined the Department of Corrections?
9 MR. LEONOUKAKIS: Objection.
10 THE WITNESS: Which?
11 Q. (By Mr. Cheffo) Issues with drug dependence
12 amongst inmates?
13 A. Historically the recordkeeping system in the
14 Department of Corrections doesn't do a good job of
15 distinguishing between drug use and drug abuse in
16 terms of just general intake. So in the broader
17 category, a segment of the population, a large segment
18 of the population indicates some history of drug use.
19 Q. With respect to drug use and abuse, has
20 there been a population of inmates who have abused
21 methamphetamine?
22 MR. LEONOUKAKIS: Objection.
23 THE WITNESS: In terms of a quantifiable number,
24 no. But yes, in terms of anecdotally, yes, inmates
25 profess to using methamphetamine.

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1 Q. (By Mr. Cheffo) And the same would be true of
2 heroin. Right?
3 MR. LEONOUKAKIS: Objection, outside the scope.
4 THE WITNESS: To some extent, yes.
5 Q. (By Mr. Cheffo) And illegal -- have you heard
6 of fentanyl, illicit fentanyl and -- and carfentanil?
7 A. Yes.
8 Q. And you know that's a big problem?
9 MR. LEONOUKAKIS: Objection.
10 THE WITNESS: I've seen the newspaper, yes, about
11 other states that are experiencing that.
12 Q. (By Mr. Cheffo) And those are illegal
13 medicines. Right?
14 MR. LEONOUKAKIS: Objection.
15 Q. (By Mr. Cheffo) Illegal drugs?
16 A. To my knowledge, yes.
17 Q. They're not used for any medicinal purpose,
18 are they?
19 MR. LEONOUKAKIS: Objection.
20 Answer if you know.
21 THE WITNESS: I believe fentanyl can be.
22 Q. (By Mr. Cheffo) Fair enough. Illicit
23 fentanyl is -- is unlawful, is an unlawful drug.
24 Right?
25 A. Correct.

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1 Q. Let's mark this. I think we're up to, what?
2 MR. TAM: Ten.
3 MR. CHEFFO: Ten? Thank you.
4 (Deposition Exhibit Number 10 marked for
5 identification purposes and made part of
6 the record.)
7 Q. (By Mr. Cheffo) Do you know what this
8 document is?
9 A. Yes.
10 Q. What is it?
11 A. It's a medical services overview from the
12 Department of Corrections website.
13 Q. Who prepares this document?
14 A. Generally the chief medical officer or his
15 administrative staff.
16 Q. So, this is an overview. Right?
17 A. Yes.
18 Q. This is on your website?
19 A. Yes.
20 Q. It says, medical services provided --
21 provides medical and dental care for offenders in
22 Oklahoma Department of Corrections ODOC facilities,
23 work centers, contract facilities and DOC offenders in
24 contract county jail beds.
25 Do you see that?

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1 A. Yes.
2 Q. What are the differences between facilities,
3 work centers, contract facilities and contract county
4 jail beds?
5 A. DOC facilities are those facilities that we
6 own and operate. Work centers is a term at this point
7 in time that has to an extent been retired. The only
8 facility that meets the work center criteria is the
9 Oklahoma State Reformatory, but it essentially means
10 the inmates that are classified and housed there are
11 at a lower security level where they can participate
12 in work release in the community. Contract facilities
13 to the extent that it's listed on medical services
14 would be those halfway house facilities that we are
15 responsible for providing the medical and mental
16 health oversight in. And contract county jails,
17 there's only one contract county jail left I believe
18 where we house inmates who are actively -- they are in
19 our custody but they're just housed in that facility.
20 So they have a medical host facility they go to.
21 Q. Are you done with your answer?
22 A. Yes.
23 Q. I was trying to see what time it was.
24 A. Oh.
25 MR. CHEFFO: Go about another 10, 15 minutes?

1 MR. LEONOUKAKIS: Sure. Are you okay with that?

2 THE WITNESS: Yeah, fine.

3 Q. [REDACTED]

4 [REDACTED]

5 [REDACTED]

6 [REDACTED]

7 [REDACTED]

8 [REDACTED]

9 [REDACTED]

10 [REDACTED]

11 [REDACTED]

12 [REDACTED]

13 [REDACTED]

14 [REDACTED]

15 [REDACTED]

16 [REDACTED]

17 Q. And that's done on a regular basis?

18 A. Quarterly.

19 Q. ODOC clinical quality outcomes routinely

20 exceed community benchmarks.

21 Do you see that?

22 A. Yes.

23 Q. Do you track whether inmates have recidivous

24 behavior with respect to drug abuse after they leave?

25 MR. LEONOUKAKIS: Objection, outside the scope.

1 You can answer if you know.

2 THE WITNESS: Recidivous behavior after they

3 leave. So what their behavior is after they're no

4 longer in the custody of the Department of

5 Corrections?

6 Q. (By Mr. Cheffo) Right. So --

7 A. No. There's -- there's not a mechanism for

8 us to capture that when they're no longer in our

9 custody.

10 Q. You couldn't check medical or public health

11 records? There's no -- there's no mechanism to do

12 that?

13 MR. LEONOUKAKIS: Objection.

14 THE WITNESS: There's not a mechanism nor the

15 staff to do that with.

16 Q. (By Mr. Cheffo) The American Correctional

17 Association accredits all the medical services units

18 along with their facilities.

19 Do you see that?

20 A. Yes.

21 Q. Are you accredited by the American

22 Correctional Association?

23 MR. LEONOUKAKIS: Objection, outside the scope.

24 You can answer if you know.

25 THE WITNESS: I know we are maintaining all of

1 the ACA standards and documents that are required for

2 audits. As to when the last audit was done of any one

3 facility, which would include their medical services,

4 that would be a question for auditing and compliance.

5 Q. (By Mr. Cheffo) I think my question I think

6 you know is a little different. Right? I asked you

7 whether the ACA has accredited the facilities.

8 A. They have in the past, yes.

9 Q. Are you accredited right now?

10 A. Not to my knowledge.

11 Q. Do you know why this is on the website then?

12 MR. LEONOUKAKIS: Objection, outside the scope.

13 You answer in your personal capacity.

14 THE WITNESS: I don't know.

15 Q. (By Mr. Cheffo) Are some prisons in Oklahoma

16 unaccredited?

17 A. I don't know.

18 Q. Well, if you know that you're not

19 accredited, wouldn't it mean that you know that some

20 of your facilities are not accredited?

21 A. I am not sure what the current stance is or

22 where we are with regards to ACA accreditation.

23 That's something the policy and procedure and auditing

24 and compliance has oversight of. We maintain all

25 documents that are necessary so that we could be

1 audited today and internal audits are continually

2 conducted using the ACA standards.

3 Q. So the last time when accreditation was

4 possible were you accredited or not?

5 A. I don't understand what you mean by the last

6 time it was possible.

7 Q. Is it done on an annual or periodic basis

8 that they do a review and audit and then accredit?

9 A. It is on -- it is done on a periodic basis.

10 Q. And the last time that you underwent a

11 review were the Department of Corrections' facilities

12 accredited or not?

13 A. Yes, the last time that they were done I

14 believe we passed all of those audits.

15 Q. So do you believe that you are accredited

16 now or not or you don't know?

17 A. I don't know because I'm not sure how many

18 of those with the -- with the periodic timeframe and

19 not all facilities are done at once, I'm not sure how

20 many of those may have lapsed beyond whatever that

21 timeframe is and how many of them are still regarded

22 as current.

23 Q. And -- and it says here in the second

24 paragraph, the pharmacy and therapeutics committee

25 composed of ODOC clinicians and pharmacist -- and

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1 pharmacist monitors prescribing practices for cost
2 efficiency and quality of care.
3 Do you see that?
4 A. Yes.
5 Q. That's accurate, isn't it?
6 A. Yes.
7 Q. And we talked a little bit about that
8 earlier, that's ensuring that at least as to the
9 formulary medicines that were deemed to be safe,
10 effective and appropriate are on the formulary.
11 Right?
12 A. Correct.
13 Q. Okay. I think, I think five -- if we go
14 five minutes we can probably finish one more document
15 and take a break, just a few questions. Let's just
16 mark this one, please.
17 While we're doing that, sir, are you
18 familiar with the National Commission on Correctional
19 Health Care?
20 A. I'm familiar with them as an organization,
21 but in terms beyond that, no.
22 (Deposition Exhibit Number 11 marked for
23 identification purposes and made part of
24 the record.)
25 Q. (By Mr. Cheffo) This is a position statement.

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1 Do you see that?
2 A. Yes.
3 Q. Do you know one way or the other whether
4 this is -- this position statement regarding the
5 management of non cancer con -- concert pain -- cancer
6 pain is consistent with any policy or procedure or
7 regulation of the Department of Corrections?
8 A. Having never seen it before, no.
9 Q. Okay. And if you look back at the 10 just
10 for a minute, hold on to that, I'm sorry, Exhibit 10,
11 if you look on the bottom right hand first page.
12 A. Uh-huh.
13 Q. There's a reference to this organization.
14 Right?
15 A. Uh-huh.
16 Q. On -- yes?
17 A. Yes.
18 Q. On the Department of Corrections' own
19 website it basically lists or has a link to the
20 National Commission on Correctional Health Care.
21 Right?
22 A. Yes.
23 Q. And that's on the medical services page.
24 Right?
25 A. Yes.

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1 Q. And the document I just showed you as ten is
2 actually from that same organization that's referenced
3 on your medical page. Right?
4 A. Yes.
5 Q. So you would agree it's a legitimate
6 organization. Right?
7 A. Yes.
8 MR. LEONOUKAKIS: Objection.
9 Q. (By Mr. Cheffo) And is it your testimony you
10 don't know what the policy is with respect to the
11 management of noncancer chronic pain?
12 A. It's my testimony that I don't believe we
13 have a specific policy relating to the management of
14 noncancer chronic pain.
15 Q. I was asking more about now Exhibit 10.
16 You, you can't testify as to whether this policy is
17 consistent or inconsistent with what is done at the
18 Department of Corrections. Is that right?
19 A. Correct.
20 Q. If you look at Number 10 on Page 2, please.
21 A. Yes.
22 Q. It says, policies banning opioids should be
23 eschewed. Opioids should be considered with caution
24 after weighing all treatment options.
25 Do you see that?

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1 A. Yes.
2 Q. That's consistent with your policies.
3 Right?
4 MR. LEONOUKAKIS: Objection.
5 THE WITNESS: I believe so based on the fact that
6 they are carried on the formulary.
7 Q. (By Mr. Cheffo) Right. There's absolutely no
8 policy in place or one that you've ever seen or even
9 suggested that would ban opioids, is there, for the
10 Department of Corrections?
11 A. No, there is not.
12 Q. Are you aware of any intention to do that?
13 MR. LEONOUKAKIS: Objection.
14 THE WITNESS: Not to my knowledge.
15 Q. (By Mr. Cheffo) That would be inconsistent
16 with the National Commission on Correctional Health
17 Care. Right?
18 A. To the extent that that is their position in
19 this paper, yes.
20 Q. That's what it says on Number 10. Right?
21 A. Yes.
22 Q. Okay.
23 MR. CHEFFO: Let's take a break. Thank you.
24 THE VIDEOGRAPHER: Going off the record. This is
25 the end of Media Number 3. The time is 12:36.

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1 (A recess was here had 12:36 to 1:28.)
2 THE VIDEOGRAPHER: Back on the record, beginning
3 Media Number 4. The time is 1:28.
4 Q. (By Mr. Cheffo) Good afternoon, sir. We're
5 back on the record. Are you ready to proceed?
6 A. Yes.
7 Q. You know you're still under oath?
8 A. Yes.
9 Q. Thank you.
10 Just have a few followup questions before I
11 move to a new topic. I think you told us earlier that
12 you spent four to -- six to eight hours preparing for
13 the deposition. Is that right?
14 A. Correct.
15 Q. And again with the caveat that I don't want
16 to know anything about conversations you had with
17 lawyers, but I think you said the majority of that was
18 spent with a meeting with your -- one or more of your
19 lawyers. Is that right?
20 A. Primarily and pulling requested documents,
21 policies and procedures back some years.
22 Q. How -- when, when did you meet with the
23 lawyers?
24 A. The exact date, had a meeting yesterday for
25 deposition prep and before that it was some weeks ago.

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1 Without my calendar in front of me I couldn't tell
2 you.
3 Q. Was the previous meeting in connection with
4 the dep prep or some other purpose?
5 A. Specifically for the deposition prep.
6 Q. And how long did you spend yesterday?
7 A. Two and a half, maybe three hours.
8 Q. Does the -- does the Department of
9 Corrections maintain prescriptions for opioids to the
10 extent that a healthcare professional who works for
11 the department prescribes an opioid medicine for an
12 inmate?
13 MR. LEONOUKAKIS: Objection.
14 THE WITNESS: When a prescription is ordered and
15 filled by the pharmacy, then, yes, that is there on
16 site.
17 Q. (By Mr. Cheffo) And thanks for that. I may
18 have asked -- here's what I'm just trying to
19 understand. The normal way that people outside of
20 correctional facilities, right, they go to their
21 doctor and if the doctor determines that they need a
22 medicine the doctor will write a prescription. Right?
23 Yes?
24 A. Yes.
25 Q. And you will typically go to your pharmacy

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1 and fill it. Right?
2 A. Correct.
3 Q. In the context of a correctional facility,
4 is the process similar in the sense that there's an
5 interaction between the inmate and a -- and a doctor
6 and then the doctor actually writes a physical
7 prescription that that gets filled by somebody in --
8 in the -- in the facility or is it -- does it operate
9 in some other way?
10 A. When a provider, when a provider writes a --
11 or orders a medication it's done electronically. That
12 is submitted electronically to Diamond offsite.
13 Diamond fills the prescription and then ships it to
14 the facility and then when it is received it is
15 already packaged, carted to the individual inmate
16 unless it is a stock medication and the ordering
17 process for that is slightly different or a scheduled
18 medication, that process is slightly different as we
19 talked about earlier, and then it is logged into the
20 medication room and into the electronic health record
21 MAR system.
22 Q. So for stock medicines there's -- there's a
23 space in the facility typically where they actually
24 probably under lock and key --
25 A. Correct.

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1 Q. -- keep certain medicines. Right?
2 A. Right.
3 Q. And if it's not a stock medicine and an
4 electronic prescription is written, that goes to the
5 essentially outside pharmacy and then is shipped into
6 the facility. Right?
7 A. Correct.
8 Q. And if it's a stock medicine, the same
9 process, right, they file an electronic prescription
10 and then somebody who is authorized goes into the
11 facility, pulls that and then gives it to the -- the
12 patient, the inmate?
13 A. I want to make sure I'm clear with what you
14 say about a stock medication. Regardless of how it's
15 ordered, once it's ordered by the provider through the
16 established processes it comes back in, it's logged
17 into the system and if it is a medication that is
18 controlled by pill line, in other words it's not a
19 keep on person or carry on person med, then yes, it
20 is -- it's logged in, dispensed by medical staff.
21 Q. And you used some terms I think I
22 understand, but why don't you just explain, keep on
23 person, pill line. What are those?
24 A. Pill line -- keep on person meds or
25 medications designated by the P and T committee is

42 (Pages 162 - 165)

1 eligible for inmate possession subject to approval by
 2 a medical provider at the facility correctional health
 3 service -- or, excuse me, and the facility
 4 correctional health service administrator or CHSA.
 5 Q. Okay. So, for example, I don't know whether
 6 this would be one or not, if someone had an asthma
 7 problem they might be able to keep their -- their
 8 inhaler --
 9 A. Inhaler.
 10 Q. -- with them. Right?
 11 But I take it with scheduled medicines they
 12 can't keep those on their person?
 13 A. Correct.
 14 Q. They have to go to a pill line and actually
 15 be handed the medicine and then presumably somebody
 16 has to watch them ingest it?
 17 A. Correct.
 18 Q. To prevent diversion. Right?
 19 A. Correct.
 20 Q. And for people who receive opioids, morphine
 21 or hydrocodone today which is on your formulary, let's
 22 use that as an example, there would be a prescription
 23 written by a healthcare provider that would enable
 24 someone to go to the pill line and get their
 25 medicines. Right?

1 A. It would be a prescription written that
 2 would initiate the order for it to be received at the
 3 facility, logged in through appropriate chain and then
 4 administered either through pill line. The only
 5 exception to that would be if you are in the
 6 infirmary, in segregated housing for disciplinary
 7 reasons at which point in time our staff go to you and
 8 administer, observe, record the same as happens in
 9 pill line.
 10 Q. Okay. But correct me if I'm wrong, the
 11 initial step of getting scheduled medicine like an
 12 opioid analgesic to an inmate requires an order and
 13 prescription by a healthcare professional, that's done
 14 electronically and then that starts the process?
 15 A. Yes.
 16 Q. And there would be records of that?
 17 A. Electronically or, let's see, in terms of
 18 ordering under the MSRM about controlled drug
 19 procedures, if it's a stock medication it's handled
 20 slightly differently where there's a specific form
 21 that's used and faxed in to Diamond, but there is a
 22 record kept of that.
 23 Q. And has that process been in place as long
 24 as you can recall?
 25 A. As long as I can recall, yes.

1 [REDACTED]
 2 [REDACTED]
 3 [REDACTED]
 4 [REDACTED]
 5 [REDACTED]
 6 [REDACTED]
 7 [REDACTED]
 8 [REDACTED]
 9 [REDACTED]
 10 [REDACTED]
 11 [REDACTED]
 12 [REDACTED]
 13 [REDACTED]
 14 [REDACTED]
 15 [REDACTED]
 16 [REDACTED]
 17 [REDACTED]
 18 [REDACTED]
 19 [REDACTED]
 20 [REDACTED]
 21 [REDACTED]
 22 [REDACTED]
 23 [REDACTED]
 24 Q. In fact, to -- to figure out whether opioid
 25 medicines were prescribed or used in prescriptions all

1 you would really have to do is go and ask the pharmacy
 2 person or the CMO and they would tell you no, we do
 3 use them under these circumstances. Right?
 4 MR. LEONOUKAKIS: Objection.
 5 THE WITNESS: They would say that we do use them
 6 because they're on formulary.
 7 Q. (By Mr. Cheffo) And -- and they would be able
 8 to talk about the circumstances in which they are
 9 used. Right?
 10 A. I believe.
 11 MR. LEONOUKAKIS: Objection.
 12 Q. (By Mr. Cheffo) Now, for any of the policies
 13 that you've looked at in preparation for this
 14 deposition, is there anything -- did you see any hint
 15 or learn of any information whatsoever that any
 16 pharmaceutical company had anything to do with any of
 17 those policies?
 18 A. Not to my knowledge, no.
 19 Q. That would strike you as unusual, wouldn't
 20 it?
 21 A. Yes.
 22 Q. Now, if I were to ask you -- well, strike
 23 it. Let me ask you a few of them.
 24 [REDACTED]
 25 [REDACTED]

1 [REDACTED]
 2 [REDACTED]
 3 [REDACTED]
 4 [REDACTED]
 5 [REDACTED]
 6 [REDACTED]
 7 [REDACTED]
 8 Q. And would -- would you assume that they
 9 would be able to identify certain databases or
 10 documents that would have utilization information?
 11 A. I believe that there is a method that they
 12 could get to that information, yes.
 13 Q. And they could probably also consult with
 14 the Diamond Pharmacy people. Right?
 15 A. Correct.
 16 Q. Because ultimately -- are they the sole
 17 supplier for pharmaceutical products?
 18 A. Yes. The only exception to that is in the
 19 contract we require that there is a backup pharmacy
 20 for anything that occurs after hours or in an
 21 emergency situation. In those instances we have
 22 articulation agreements with the backup pharmacy and
 23 specific facility so that when we fill that med that
 24 backup pharmacy bills Diamond and then Diamond bills
 25 us.

1 Q. And are there audits done in order to
 2 validate that what you're receiving is what you're
 3 paying for?
 4 A. There are -- I know financially there are
 5 audits that occur that are spot checks to make sure
 6 that the invoices that we receive match the quantity
 7 and amounts that are received. Beyond that in terms
 8 of any other type of audit that's done I'm not aware.
 9 Q. And you would expect though that if you
 10 wanted to know how many prescriptions, for example, of
 11 Oxycontin were written for 10 milligrams in 2017, that
 12 would be something that you could call up Diamond and
 13 say give us a printout and they would be able to
 14 supply that information?
 15 MR. LEONOUKAKIS: Objection.
 16 THE WITNESS: I believe so, yes.
 17 Q. [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

1 Q. And how long has Diamond, Diamond been your,
 2 when I say your I'm talking Department of
 3 Corrections --
 4 A. I understand.
 5 Q. -- your primary pharmacy provider?
 6 A. Since I began in this position in 2015 and
 7 I -- for some time period prior to that.
 8 Q. Have you ever had occasion either yourself
 9 or through your department to ask for reports or
 10 information such as things like utilization from
 11 Diamond?
 12 MR. LEONOUKAKIS: Objection, outside the scope.
 13 THE WITNESS: I have not -- I have not personally
 14 asked for utilization reports. My focus is more on
 15 the budgetary end.
 16 Q. (By Mr. Cheffo) And in terms of your focus,
 17 is that providing budgets for the types of medicines
 18 and the nature of medicines that are provided to the
 19 facilities?
 20 A. Not necessarily the types and nature.
 21 That's more what the P and T committee does when
 22 they're looking at it. Mine is just the bottom line
 23 dollar amount on what we're expending month to month
 24 versus the agency budget and what we're given to
 25 operate on.

1 [REDACTED]
 2 [REDACTED]
 3 [REDACTED]
 4 [REDACTED]
 5 [REDACTED]
 6 [REDACTED]
 7 [REDACTED]
 8 [REDACTED]
 9 [REDACTED]
 10 [REDACTED]
 11 [REDACTED]
 12 [REDACTED]
 13 [REDACTED]
 14 [REDACTED]
 15 Q. (By Mr. Cheffo) Isn't that a question you
 16 would ask the CMO?
 17 A. In terms of utilization we primarily for my
 18 purposes focus on the budgetary constraints and
 19 looking at what pharmaceuticals are costing us.
 20 Through the CMO in his function as the chief medical
 21 officer that's something that his role within pharmacy
 22 and therapeutics.
 23 Q. And I'm not being critical, sir, but your --
 24 your role here is beyond your own personal role, your
 25 role here is as -- as a corporate designation,

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1 designee, right, to talk about broader areas? You
2 understood that. Right?
3 A. Sure.
4 Q. And if, in fact, there were no prescriptions
5 written for opioids, wouldn't that fall within
6 practices or procedures regarding the treatment of
7 pain for the use of opioid medications?
8 MR. LEONOUKAKIS: Objection.
9 THE WITNESS: Well, the practice and the
10 procedure when -- when that's applied to just general
11 correctional terms, the practices and procedures are
12 normally what's in front of us in terms of the
13 exhibits that are here. Those are procedures for
14 general operating guidelines, which is what I focused
15 my efforts on reviewing those.
16 Q. (By Mr. Cheffo) Well, I agree practices and
17 procedures are what's in front of you, but it depends
18 on what you put in front of you in order to have that
19 information. Right?
20 MR. LEONOUKAKIS: Objection.
21 THE WITNESS: True.
22 Q. (By Mr. Cheffo) So if you wanted to
23 understand how many prescriptions of a particular
24 opioid were written, that's something that you had
25 access to do if you wanted to or you were asked to do

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1 that?
2 MR. LEONOUKAKIS: Objection.
3 THE WITNESS: I was not asked to do that.
4 Q. (By Mr. Cheffo) If you were you could have
5 done that?
6 A. Correct, I believe there is a way that that
7 can be done.
8 Q. And you could have actually brought charts
9 of all the opioids that were prescribed and the
10 numbers with specifics in the correctional facility if
11 you were asked to do that?
12 MR. LEONOUKAKIS: Objection, outside the scope of
13 the noticed topic.
14 You can answer if you know.
15 THE WITNESS: To -- to the extent that it didn't
16 violate any HIPAA concerns, yes, I think so.
17 Q. (By Mr. Cheffo) And -- and I think I might
18 have asked you this but let me just confirm before we
19 move to the next topic. The -- other than the two
20 formularies that I put in front of you, you don't know
21 what other opioids were or not on any of those going
22 back five, ten years, do you?
23 A. No. Not without reviewing those documents.
24 Q. So therefore you would have no information
25 about -- strike that.

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1 [REDACTED]
2 [REDACTED]
3 [REDACTED]
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]
9 [REDACTED]
10 [REDACTED]
11 [REDACTED]
12 [REDACTED]
13 Q. (By Mr. Cheffo) Now, I think I asked you
14 briefly and I just want to make sure that I -- I
15 understood what you testified earlier. The concept of
16 abuse of illegal drugs is something that is a problem
17 and a longstanding issue for correctional facilities
18 like the Department of Corrections in Oklahoma.
19 Right?
20 A. I believe I said use and abuse of illegal
21 drugs is something that is commonly reported to us by
22 inmates who are in our custody.
23 Q. And -- and you know that use and abuse of
24 illegal drugs including opioids is something that's a
25 societal problem going back many, many years?

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1 MR. LEONOUKAKIS: Objection.
2 THE WITNESS: Yes, I know that illegal drugs are
3 an issue for society.
4 Q. (By Mr. Cheffo) And you -- you know probably
5 from either seeing on TV or reading in the history
6 books that abuse of heroin was an issue after the
7 Vietnam War. Right?
8 MR. LEONOUKAKIS: Objection.
9 THE WITNESS: I know that there is a history of
10 abuse of heroin in the general population, yes.
11 Q. (By Mr. Cheffo) And heroin's an opioid.
12 Right?
13 A. Yes.
14 Q. And that goes back to the Vietnam War if not
15 before. Right?
16 MR. LEONOUKAKIS: Objection.
17 THE WITNESS: Sure.
18 Q. (By Mr. Cheffo) And you know that there was a
19 history of drug abuse in -- with opioids even after
20 the Civil War with soldiers who were administered
21 battlefield issues? Are you aware of that?
22 MR. LEONOUKAKIS: Objection to this line of
23 questioning as outside the scope of the topic.
24 THE WITNESS: I don't recall ever seeing anything
25 about drugs and abuse in the Civil War.

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1 Q. (By Mr. Cheffo) So you would agree with me at
2 least that the problems of drug abuse in America,
3 particularly with opioids, didn't start in 1995 or
4 1996 or 1999. Right?
5 MR. LEONOUidakis: Same objection.
6 THE WITNESS: I agree that there were drugs being
7 abused in those timeframes and before.
8 Q. (By Mr. Cheffo) So, so the answer is yes?
9 A. Yes.
10 MR. LEONOUidakis: Objection, misstates the
11 testimony.
12 Q. (By Mr. Cheffo) Is -- are the concept of --
13 strike that.
14 You, you mentioned the terms I think use and
15 abuse?
16 A. Yes.
17 Q. Do you draw a distinction between those two?
18 A. Not one that's listed in policy, no.
19 Q. Are use, abuse and addiction, are those
20 related, can they be related to prescription of
21 Schedule II medicines?
22 MR. LEONOUidakis: Objection.
23 THE WITNESS: There's nothing that limits it in
24 anything in writing or practice that I'm aware of in
25 the agency to just illicit drugs.

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1 Q. (By Mr. Cheffo) But they are -- the concepts
2 of addiction and abuse, they are related to or can be
3 related to the use of opioids. Right?
4 MR. LEONOUidakis: Objection, outside the scope.
5 THE WITNESS: Yes.
6 MR. CHEFFO: Well, I don't think it's out -- any
7 of it's outside the scope, but you can make the
8 objections.
9 Q. (By Mr. Cheffo) What I'm trying to
10 understand -- let's look at Exhibit 1.
11 MR. LEONOUidakis: The Notice.
12 Q. (By Mr. Cheffo) Yes, the Notice. I -- I
13 think I have it. I'm sorry.
14 A. Okay.
15 MR. CHEFFO: Do we have another copy, John?
16 Q. (By Mr. Cheffo) So I'm just trying to
17 understand because there's been a number of objections
18 that this is outside the scope. But do you -- do you
19 see the concepts of -- let me start with abuse. Is
20 that unrelated to the prescription or use of opioid
21 medicines?
22 A. Are you asking me the question?
23 MR. LEONOUidakis: Objection.
24 Q. (By Mr. Cheffo) Yeah.
25 MR. LEONOUidakis: Objection.

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1 THE WITNESS: When you use the term abuse, I
2 think it covers anything that has an addictive
3 potential.
4 Q. (By Mr. Cheffo) Okay. Would it include
5 potentially opioids?
6 A. Potentially.
7 Q. So it's not exclusive to opioids. Right?
8 A. No.
9 Q. Abuse can be alcohol. Right?
10 A. Correct.
11 Q. Cigarettes, cocaine. Right?
12 A. Correct.
13 Q. Methamphetamines?
14 A. Correct.
15 Q. It could also include unlawfully obtained
16 opioids. Right?
17 A. Yes.
18 Q. So, the concept at least of abuse is related
19 to treatment of pain using opioid medicines. Right?
20 MR. LEONOUidakis: Objection.
21 THE WITNESS: Repeat that back.
22 Q. (By Mr. Cheffo) Sure.
23 The concept of abuse can be related to the
24 treatment of pain with opioid medications?
25 MR. LEONOUidakis: Objection.

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1 THE WITNESS: The concept of abuse can be related
2 to the medication however the medication is obtained.
3 Q. (By Mr. Cheffo) Okay. So my an -- the answer
4 is yes then. Right?
5 MR. LEONOUidakis: Objection, misstate the
6 testimony.
7 THE WITNESS: No.
8 Q. (By Mr. Cheffo) Let me restate it. The
9 concept of abuse can be related to the use of opioids
10 medicines for the treatment of pain?
11 MR. LEONOUidakis: Objection.
12 THE WITNESS: No, that's not what I said.
13 Q. (By Mr. Cheffo) I'm asking the question. Do
14 you agree with it?
15 A. Repeat it one more time.
16 MR. CHEFFO: Sure.
17 (The record was read as directed.
18 "Q. The concept of abuse can be related to the
19 use of opioids medicines for the treatment of pain?")
20 MR. LEONOUidakis: Objection.
21 THE WITNESS: Yes.
22 Q. (By Mr. Cheffo) And the concept of addiction
23 can be related to the use of opioid medicines for the
24 treatment of pain?
25 MR. LEONOUidakis: Objection.

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1 THE WITNESS: Not singularly, but yes, it is one,
2 one avenue.
3 Q. (By Mr. Cheffo) And the concept of dependence
4 can be related to the use of opioids for the treatment
5 of pain. Correct?
6 MR. LEONOUKAKIS: Objection.
7 THE WITNESS: Again, not singularly as one form
8 of drug, but yes.
9 Q. (By Mr. Cheffo) You would also agree that
10 there can be and you have seen it in connection with
11 the Department of Corrections population, there can be
12 widespread abuse of chemical substances even without
13 any advertising by a pharmacy manufacturer. Right?
14 MR. LEONOUKAKIS: Objection.
15 THE WITNESS: I have no idea what form of
16 advertising any one single segment of our population
17 is or isn't exposed to.
18 Q. (By Mr. Cheffo) Well, certainly no one
19 advertises heroin. Right?
20 A. Well, no.
21 Q. Right.
22 A. Other than other inmates possibly.
23 Q. Right. But -- and there still can be a
24 heroin crisis. Right?
25 MR. LEONOUKAKIS: Objection.

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1 THE WITNESS: Sure.
2 Q. (By Mr. Cheffo) And the same, you haven't
3 seen any advertisements for methamphetamines. Right?
4 MR. LEONOUKAKIS: Objection.
5 THE WITNESS: Not to my knowledge.
6 Q. (By Mr. Cheffo) And there still can be a
7 methamphetamine crisis. Right?
8 MR. LEONOUKAKIS: Objection.
9 THE WITNESS: Sure.
10 Q. (By Mr. Cheffo) And you haven't seen any
11 advertisements for crack cocaine, have you?
12 A. No.
13 Q. And there still could be a crack cocaine
14 crisis. Right?
15 MR. LEONOUKAKIS: Same objections.
16 THE WITNESS: Yes.
17 Q. (By Mr. Cheffo) And you haven't seen any
18 advertisements for marijuana. Right?
19 MR. LEONOUKAKIS: Objection.
20 Q. (By Mr. Cheffo) Outside of Colorado perhaps?
21 A. No, here too.
22 Q. That's -- that's a fair point, under your
23 recent law. So let me --
24 A. Yes.
25 Q. Let me withdraw that. I need to be more --

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1 more in tune with -- with recent legislation.
2 You haven't seen any advertisements for
3 regular cocaine, have you?
4 MR. LEONOUKAKIS: Objection.
5 THE WITNESS: No.
6 Q. (By Mr. Cheffo) And there still could be a
7 cocaine crisis. Right?
8 A. Yes.
9 Q. And the drug cartels from Mexico and -- and
10 China, they don't advertise illegal carfentanil or
11 fentanyl analogues. Right?
12 MR. LEONOUKAKIS: Objection, outside the scope.
13 THE WITNESS: I have no idea what illegal cartels
14 do or don't do. Certainly no commercials I've seen
15 for them.
16 Q. (By Mr. Cheffo) But illegal, illegal fentanyl
17 and fentanyl analogues are a major problem in -- in
18 prisons, aren't they?
19 MR. LEONOUKAKIS: Objection.
20 THE WITNESS: To my immediate knowledge they are
21 a growing problem within correctional entities. I
22 believe our exposure to date has been very few.
23 Q. (By Mr. Cheffo) And what -- help me
24 understand that distinction.
25 A. Based on death reports, inmate deaths, what

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1 the medical examiner may rule as the cause of death or
2 just based on intelligence reports that our internal
3 intelligence sends out in terms of education materials
4 is be on the lookout in terms of contraband that's
5 received into the facilities. When I look at it in
6 comparison to what other states are experiencing it
7 does not seem to be at the same volume.
8 Q. Part of -- I'm sorry.
9 A. Yet.
10 Q. Part of what you do, right, as a -- to do
11 your job well is to try to at least be aware of what
12 other states are doing and following best practices.
13 Right?
14 A. To an extent, yes.
15 Q. You don't kind of --
16 A. We don't operate in a vacuum.
17 Q. -- put your head in the sand, you want to
18 understand what your colleagues around the country are
19 doing, find some best practices and then figure out if
20 it makes sense for your state to follow and if you
21 have the ability to do it. Right?
22 A. Correct.
23 Q. Now, if someone, if an inmate dies in
24 prison, that's tracked. Right?
25 A. Yes.

1 Q. And is there an autopsy done if there is a
2 suspicion of an overdose death?

3 A. The medical examiner is contacted in every
4 instance of death, but the ME determines whether or
5 not they take the body and perform an autopsy.

6 Q. And there are situations where someone in
7 prison dies of an overdose even though that person is
8 not supposed to be receiving any type of medicine that
9 would cause an overdose?

10 MR. LEONOUKAKIS: Objection, outside the scope.

11 Q. (By Mr. Cheffo) Do you understand my
12 question? In other words, there are situations where
13 someone, inmates are dying of overdose from illicit
14 fentanyl where they're not getting that obviously from
15 doctors?

16 MR. LEONOUKAKIS: Object, same objection.

17 THE WITNESS: In that exact instance, yes.

18 Q. (By Mr. Cheffo) What do you mean in that
19 exact instance?

20 A. Is your question specific to fentanyl
21 itself?

22 Q. No, it's -- it's broader. It could be
23 fentanyl, it could be even a prescription medicine, it
24 could be something else. My question is, is there
25 situations where inmates are being exposed to either

1 lawful medicines illegally or illegal drugs and
2 overdosing in prisons?

3 MR. LEONOUKAKIS: Objection, outside the scope.

4 THE WITNESS: The information that I've seen on
5 any reports from the medical examiner will simply
6 state cause of death or manner of death and a
7 toxicology report if one is performed. Beyond that
8 the chief medical officer and his staff review what
9 medications they may or may not be on.

10 Q. (By Mr. Cheffo) Is there any type of survey
11 or document or analysis of the amount of illegal drugs
12 that are being used or brought into Oklahoma
13 correctional facilities?

14 MR. LEONOUKAKIS: Objection, outside the scope.

15 THE WITNESS: If there is I have no knowledge of
16 it. It would not be something that my division would
17 handle.

18 Q. (By Mr. Cheffo) If someone died in prison in
19 Oklahoma and the cause of death was an overdose, we
20 would be able to run a report or ask someone to say
21 identify all of those deaths that were attributable to
22 an overdose based on either a medical examiner
23 evaluation or, you know, a treating physician. Right?

24 MR. LEONOUKAKIS: Objection, outside the scope.

25 THE WITNESS: For any death that occurs while in

1 custody if the medical examiner assumes the body and
2 whatever reporting they do, if they do a full autopsy,
3 toxicology, whatever, that report is furnished to the
4 Department of Corrections. So the medical examiner's
5 office I would assume is the repository of that
6 information.

7 Q. (By Mr. Cheffo) What about you -- let's say
8 John Smith unfortunately expires and -- and there's no
9 autopsy done. Someone has to I assume do some type of
10 an analysis or conclusion as to what the most likely
11 cause of death is?

12 A. We make a distinction in policy between
13 attended and non-attended deaths. Attended deaths can
14 be those that fall in the category of expected deaths.
15 So elderly inmate who may be receiving palliative care
16 in an infirmary who has stage four cancer as a generic
17 example, more than likely that would be an attended
18 death and the ME would probably not take the body,
19 we'd contact family and determine what the next steps
20 were.

21 Q. Understood.

22 A. Anything that is determined to be
23 unattended, the normal process is that chain of
24 commands are alerted and the ME is contacted for their
25 determination whether or not they will take the body

1 to determine if they will do an autopsy or toxicology
2 review. But then yes, internally the chief medical
3 officer or an external panel we have the ability to
4 send it to for review in terms of care.

5 Q. With -- with every, every inmate death is
6 there someone or somebody who does a cause of death
7 analysis?

8 MR. LEONOUKAKIS: Objection, outside the scope.
9 You can answer.

10 THE WITNESS: I'm not sure if the terminology is
11 the same in terms of cause of death, but when there is
12 a death that occurs, yes, there is a review of that
13 death that is conducted at a minimum internally by the
14 chief medical officer.

15 Q. (By Mr. Cheffo) Whether it's from the outside
16 ME or the chief medical officer or some outside panel,
17 there would be some documentation for every death that
18 occurred that it would at least identify whatever
19 conclusions were drawn by folks. Correct?

20 MR. LEONOUKAKIS: Same objection.

21 THE WITNESS: There is -- there is a recording of
22 every death. To the extent as to how in depth someone
23 went in terms of examining it, that would vary.

24 Q. (By Mr. Cheffo) As part of the corrections
25 umbrella of various programs and facilities, do you

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1 have any type of outpatient or halfway house type
2 facilities where you provide substance abuse
3 counseling and guidance?
4 A. We don't have -- we have halfway houses. I
5 don't believe -- it depends on what your definition is
6 of outpatient services. I don't believe we have
7 anything that would -- would qualify as that. The
8 programs that we discussed earlier from a historical
9 concept all happen while incarcerated. In terms of
10 halfway houses, we are still responsible for their
11 healthcare, which is medical and mental health
12 services. Most of that is performed by a host
13 facility, so the halfway house is transporting back to
14 a facility so that our in-house staff provide those
15 services with the rare instance of a couple of halfway
16 houses that are in the Tulsa area where we contract
17 out the medical and mental health services.
18 Q. In -- in those situations where the
19 Department of Corrections contracts out to other
20 entities to assist with healthcare for a certain
21 population wherever that may be, do any of them
22 provide medically assisted treatment?
23 A. No.
24 Q. Is that a policy of the Department of
25 Corrections that no one shall provide medically

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1 assisted treatment?
2 A. Not to my knowledge, no.
3 Q. So do you have a reason as to why it is that
4 no doctor associated in any way with the Department of
5 Corrections provides or prescribes medically assisted
6 treatment for people who have addiction or abuse
7 disorders?
8 MR. LEONOUKAKIS: Objection.
9 THE WITNESS: Say it again.
10 Q. (By Mr. Cheffo) Sure.
11 Do you have an explanation as to why no
12 healthcare provider in any way associated with the
13 Department of Corrections prescribes medically
14 assisted treatment for inmates who have abuse or
15 addiction disorders?
16 MR. LEONOUKAKIS: Objection.
17 THE WITNESS: Because we've not created policies,
18 processes or contracts around it, nor has the chief
19 medical officer pursued that as an avenue.
20 Q. (By Mr. Cheffo) Are you aware of anybody who
21 has prescribed it who has been rejected?
22 A. An inmate who has been prescribed it while
23 incarcerated?
24 Q. Incarcerated, halfway house, contract.
25 A. Not to my knowledge. I don't know anybody

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1 that's been prescribed it.
2 Q. So is there a prohibition against it or you
3 just don't have policies in place to administer it?
4 A. It's just not an avenue of treatment that
5 the agency has undertaken at this point by developing
6 policies or practices around it.
7 Q. Right. But I thought you told me that the
8 agency doesn't set medical guidelines, that's up to
9 doctors?
10 A. Right.
11 MR. LEONOUKAKIS: Objection, misstates the
12 testimony.
13 Q. (By Mr. Cheffo) So if a doctor wanted to
14 prescribe medically assisted treatment, could he or
15 she?
16 A. As I said earlier, I think that would be up
17 to the chief medical officer to design whatever that
18 process would look like if that was his interest.
19 Q. No, no, let's assume someone went to see a
20 staff doctor, I'm not being pejorative, just a regular
21 treating physician at a facility, and could that
22 doctor say I think inmate X, Y, Z would benefit and I
23 think it's medically necessary for them to have this
24 medically assisted treatment, I'm going to prescribe
25 that, could they do it?

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1 A. I believe there's a distinction between DEA
2 licenses where you have to have a specific DEA license
3 for pain management versus addiction treatment. I
4 seem to recall that none of our existing physicians
5 have the addiction treatment specialty which may be
6 why they don't prescribe that nor is it a requirement
7 of their employment with the agency.
8 Q. So is it that they're just not licensed to
9 prescribe it and that's why it doesn't happen or is it
10 that you would formally prevent someone from receiving
11 medically assisted treatment?
12 A. It's a chicken or the egg.
13 Q. I guess if you don't hire people who could
14 actually do the job then you -- let's assume
15 hypothetically someone got up tomorrow and said I'm a
16 doctor for the Department of Corrections, I read this
17 article, this looks like it's a really good thing,
18 there's this council out there that says this is best
19 practices, gosh, I'm going to go and get a license to
20 prescribe. Right?
21 MR. LEONOUKAKIS: Objection.
22 Q. (By Mr. Cheffo) If that person did that could
23 they then prescribe and would it be fulfilled?
24 A. I believe administratively they would have
25 to have the support of the chief medical officer and

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1 there would have to be some policy or rule promulgated
2 around that in order for them to do it.
3 Q. To do what, to get licensed?
4 A. No, to provide the treatment.
5 Q. So even if they were licensed and could do
6 it, your testimony is that they would have to change
7 policy in order to provide medically assisted
8 treatment?
9 A. I believe so. We essentially did that for
10 pregnant females which is why they were added to
11 policy. That did not exist until we received our
12 first pregnant female who was already on methadone.
13 Q. And then how -- if no one's licensed how do
14 they prescribe it to --
15 A. We contracted it out.
16 Q. So you could contract that same service out
17 to as many people as you'd like to if you wanted to?
18 A. If funding allowed and there was support to
19 do so.
20 Q. Who makes the decision?
21 A. On what?
22 Q. On whether to expand the program.
23 A. Well, normally to do something like that you
24 would have to have funding secured first, so there
25 would have to be a proposal from the chief medical

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1 officer that was supported through my office to the
2 agency's budget work program which would have to be
3 carried to budget committees at the capital.
4 Q. How much does it cost, how much would it
5 cost do you think?
6 MR. LEONOUKAKIS: Objection.
7 THE WITNESS: I have no idea.
8 Q. (By Mr. Cheffo) How much does it cost for the
9 pregnant females?
10 MR. LEONOUKAKIS: Objection, outside the scope.
11 THE WITNESS: Without the contract in front of me
12 I couldn't tell you.
13 (Deposition Exhibit Number 12 marked for
14 identification purposes and made part of
15 the record.)
16 Q. (By Mr. Cheffo) I just want to show you what
17 we marked as Exhibit 12. Do you know what this
18 document is, sir?
19 A. It's essentially our network providers, our
20 outside providers for specialty care.
21 Q. And what's the point of this document?
22 A. Based on the state statute if the level of
23 care that's needed by the inmate is determined to be
24 in excess of what the agency can provide, we have the
25 ability to go outside of the agency to specialists.

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1 This is a network that's developed by law by EGID, the
2 Employee Group Insurance Department, so that we have
3 access to network specialists across the state.
4 Q. So is this basically like a supplement to
5 your budget to the extent that you have extraordinary
6 expenses requiring specialist treatment?
7 MR. LEONOUKAKIS: Objection.
8 Q. (By Mr. Cheffo) Is that -- is that one of the
9 things? Do you understand my question?
10 A. No.
11 Q. Okay. Look at the introduction if you would
12 on Page 3.
13 A. Yes.
14 Q. It says, the Department of Corrections' plan
15 is managed healthcare program providing comprehensive
16 health and dental benefits to approximately 20,000
17 inmates who have been sentenced to a term of
18 incarceration with the Oklahoma DOC.
19 Do you see that?
20 A. Uh-huh.
21 Q. And this is -- this is a 2005 document.
22 Right?
23 A. Yeah.
24 MR. LEONOUKAKIS: Objection.
25 THE WITNESS: 2015.

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1 Q. (By Mr. Cheffo) Oh, I apologize. 2015.
2 And the next sentence says, the DOC provider
3 network is administered by the Employees Group
4 Insurance Department, EGID, of the Office of
5 Management and Enterprises Services, an agency of the
6 State of Oklahoma.
7 Do you see that?
8 A. Uh-huh.
9 Q. Do you -- do you know what those
10 organizations are, that department?
11 A. Yes. The Office of Management and
12 Enterprise Services essentially is over all budget and
13 IT functions for the state. EGID is essentially the
14 Employee Group Insurance Department, they manage the
15 state employee healthcare plans.
16 Q. And -- and I apologize, I tried not to do
17 this but I think I may have misheard you earlier. How
18 is the Employer Group Insurance Department plan, how
19 does that interact or interface with the DOC?
20 A. So the statute specifically states that EGID
21 or I think as it was actually officially titled in
22 statute is OSEEGIB, I don't know what the acronym was
23 for without it in front of me, but to the extent that
24 the agency needed additional providers who were in the
25 community, we struggled to find people who would see

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1 inmates. So going through EGID which had a developed
2 network because they had network and nonnetwork
3 providers allowed us to piggyback off of the existing
4 network in the state, established rates that were
5 there and also in statutes state that anyone who is
6 nonnetwork receives I believe Medicaid rates. So it
7 was in an effort, and this is historical because it
8 was before me, was in an effort statutorily to create
9 a network of providers for specialty care service and
10 incentivize those specialty care services so that we
11 could find doctors who would see inmates across the
12 state.

13 Q. So, to the extent then, thank you for that,
14 to the extent that there was or that there were visits
15 to some of these specialty care doctors by inmates, is
16 it the EGID who would maintain the records of those or
17 is that somehow maintained by the DOC or both?

18 A. So the network itself because its providers
19 can be in network and go out of business, retire, go
20 out of network, so whatever changes, EGID should have
21 the record of who is network and I would assume who is
22 network historically. When we have --

23 Q. Not to draw you back because I asked a bad
24 question, but I'm just trying to find out, so if
25 someone -- let's assume they have a, just pick it, a

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1 sophisticated cardiac issue, right, and they need to
2 see a specialist, right.

3 A. Uh-huh.

4 Q. You can go to this network. I assume the
5 patient care is ultimately on the nickel of the DOC.
6 Right?

7 A. Correct.

8 Q. So, does -- how do the -- how do the patient
9 records and care and billing and costs, how does that
10 all get worked out?

11 MR. LEONOUKAKIS: Objection.

12 THE WITNESS: So, an appointment is set with the
13 network provider, a transport happens to the provider.
14 The recommendation, whatever the treatment is, those
15 treatment files follow the inmate and they are scanned
16 into the electronic health record.

17 Q. (By Mr. Cheffo) Okay. And that's accessible
18 by the Department of Corrections for that patient?

19 A. Yes.

20 Q. If you'd turn to the next page, please. It
21 says, DOC utilizes a medical and dental claims
22 administrator with vast experience in the
23 administration of medical and dental care benefit
24 plans.

25 Do you see that?

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1 A. Yes.

2 Q. And is that the -- the administrator?

3 A. HP is no longer the administrator as of
4 January 1. It is HealthSCOPE.

5 Q. January 1 of 2018?

6 A. Yes.

7 Q. What's the general role and responsibility
8 of the claims administrator?

9 A. Broadly, claims administration reviews all
10 the billing documents, determines -- insures that
11 the -- the services were in network or out of network
12 and that the agency is ultimately billed for what we
13 are required to be billed for.

14 Q. And is the -- is the administrator an agent
15 of the Department of Corrections?

16 A. No. They are a contractor for EGID.

17 Q. And then if you'd turn to Page 10, please.
18 It says DOC formulary. The DOC network provider must
19 adhere strictly to the medication that comprise the
20 DOC formulary.

21 Do you see that?

22 A. Yes.

23 Q. What does that mean?

24 A. It means they are to follow our formulary.

25 Q. And then -- I think that's it.

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1 I'm going to show you what we're going to
2 mark as 13.

3 (Deposition Exhibit Number 13 marked for
4 identification purposes and made part of
5 the record.)

6 Q. (By Mr. Cheffo) Did you look at this document
7 in connection with your preparation?

8 A. No.

9 Q. You're familiar with it though?

10 A. Cursorily.

11 Q. Do you know what it is?

12 A. It's the network provider contract, I
13 believe.

14 Q. And what is -- what does the network
15 provider contract govern or relate to?

16 (A brief pause.)

17 A. Sorry, ask your question again.

18 MR. CHEFFO: Sorry. Please read it back.
19 (The record was read as directed.)

20 "Q. And what is -- what does the network
21 provider contract govern or relate to?")

22 THE WITNESS: It governs or relates to this is
23 essentially the contract that an entity is agreeing to
24 in order to be considered a network provider.

25 Q. (By Mr. Cheffo) A network provider for

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1 inmates?

2 A. Yes.

3 Q. And is this typically a contract that would

4 be for entities or individuals outside the physical

5 confines of a correctional facility?

6 A. Yes.

7 Q. So if there was a network provider that just

8 as an example provided dialysis services and that

9 wasn't available in the facility, maybe that was a bad

10 example, but is that the type of thing that there

11 would be a contract for or is it more specific to

12 specialty?

13 A. A little of both and it's hard to

14 distinguish the two. And when you say dialysis, we do

15 have an on site contract dialysis provider.

16 Q. That's why -- I figured you might. So --

17 A. So there is a distinction within state law

18 that allows us to do professional service contracts

19 and then those that allow us to do the network

20 provider contracts. The intent of the network

21 providers are generally for services that are outside

22 the scope of the facilities. I need to go back and

23 look at the specific ones.

24 Q. So, so as a general matter this is for

25 entities that are outside the scope of the facilities?

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1 A. For general, yes.

2 Q. There could be exceptions?

3 A. Right.

4 Q. But that's the general understanding?

5 A. The general purpose of it is to, again as we

6 discussed, develop a network of providers that can be

7 accessed.

8 Q. And -- and it -- and the contract probably

9 does many things, but one of the things that I'm

10 looking at the definition of covered services, it

11 means that covered services are medically necessary

12 services delivered by a facility pursuant to this

13 contract. Right?

14 A. Yes.

15 Q. That's basically saying the DOC will cover

16 certain surfaces -- services to the extent that they

17 are medically necessary under this contract?

18 A. Yes.

19 Q. And then if you look on the next page, 2.13,

20 it says -- it says medic -- I'm in the medically

21 necessary.

22 A. Yes.

23 Q. And that's a definition from the Department

24 of Corrections as to what is medically necessary?

25 MR. LEONOUKAKIS: Objection.

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1 Q. (By Mr. Cheffo) Correct?

2 A. This contract is developed in conjunction

3 with EGID. To what extent this is our verbatim

4 language I don't know.

5 Q. Whether it's -- it's not your verbatim

6 language or not, this is something that is used when

7 you, the Department of Corrections, and your looks

8 like chief medical officer enter into contracts with

9 outside entities. Is that right?

10 A. Correct.

11 Q. So when someone -- when you -- when you

12 contract with other outside entities and create a

13 contractual relationship, this is the document that's

14 used and this medically necessary definition is

15 incorporated into that contract. Right?

16 A. It is in that contract.

17 Q. And it's one of many contractual terms,

18 right, that's listed here?

19 A. Yes.

20 Q. And one of the things it says in 2.13, it's

21 medically necessary means services or supplies which

22 are provided for the diagnosis and treatment of the

23 medical and/or mental health slash substance abuse

24 condition and applies with criteria adopted by the

25 DOC.

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1 Do you see that?

2 A. Yes.

3 Q. So there's criteria that the DOC adopts

4 and -- and that helps define what medically necessary

5 is. Right?

6 A. Yes.

7 MR. LEONOUKAKIS: Objection.

8 THE WITNESS: Yes.

9 Q. (By Mr. Cheffo) Then it goes on, direct care

10 and treatment are within standards of good medical

11 practice within a community and are appropriate and

12 necessary for the symptoms, diagnosis or treatment of

13 the condition. Right?

14 A. Yes.

15 Q. And that's part of this defined contractual

16 term that the DOC uses in its normal business

17 practices. Right?

18 MR. LEONOUKAKIS: Objection.

19 THE WITNESS: It's part of what we use in

20 relation to a specific network contract.

21 Q. (By Mr. Cheffo) And that's a business

22 practice, isn't it?

23 MR. LEONOUKAKIS: Objection.

24 THE WITNESS: Yes.

25 Q. (By Mr. Cheffo) Before entering into this

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1 contract does an expert make any determinations as to
2 what medical necessity is?
3 MR. LEONOUKAKIS: Objection, outside the scope.
4 THE WITNESS: I don't know.
5 Q. (By Mr. Cheffo) Have you ever heard of that
6 happening?
7 MR. LEONOUKAKIS: Same objection.
8 THE WITNESS: Not to my knowledge. I don't know.
9 Q. (By Mr. Cheffo) Typically you want -- you've
10 seen these documents before. Right?
11 A. Yes.
12 Q. Typically somebody who is either a lawyer or
13 a business person from the Department of Corrections,
14 right, sends the contract to the business person at
15 the provider, they look at it and they sign it.
16 Right?
17 MR. LEONOUKAKIS: Objection, form, outside the
18 scope.
19 THE WITNESS: It's my understanding that, yes,
20 these are reviewed by legal and are reviewed at least
21 internally aside from the chief medical officer's
22 signature by our business services administration.
23 Q. (By Mr. Cheffo) And if there's a question
24 about whether something is medically necessary or not,
25 do you -- who makes the determination?

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1 MR. LEONOUKAKIS: Objection, outside the scope.
2 THE WITNESS: So any type of treatment protocol
3 that is listed through whatever means an outside
4 provider may see someone through a hospitalization,
5 that information is communicated back to the facility
6 CHSA the inmate originated from, it's reviewed by that
7 provider there. If there's questions or concerns
8 that's kicked to the chief medical officer for his
9 additional review and guidance.
10 Q. (By Mr. Cheffo) So that whole determination
11 about if there's -- first of all, if there's no
12 dispute then the provider does something, they say
13 it's medical nec -- medically necessary and if there's
14 agreement then the provider at your institution says
15 yes, we agree. Right?
16 A. Right.
17 Q. And that's something that's done internally
18 at the DOC. Right?
19 MR. LEONOUKAKIS: Objection.
20 THE WITNESS: Correct, it's done at the facility
21 of origin.
22 Q. (By Mr. Cheffo) And then if there's a dispute
23 about whether something is or is not medically
24 necessary, that gets elevated to someone also at the
25 Department of Corrections who in their normal course

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1 makes the determination. Right?
2 MR. LEONOUKAKIS: Objection, outside the scope.
3 THE WITNESS: Yes.
4 Q. (By Mr. Cheffo) And that person is the chief
5 medical officer?
6 A. Yes.
7 Q. That doesn't require any out -- you don't go
8 to any outside experts, do you?
9 MR. LEONOUKAKIS: Objection.
10 THE WITNESS: We have the ability to request an
11 authorized second opinions if there was a necessity
12 for that.
13 Q. (By Mr. Cheffo) But you don't need to, do
14 you?
15 MR. LEONOUKAKIS: Objection.
16 THE WITNESS: I wouldn't want to hazard a guess.
17 Q. (By Mr. Cheffo) But it's typically done all
18 within the confines of the relationship and the
19 Department of Corrections' healthcare providers.
20 Right?
21 MR. LEONOUKAKIS: Objection, misstates the
22 testimony.
23 THE WITNESS: If -- if there's something that
24 there is a question about the medical necessity of it
25 is the process that I described, go back to the

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1 facility and potentially the chief medical officer
2 from there if there was a concern.
3 Q. (By Mr. Cheffo) So if I were to say that it's
4 beyond the scope of the state through its contractual
5 ability to determ -- to determine medical necessity,
6 you would disagree with me. Right?
7 MR. LEONOUKAKIS: Objection, scope.
8 You can answer in your personal capacity if
9 you know.
10 THE WITNESS: Ask it again, please.
11 Q. (By Mr. Cheffo) Sure. I'm asking our court
12 reporter to read it because I can't remember that far
13 back.
14 (The record was read as directed.)
15 "Q. So if I were to say that it's beyond the
16 scope of the state through its contractual ability to
17 determine medical necessity, you would disagree with
18 me. Right?"
19 MR. LEONOUKAKIS: Objection, scope, calls for a
20 legal conclusion.
21 THE WITNESS: I would disagree.
22 Q. (By Mr. Cheffo) And you would agree with me
23 that this process of what's medically necessary or not
24 medically necessary and that whole determination, a
25 pharmaceutical company has no role in that process or

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1 evaluation or determination. Isn't that right?

2 MR. LEONOUidakis: Objection, outside the scope.

3 THE WITNESS: Yes.

4 Q. (By Mr. Cheffo) While we're looking for the

5 next document, sometimes people need a shorter break

6 after lunch than before lunch, so if that's the case

7 you'll let me know if that happens.

8 THE WITNESS: I'm doing fine. I'm doing fine.

9 (Deposition Exhibit Number 14 marked for

10 identification purposes and made part of

11 the record.)

12 Q. (By Mr. Cheffo) This is Exhibit 14, sir.

13 We've marked this as 14. Is that one of the documents

14 that you reviewed in connection with your preparation?

15 A. Yes.

16 Q. I'll give you a chance to take a look at it

17 and maybe you can tell us what this is.

18 A. This is the MSRM guide for detoxification.

19 Q. And just for the record is clear, the MSRM

20 is a essentially addendum to a procedure and policy?

21 A. Correct.

22 Q. Provides a little more detail and

23 information to build out a policy. Is that generally

24 fair?

25 A. Specifically for healthcare staff.

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1 Q. And this one is labeled detoxification?

2 A. Yes.

3 Q. And what is the purpose of this MSRM?

4 A. It's to provide guidance on the safe

5 withdrawal from drugs of dependence and enable

6 individuals to become drug free. The detox services

7 that are designed to administer are the severity of

8 the inmate's level of physical dependence, achieve a

9 safe and supportive withdrawal for alcohol or drugs

10 and effectively facilitate the inmate's transition

11 into ongoing services, including referral to mental

12 health services.

13 Q. And it talks about detoxification from

14 alcohol, opiates, hypnotics, benzodiazepines, other

15 stimulants and sedative, hypnotic drugs may be

16 conducted in a variety of inmate housing settings and

17 may include an infirmary setting in a DOC facility or

18 a hospital as ordered by the attending psychiatrist,

19 healthcare provider.

20 Do you see that?

21 A. Yes.

22 Q. And those are all kind of substance of

23 abuse, right, alcohol, opioids, hypnotics,

24 benzodiazepines, stimulants, sedatives, hypnotic

25 drugs?

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1 A. Yes.

2 Q. In the next paragraph it actually says that

3 all chemical dependencies require monitoring and

4 treatment.

5 Do you see that?

6 A. Uh-huh.

7 Q. Does the DOC provide that?

8 A. In terms of monitoring, the intent of the

9 language here, chemical dependencies require

10 monitoring as it relates to the detox process and

11 treatment as it relates to the detoxification.

12 Q. So what does -- what does that mean in

13 practical terms?

14 A. In practical terms it's instructing the

15 staff to agree that they're in charge of monitoring

16 and providing the treatment during the detoxification

17 process.

18 Q. What is the treatment?

19 MR. LEONOUidakis: Objection.

20 THE WITNESS: Under six where it says withdrawal

21 management, the initial evaluation, every effort made

22 to ease the discomfort of detoxification, but

23 essentially there's not a specific treatment regimen

24 that is prescribed. It's left -- left up to the

25 qualified healthcare professional to determine what

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1 that detox plan looks like.

2 Q. (By Mr. Cheffo) And as we discussed, that

3 detox plan cannot currently include medically assisted

4 treatment like methadone or buprenorphine?

5 MR. LEONOUidakis: Objection, misstates the

6 testimony.

7 Go ahead.

8 THE WITNESS: As I -- as I said, I don't believe

9 our current practitioners have the appropriate

10 licensure to prescribe it.

11 Q. (By Mr. Cheffo) And even if they did you told

12 us they'd have to go and get some kind of approval

13 from the CMO?

14 A. There would have to be --

15 MR. LEONOUidakis: Objection.

16 THE WITNESS: -- some policy, rule or regulation

17 promulgated around that.

18 Q. (By Mr. Cheffo) And we know that because that

19 was required when you wanted to give methadone to

20 pregnant mothers, pregnant women?

21 A. It was created when we received a pregnant

22 female already on methadone.

23 Q. It says alcohol, benzodiazepines and

24 barbiturates are associated with the highest risk of

25 severe withdrawal symptoms.

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1 Do you see that --

2 A. I do.

3 Q. -- on the first page?

4 You believe that to be true, right, if it's

5 in the policy?

6 A. I believe that to be the way the policy is

7 written, yes.

8 Q. You don't disagree with it, do you?

9 A. Don't disagree.

10 Q. Probably outside your area of expertise.

11 Right?

12 A. Yes.

13 Q. And then there's various provisions here

14 about intake assessment, withdrawal management, right,

15 on the next page?

16 A. Yes.

17 Q. And on Page 3 there's a section for medium

18 and high risk symptomatic inmates. Do you see that?

19 A. Yes.

20 Q. And I take it from this that there's certain

21 potential situations where an inmate may be required

22 to be hospitalized outside of a facility?

23 A. Correct.

24 Q. And if that's the case there's a specific

25 receiving hospital, the Lindsay Municipal Hospital?

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1 I'm in the second paragraph under C, second sentence.

2 Right here, sir. (Indicating.)

3 A. Yes, yes.

4 Q. When appropriate, inmates requiring

5 hospitalization will be admitted to Lindsay Municipal

6 Hospital.

7 A. Yes.

8 Q. Is that the only hospital to take outpatient

9 DOC inmates?

10 A. It is not. This is written in such a way as

11 it primarily refers to intake and assessment. Lindsay

12 is the closest hospital to the assessment reception

13 center. But certainly it is possible that you can

14 become hospitalized through an emergency setting at

15 any hospital in the state.

16 Q. I see. So, this is more written for if

17 someone is kind of in a crisis situation or at high

18 risk during the intake the closest hospital would be

19 Lindsay Municipal but if they were outside of that

20 situation of intake they could go to some other

21 hospitals?

22 A. Correct.

23 Q. Is Lindsay Municipal Hospital able to use

24 medically assisted treatment if the doctors in that

25 hospital determine that it's appropriate?

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1 MR. LEONOUidakis: Objection.

2 THE WITNESS: I don't know that there's anything

3 that prohibits them from it but I don't know that

4 that's ever been anything that they have done.

5 Q. (By Mr. Cheffo) Do you know one way or the

6 other how they treat the patients that are sent there?

7 MR. LEONOUidakis: Objection.

8 THE WITNESS: Well, the Lindsay Municipal

9 Hospital is a hospital that primarily cares for DOC

10 inmates for a variety of health purposes. We -- we

11 rarely have inmates who are received into our system

12 who are actively in withdrawals because they sit so

13 long in county jail before they are received into our

14 custody.

15 Q. (By Mr. Cheffo) And does the DOC have any

16 jurisdiction or oversight over county jails?

17 A. Only insofar as if we contract bed space

18 with them, otherwise we have no oversight for inmates

19 who are in county jail. If they are sentenced to our

20 custody and the sentencing documents have been

21 received by population, then they are the

22 responsibility for us in terms of the cost of their

23 medical care that's provided or arranged by the

24 county.

25 Q. So that's a good distinction. I'm glad you

Page 217

1 raised that. So am I correct that if somebody is

2 arrested and is a drug abuser and has an addict, first

3 they're going to likely be in county jail. Right?

4 A. Yes.

5 Q. And if -- if their experience -- if they're

6 there for a day or two or three days, if they're

7 experiencing significant withdrawal it's more likely

8 to happen in the county jail. Is that right?

9 MR. LEONOUidakis: Objection.

10 Answer if you know.

11 THE WITNESS: I don't know but I would assume.

12 Q. (By Mr. Cheffo) With respect to any of those

13 treatment records or intake forms or evaluations that

14 are done at the county level, does the Department of

15 Corrections, the State Department of Corrections have

16 access to those, that information?

17 A. We have access to the documents that we

18 receive from the county. In the -- in the situation

19 that you specifically described of someone who may

20 have been picked up on charges, be there four or five

21 days, DOC would have no record of them ever being in

22 county jail. We would only have record of people who

23 are sentenced to our custody.

24 Q. Okay. I'm sorry. I didn't mean to cut you

25 off.

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1 A. No.
2 Q. Yeah, and I was just clarifying. I was
3 saying, so I'm talking about a person who ultimately
4 winds up in your facility. Right?
5 A. Okay.
6 Q. They get picked up, they commit some crime,
7 right, they can't get out, they go through the process
8 to the extent that they have any medical issues that
9 happens in the first, but they -- they maintain in the
10 county, they're maintained in the county until such
11 time as they either plead guilty or either found
12 guilty and then they are sentenced and then they wind
13 up in a state facility. Okay?
14 A. Correct.
15 Q. With respect to that person, that
16 individual, do the records kind of carry with him or
17 her?
18 A. To the extent that if the county delivers
19 records to us that are medical or mental health
20 records, we obtain those, scan them into the
21 electronic health record. If the inmate tells us at
22 intake or at any time point in time during their
23 incarceration that they received some type of
24 treatment and provide us with the proper releases for
25 contact of who that entity was so we can obtain those

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1 documents we do. Those are the two most common.
2 Q. But it's not a centralized system?
3 A. No. Not to my knowledge.
4 Q. So, if there was an intake -- and are you
5 aware as being in this, this industry if you will,
6 this profession for almost twenty years, is it typical
7 that an intake is done at the county level as well
8 when someone is first incarcerated?
9 A. If the county has on site medical, which I
10 believe there are still some counties in Oklahoma that
11 are small enough that they don't have a contract on
12 site medical provider, they -- they may have some
13 record, but we are at the mercy of what is delivered
14 to us by the county and/or what the inmate tells us in
15 terms of their history of being seen from a medical
16 standpoint.
17 Q. If you'd turn to the next page, Page 4,
18 please. And I'm now still in Section C. It appears
19 that there's certain requirements that need to be
20 taken by a healthcare professional at certain
21 intervals. Do you see that?
22 A. Are you talking Number 3?
23 Q. Three, four, five --
24 A. Yes.
25 Q. -- through 10. A wellness check. Right?

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1 See that on nine?
2 A. Right.
3 Q. Eight, sorry.
4 Medical provider will enter a note on each
5 working day.
6 Do you see that?
7 A. Yes.
8 Q. And the QMHP and psychiatric provider will
9 enter a note weekly.
10 Do you see that?
11 A. Yes.
12 Q. What's the QMHP?
13 A. Qualified mental health provider.
14 Q. And all these notes and records weekly,
15 daily, you know, or more or less, where are they all
16 maintained?
17 A. Electronic health record in DOC.
18 Q. For the patient, for the inmate?
19 A. Yes.
20 Q. So we talked a little bit about this but I
21 think this is the policy, if you turn to Page 5,
22 methadone treatment for pregnant inmate.
23 A. Yes.
24 Q. It says, the federal Narcotic Addict
25 Treatment Act of 1974 restricts the use of methadone

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1 in the treatment of opioid dependence to facilities
2 that are appropriately licensed as a narcotic
3 treatment program for maintenance of detox -- or
4 detoxification with methadone.
5 Do you see that?
6 A. Yes.
7 Q. And that's I believe what you told us that
8 you need to send out or get consult from an outside
9 entity because the physicians or healthcare providers
10 in the facilities are not licensed to prescribe
11 methadone?
12 A. Correct.
13 Q. But your policy does go on. Right?
14 A. Uh-huh.
15 Q. It says, methadone can be provided without
16 an institutional license for up to three days while
17 arranging for an appropriate referral of the inmate to
18 a licensed facility.
19 Do you see that?
20 A. Yes.
21 Q. And that would apply to men and women.
22 Right?
23 A. Correct.
24 Q. So there is an ability for a physician to
25 write methadone prescriptions for three days?

1 A. It's my understanding that based on the act
2 that this section of policy was developed on, yes,
3 that is correct.

4 Q. But in practice that never happens in the
5 Department of Corrections' facilities, does it?

6 MR. LEONOUKAKIS: Objection.

7 THE WITNESS: To the best of my knowledge, no, it
8 does not, unless they are pregnant females.

9 Q. (By Mr. Cheffo) And is there a certain rule
10 that says healthcare provider, don't ever do this, or
11 is it an unwritten rule around the institutions?

12 MR. LEONOUKAKIS: Objection.

13 THE WITNESS: Again, without a policy or
14 direction from the chief medical officer, I think it's
15 something that we as an agency has not adopted as
16 practice.

17 Q. (By Mr. Cheffo) I'm just trying to
18 understand. You know, on the one hand, and help me
19 understand this, you -- I think it's been the position
20 that the Department of Corrections doesn't practice
21 medicine and that you trust the judgment of your --
22 your doctors and your health care providers. Right?

23 A. Yes.

24 Q. And the ability for a healthcare provider to
25 prescribe methadone for at least three days is not

1 restricted by law. Right? Correct?

2 A. Yes.

3 Q. Yet it's been your repeated testimony that
4 there would have to be some change in policy or
5 approval or recommendation by the chief, CMO or
6 somebody else in order for a doctor or healthcare
7 provider to do what they're able to do under law in
8 their medical judgment and I'm trying to understand
9 why that is.

10 MR. LEONOUKAKIS: Objection.

11 THE WITNESS: Well, just in terms of the way the
12 policies, MSRMs are meant to be guidelines that better
13 explain or expand certain practices. We don't have
14 providers nor is the chief mental health officer --
15 excuse me, the chief medical officer engage in brain
16 surgery. I'm sure there's probably regulations as to
17 why they wouldn't do that. But in terms of having
18 something like this, some type of medication assisted
19 treatment where you're talking about medications of
20 this type, historically the agency has adopted some
21 framework of how that would work and not just all over
22 the place for three days.

23 Q. (By Mr. Cheffo) This isn't brain surgery
24 though. Right?

25 A. No.

1 Q. I mean, this is just methadone of which your
2 healthcare providers are doing this for pregnant
3 women. Right?

4 A. Our healthcare providers are not doing it
5 for pregnant women. We're contracting that service
6 out.

7 Q. Okay. But, I mean, do they -- do they
8 literally leave the facility, the pregnant women?

9 A. Yes.

10 Q. And they go off site?

11 A. Yes. Two officers, transport, off site,
12 medical care provided by the contractor, transported
13 back to the facility, notes provided to the provider.

14 Q. And it can't be done inside the prison?

15 A. I don't believe it can be done based on the
16 licensure issues that we discussed earlier. I believe
17 our providers have the licensure to do it beyond the
18 scope of the three days we're talking.

19 Q. But so, so what I'm hearing you say is that
20 even though it says this here in terms of they can
21 prescribe for three days, in fact, they really can't?

22 MR. LEONOUKAKIS: Objection, misstates the
23 testimony.

24 THE WITNESS: They -- they don't.

25 Q. (By Mr. Cheffo) Even though they could for

1 three days. Right?

2 A. Methadone can be provided. In essence what
3 we have done to date I believe is we are receiving the
4 methadone from the clinic that the female has been
5 attending while in county jail and that is
6 administered by our staff for up to three days until
7 we can coordinate the appointment with the contractor
8 at which point in time they take over the dosing.

9 Q. Somebody said -- who ultimately, who would
10 be the person to make the decision? If -- if you
11 wanted to evaluate or the institution wanted to say we
12 know other institutions are doing this, right, we
13 don't historically do it, we know that there's certain
14 guidelines out there including for some organizations
15 that we are a member of and support, we'd like to
16 evaluate this and change our policy, who would be the
17 person to do that? Would it be the CMO?

18 A. It would be the chief medical officer and
19 the chief mental health officer would both be expected
20 to weigh in on that and provide input, insight into
21 the development of a policy recommendation and a
22 proposed budget in terms of what that program looks
23 like, what segment of the population it would target.

24 Q. And how, how could something like that get
25 on the desk of the CMO? Could a bunch of prisoners

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1 ask that it be considered, would it be an outside
2 law -- lawsuit, could it be public concerned citizens?
3 How would it --
4 MR. LEONOUDAKIS: Objection.
5 THE WITNESS: Conceivably anyone can make that
6 type of recommendation for his consideration.
7 Q. (By Mr. Cheffo) Okay. And are you -- have
8 you ever had a conversation with him about whether
9 that should be implemented?
10 A. No. Not in terms of specifics of should we
11 adopt it and what it would look like.
12 Q. What have you -- have you talked to him at
13 all about it?
14 A. In the context of preparation for this we
15 know that other states certainly do offer it, some do,
16 some don't, some do it outpatient as part of reentry,
17 some do it earlier while incarcerated or during the
18 period of incarceration and some like us don't do it
19 at all.
20 Q. Did he give you any reason as to why he
21 thinks from a medical perspective it would be a bad
22 idea?
23 A. We didn't go that far into conversation.
24 Q. Did he say it would be a good idea?
25 A. No. We, again, didn't have that type of

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1 conversation.
2 Q. Do you think that it would have a positive
3 impact on people who are released from prison and
4 reenter into the community if they had a way of
5 addressing their abuse and addiction issues?
6 MR. LEONOUDAKIS: Objection, outside the scope.
7 You can answer.
8 THE WITNESS: Just from my personal perspective,
9 sure, any type of treatment or educational services in
10 general is designed to assist with reentry.
11 Q. (By Mr. Cheffo) So being a student of other
12 policies, obviously you're not bound by them or guided
13 by them, but other states, what are some of the
14 experiences from the states that have done it that you
15 think are lessons learned in a positive way?
16 MR. LEONOUDAKIS: Objection, it's outside the
17 scope.
18 You can answer in your personal capacity.
19 THE WITNESS: And I don't know that I
20 specifically read any specific research articles
21 around it or reviewed anyone's specific policies. I
22 know there are a couple states that have -- like I
23 said, they do it from anywhere from thirty days to six
24 or nine months prior to discharge. Some of them
25 manage it in-house, some of them contract it out, some

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1 of them do nothing more than set up the appointment or
2 referral for the date of discharge. There seems to be
3 a wide variety of how it's done. I don't know that
4 I've seen or heard anyone really talk about
5 longitudinally what -- what the overall impact is in
6 terms of reducing opioid related deaths with segments
7 of previous incarcerates. That's probably in the
8 works somewhere but I don't know that I've seen it.
9 Q. (By Mr. Cheffo) With regard to any of those,
10 the short term, the long term, Oklahoma doesn't do any
11 of those. Right?
12 A. Not while incarcerated, no, or not as part
13 of a reentry service.
14 Q. Would you say there's a trend towards
15 medically assisted treatment in the states or a trend
16 against it?
17 MR. LEONOUDAKIS: Objection, outside the scope.
18 THE WITNESS: Just from a -- a personal
19 perspective, I'd say that there is more of a trend in
20 the treatment community in general, not necessarily in
21 the state, but towards medication assisted treatment.
22 MR. CHEFFO: Let's mark this, please, as -- I've
23 marked it as 15.
24 (Deposition Exhibit Number 15 marked for
25 identification purposes and made part of

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1 the record.)
2 Q. (By Mr. Cheffo) I believe this is one the
3 documents you may have referenced earlier?
4 A. Yes.
5 Q. Can you just tell us what it is?
6 A. This is an MSRM that was developed for the
7 use of naloxone and Narcan.
8 Q. And what's the purpose of this document?
9 A. The intent is to provide some guidance for
10 how to respond using naloxone or Narcan if an opioid
11 overdose is suspected.
12 Q. Do you have any sense of how often Narcan is
13 administered in the DOC facilities?
14 MR. LEONOUDAKIS: Objection.
15 THE WITNESS: Anecdotally I could tell you it's
16 been used a couple of times. In terms of an actual
17 number of count or actual count of the number,
18 naloxone kits that are being used, those are reported
19 to the Department of Mental Health and Substance Abuse
20 Services. We received our nasal Narcan and training
21 on how to use them from the Department of Mental
22 Health and Substance Abuse Services. Prior, prior to
23 that our naloxone was the injectable form.
24 MR. CHEFFO: It's warm in here, isn't it?
25 THE WITNESS: It's getting that way.

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1 MR. KINNEY: Yes.
2 MR. CHEFFO: Take five minutes?
3 MR. LEONOUKAKIS: If you want to take a break.
4 MR. CHEFFO: Not to make you the keeper of the
5 air conditioner.
6 THE VIDEOGRAPHER: Off the record. End of Media
7 Number 4. The time is 2:52.
8 (A recess was here had 2:52 to 2:59.)
9 THE VIDEOGRAPHER: Back on the record. Beginning
10 Media Number 5. The time is 2:59.
11 (Deposition Exhibit Number 16 marked for
12 identification purposes and made part of
13 the record.)
14 Q. (By Mr. Cheffo) Sir, I'm going to show you
15 Exhibit 16. Are you familiar with the American
16 Correctional Association?
17 A. Yes.
18 Q. Are you a member of that?
19 A. I have been off and on. I think my
20 membership has actually lapsed at this point.
21 Q. What other organizations are you a member of
22 related professionally?
23 A. Salt and Light Leadership, I'm a member of
24 the Governor's Interagency Council on Homelessness and
25 then a past member of a couple of grant governance

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1 boards through the state's District Attorney's
2 Council.
3 Q. What do those do?
4 A. They're oversight for some specific grant
5 funding for which the -- I guess the District
6 Attorney's Council is the actual recipient of the
7 grant funds.
8 Q. What are the subject matters typically?
9 A. One of them is justice assistance grants,
10 the other one is residential substance abuse
11 treatment. And I rotated off those boards shortly
12 after leaving the programs department within the
13 agency.
14 Q. Do you sit as a person who helps decide
15 which programs should be funded or do you assist in
16 making grants or did you?
17 A. At the time it was assistance with funding
18 decisions on justice assistance grant and it was just
19 oversight of the state's already received grants on
20 our staff.
21 Q. Have you ever published anything
22 professionally?
23 A. I think I had one magazine article in
24 Corrections Today where I was a coauthor with our
25 director at the time, Justin Jones.

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1 Q. What was the subject matter?
2 A. I think it was around evidence based
3 practices and maybe reentry services and programming.
4 Q. Can you give me a little more detail?
5 A. That's been a long time ago.
6 Q. Do you know what year it was?
7 A. I would be guessing, but I think it was 2010
8 or earlier.
9 Q. Do you -- what was the name of your
10 coauthor?
11 A. Justin Jones.
12 Q. Do you regularly or from time to time speak
13 on panels or participate in forums as a speaker?
14 A. I have for a couple of college classes.
15 Q. In what context?
16 A. Usually criminal justice in general.
17 Q. Is there a specific area or focus that you
18 talk about?
19 A. When I do talk about it's usually health
20 services because that's my area currently, but we also
21 talk about broader needs of the agency. Usually
22 there's somebody with me who is from human resources.
23 Most recently the last couple years it's been UCO's
24 College of Criminal Justice. So, we like to use it as
25 an opportunity for HR to talk to people who may be

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1 seeking employment.
2 Q. So, just so from a perspective of college
3 students or students who I take it you -- one of the
4 goals here is to try and talk about the interesting or
5 important aspects of your work. What are the basic
6 things that you convey about health services? Because
7 it's not just administrative. Right?
8 A. Basically just because of the timeframe
9 that's allowed we talk about Eighth Amendment rights
10 of inmates to receive constitutional level of care
11 that's not cruel and unusual, talk about the overall
12 population, what are the most common conditions as
13 defined by nursing protocols or chronic clinic and
14 then just the cost of inmate care and aging inmate
15 populations. I would say briefly about that we
16 operate infirmaries and that we operate mental health
17 units just to give an overview of the types of
18 individuals that are incarcerated with us.
19 Q. And do you typically put a PowerPoint or
20 other presentation together?
21 A. It depends. I mean, there are a couple of
22 PowerPoints that I've used before.
23 Q. Putting aside the preparation for this
24 deposition and certainly not any lawyers, involving
25 any lawyers, have you had discussions with colleagues

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1 or e-mails with colleagues about ways to address
2 opioid abuse or illicit fentanyl or carfentanil abuse
3 in the prison system?
4 MR. LEONOUKAKIS: Objection, outside the scope of
5 the testimony.
6 Answer in your personal capacity.
7 THE WITNESS: The only thing that immediately
8 comes to mind are e-mails that I have had with
9 internal staff as well as a staff member from
10 Department of Mental Health and Substance Abuse
11 Services through coordinating with them to go through
12 naloxone training for our direct care staff and some
13 nonuniform staff in facilities.
14 Q. (By Mr. Cheffo) You mentioned or you
15 testified that the nalox -- I'm sorry, the methadone
16 program for pregnant inmates began with essentially a
17 real life person, a woman who I guess was incarcerated
18 who was pregnant and that caused you to evaluate your
19 policies or programs with respect to drug assisted
20 treatment for pregnant women. Is that right?
21 A. Correct.
22 Q. How long ago was that?
23 A. Within the last 12 months or so.
24 Q. So that policy we read earlier was new, the
25 one about drug assisted treatment for pregnant women?

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1 A. Are you referring to Exhibit 14?
2 Q. Yes, sir.
3 A. The portion about the methadone treatment
4 for pregnant inmates was specifically new there.
5 Q. And I don't need any details about the
6 specific patient or inmate, but just tell me what --
7 help me understand how that process came to be as best
8 as you can recall it. In other words, she -- she came
9 to a facility, she either made it known that she was
10 pregnant or it was obvious and she was I guess abusing
11 medicines or taking methadone?
12 MR. LEONOUKAKIS: Objection.
13 THE WITNESS: We -- we have a provider who works
14 at the Mabel Bassett assessment and reception center,
15 which is our site for female receptions in the state,
16 that's where everybody goes to when they're coming
17 into our custody, who was also at the time working
18 part time in the county jail from which she was
19 received. So, he had knowledge of the fact that she
20 was slated to come into our custody a few days prior
21 to her reception and that she was actively receiving
22 methadone treatment through some program prior to her
23 sentencing and shipment.
24 Q. (By Mr. Cheffo) And then that started the
25 process?

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1 A. That started the conversation because he had
2 a conversation with the chief medical officer who
3 alerted me and then the roundtable discussions of how
4 that could be dealt with.
5 Q. Who else was involved in the decision to
6 implement that program or policy?
7 A. The chief mental health officer had input
8 into it as well.
9 Q. You, the CMO and the chief mental health
10 officer?
11 A. Yes.
12 Q. Anyone else?
13 A. If you're talking specifically about the
14 medical service resource manual since that serves as
15 sort of an addendum and attachment, it did not have to
16 circulate outside for a full stakeholder review. So,
17 yes, it was primarily in-house in health services
18 division.
19 Q. Okay. Can you just look at the document?
20 The American Correctional Association and the American
21 Society of Addiction Medicine, are you familiar with
22 that organization?
23 A. ACA, yes, ACAM, yes.
24 Q. Okay. And this is a relatively recent
25 document, March 20th, 2018?

Page 237

1 A. Yes.
2 Q. Do you see the one, two, the third paragraph
3 below the heading, it says in quotes, ACAM is pleased
4 to join ACA in releasing this important statement
5 which makes clear that justice involved individuals
6 should have access to the same evidence based
7 treatment options that are available in traditional
8 healthcare settings? Do you see that?
9 A. Yes.
10 Q. Do you agree with that?
11 MR. LEONOUKAKIS: Objection.
12 THE WITNESS: It's a policy statement that was
13 adopted by ACA and ACAM. I don't -- I don't have an
14 issue with the statement.
15 Q. (By Mr. Cheffo) Okay. Do you agree with it?
16 A. Sure.
17 Q. Do you think that the DOC complies with that
18 statement?
19 MR. LEONOUKAKIS: Objection.
20 Q. (By Mr. Cheffo) Strike that.
21 Do you think the DOC has policies and
22 procedures that are fully consistent with that
23 statement?
24 MR. LEONOUKAKIS: Objection.
25 THE WITNESS: I think the DOC has policies and

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1 procedures that govern the deliverance of a
 2 constitutional level of care to all the inmates in our
 3 jurisdiction. I believe we specifically have a policy
 4 that addressed methadone treatment for pregnant
 5 females.
 6 Q. (By Mr. Cheffo) And the next page, there's a
 7 joint public correctional policy on the treatment of
 8 opioid use disorders for justice involved individuals.
 9 Do you see that?
 10 A. Yes.
 11 Q. It says 17 to 19 percent of individuals in
 12 America's jails and state prison systems have
 13 regularly used heroin or opioids prior to
 14 incarceration. While release from jail and prison is
 15 associated with a dramatic increase in death from
 16 opioid overdose among those with untreated opioids use
 17 disorder, there are considerably -- considerable data
 18 to show the treatment with opioid agonists and partial
 19 agonists reduce deaths and improve outcomes for those
 20 with opioids use -- opioid use disorders.
 21 Do you see that?
 22 A. Uh-huh.
 23 Q. Preliminary data suggests that treatment
 24 with an opioid agonist could also reduce overdose. As
 25 a result, a 2017 bipartisan Presidential Commission on

Page 239

1 Combating Drug Addiction and the Opioid Crisis has
 2 recommended increased usage of medications for
 3 addictive treatment, MAT, in correctional settings.
 4 Do you see that?
 5 A. Yes.
 6 Q. These are both legitimate well recognized
 7 organizations, aren't they?
 8 A. Yes.
 9 Q. Do you agree with the introduction paragraph
 10 I just read?
 11 MR. LEONOUKAKIS: Objection.
 12 THE WITNESS: Yes.
 13 Q. (By Mr. Cheffo) Is it consistent with the
 14 policies of the DOC?
 15 MR. LEONOUKAKIS: Objection.
 16 THE WITNESS: In such that we've adopted a
 17 procedure to address pregnant females, yes.
 18 Q. (By Mr. Cheffo) Is that what you think this
 19 means?
 20 A. Well, certain there are -- there -- both
 21 organizations provide policy statements on what they
 22 recognize as best practices in the field.
 23 Q. So you would agree with me that if we were
 24 to talk to the people who wrote this that this is
 25 broader than applying methadone to pregnant women

Page 240

1 Right?
 2 A. Yes.
 3 MR. LEONOUKAKIS: Objection.
 4 Q. (By Mr. Cheffo) So in that regard it would be
 5 inconsistent with the current policies and procedures
 6 of the Oklahoma Department of Corrections?
 7 A. I do not believe that the Department of
 8 Corrections has a policy that is as broad as the
 9 policy statement and recommendations made by the ACA
 10 and ASAM.
 11 Q. The only consistency and overlap would be
 12 with respect to pregnancy inmates. Right?
 13 A. Yes.
 14 Q. And then there's also on the next page, I'm
 15 sorry, two pages, sir, C.
 16 A. Yes.
 17 Q. Do you see the reentry and community
 18 supervision considerations?
 19 A. Yes.
 20 Q. Can you just read to yourself, take as much
 21 time as you need, one, two and three and let me know
 22 if the DOC has policies that are consistent with those
 23 considerations?
 24 MR. LEONOUKAKIS: Object to this as outside the
 25 scope.

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1 But you can answer.
 2 THE WITNESS: With respect to reentry in general
 3 and to the extent that the inmate tells us
 4 legitimately where they are discharging to, any type
 5 of referral can be made. To the extent community
 6 supervision occurs it is still possible within the
 7 State of Oklahoma to release without any type of
 8 community supervision. So you can flat discharge a
 9 sentence. When that occurs there is limited oversight
 10 or coordination that DOC can provide. So, with those
 11 two caveats stated, repeat the question for me one
 12 more time.
 13 Q. (By Mr. Cheffo) I was basically just asking
 14 you if looking at these you believe that the DOC
 15 current policies and procedures are fully consistent
 16 with one, two and three of the recommendations of the
 17 organizations that we've been talking about?
 18 MR. LEONOUKAKIS: Objection, outside the scope.
 19 You can answer in your personal capacity.
 20 THE WITNESS: The existing policies that I am
 21 familiar with that are within regard to reentry do not
 22 get this specific as they pertain to this type of
 23 treatment.
 24 (Deposition Exhibit Number 17 marked for
 25 identification purposes and made part of

Page 242

1 the record.)

2 Q. (By Mr. Cheffo) This is my second to last

3 document, sir. This is 17. Have you seen this

4 document in connection with your preparation?

5 A. Yes.

6 Q. What is it?

7 A. It's the operational policy for care of the

8 actively dependent inmate.

9 Q. And in Section B it's medical detoxification

10 and tapered withdrawal. Do you see that?

11 A. Yes.

12 Q. Do you know what tapered withdrawal means?

13 A. It means they are decreasing the amount of

14 medication that's being prescribed.

15 Q. Does -- does the DOC engage in medical

16 detoxification and tapered withdrawal?

17 A. We specifically do with pregnant females.

18 Once the female has delivered they are tapered in

19 conjunction with the contract provider and the chief

20 medical officer. Beyond that if we received someone

21 who was actively detoxing the process would be similar

22 with the chief medical officer and attending physician

23 would determine what was necessary and relating back

24 to the MSRM that's referenced they could be sent out

25 for hospitalization if necessary.

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1 Q. And to the extent that that happened there

2 would be records of that. Right?

3 A. In the electronic health record.

4 Q. Okay.

5 (Deposition Exhibit Number 18 marked for

6 identification purposes and made part of

7 the record.)

8 Q. (By Mr. Cheffo) This is 18. Have you seen

9 this document in connection with your preparation?

10 A. Yes.

11 Q. And what is it?

12 A. It's the policy for outside providers for

13 healthcare management.

14 Q. What -- what's the purpose of this document?

15 A. When medical needs require -- when an

16 inmate's medical needs are -- excuse me, inmate whose

17 medical needs require health related services not

18 available at the DOC or primary medical contract

19 provider will have treatment and/or hospitalization

20 made through an outside community provider. When

21 referral for community specialist care is warranted,

22 the indication will fall within the four levels of

23 care described below.

24 Q. One of the levels is on Page 4, medically

25 necessary. Do you see that?

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1 A. Yes.

2 Q. And the determination of medical necessity

3 is a determination that's made internally by the

4 medical staff. Right?

5 MR. LEONOUKAKIS: Objection.

6 THE WITNESS: By the facility medical provider.

7 Q. (By Mr. Cheffo) Who would -- is that

8 typically? Is it a doctor or --

9 A. It can be a midlevel or a doctor.

10 Q. When you say midlevel --

11 A. Physician's assistant or doctor.

12 Q. So, if there's a question about med --

13 whether something is medically necessary, either a

14 physician's assistant or a staff physician makes that

15 determination. Right?

16 A. Yes.

17 Q. And if there's a question I guess they could

18 seek consult from the chief medical officer?

19 A. Well, essentially they by policy initiate a

20 request electronically. And then that request is sent

21 to the regional physician who supervises that

22 physician within 24 hours for approval or disapproval.

23 Q. The idea of -- of determining medical

24 necessity is something that's pretty common for

25 healthcare professionals in the Department of

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1 Corrections, isn't it?

2 MR. LEONOUKAKIS: Objection.

3 THE WITNESS: To the extent we have policy

4 written on it, yes.

5 Q. (By Mr. Cheffo) And, I mean, it's something

6 that they're expected to know and be able to make

7 judgment calls and implement on a daily basis as

8 necessary. Right?

9 MR. LEONOUKAKIS: Objection.

10 THE WITNESS: It's certainly something that we

11 expect them to assess and provide services.

12 Q. (By Mr. Cheffo) And they're able -- they

13 should be able to do that within the scope of their

14 general responsibilities. Right?

15 MR. LEONOUKAKIS: Objection.

16 THE WITNESS: And within the scope of what their

17 licensure allows.

18 Q. (By Mr. Cheffo) Okay. And they to your

19 knowledge they do that with frequency without ever

20 having to consult the CMO. Right?

21 MR. LEONOUKAKIS: Objection.

22 THE WITNESS: Can you rephrase the question?

23 Q. (By Mr. Cheffo) Sure.

24 Nurse practitioners, physician's assistants,

25 doctors, they make determinations about what's

Page 246

1 medically necessary and what's not medically necessary
 2 on a regular basis as part of their regular job
 3 function without having to consult with the chief
 4 medical officer?
 5 MR. LEONOUidakis: Objection.
 6 THE WITNESS: Within the scope of how the policy
 7 is worded. If it's routine treatment provided to
 8 maintain a chronic or non -- nonlife threatening
 9 condition that can be reasonably delayed without risk
 10 of further complications, serious deterioration,
 11 significant pain or discomfort, yes.
 12 Q. (By Mr. Cheffo) They -- they could also make
 13 a determination as part of their daily work as to
 14 whether a prescription is medically necessary. Right?
 15 MR. LEONOUidakis: Objection.
 16 THE WITNESS: Their prescribing capabilities are
 17 more closely tied to what's in the pharmaceutical op
 18 and what is in formulary.
 19 Q. (By Mr. Cheffo) Okay. But assuming it's on
 20 formulary, the determination of whether a prescription
 21 is medically necessary for a patient is something
 22 within the sound discretion of the staff or line
 23 doctor or healthcare provider in a facility. Right?
 24 MR. LEONOUidakis: Objection.
 25 THE WITNESS: I would agree in general, yes.

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1 Q. (By Mr. Cheffo) That's not something that
 2 requires CMO or outside panels or experts, right,
 3 that's something they do every day?
 4 MR. LEONOUidakis: Objection.
 5 Q. (By Mr. Cheffo) Is that right?
 6 A. Are you talking generalities or are you
 7 talking specific?
 8 Q. I'm talking generally. I'm not -- I'm not
 9 even talking about that document, I'm just talking
 10 generally.
 11 MR. LEONOUidakis: Same objection.
 12 THE WITNESS: State it again, please.
 13 MR. CHEFFO: Sure.
 14 Could you read it?
 15 (The record was read as directed.
 16 "Q. Okay. But assuming it's on formulary, the
 17 determination of whether a prescription is medically
 18 necessary for a patient is something within the sound
 19 discretion of the staff or line doctor or healthcare
 20 provider in a facility. Right?
 21 MR. LEONOUidakis: Objection.
 22 THE WITNESS: I would agree in general, yes.
 23 Q. (By Mr. Cheffo) That's not something that
 24 requires CMO or outside panels or experts, right,
 25 that's something they do every day?"

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1 THE WITNESS: Prescribing what's within the scope
 2 of their practice, licensure and based on what's on
 3 the agency formulary, yes, is within the scope of
 4 their practice.
 5 Q. (By Mr. Cheffo) Does the -- does the
 6 Department of Corrections have a policy about allowing
 7 pharmaceutical sales reps to come into the facilities
 8 to talk to doctors or detail?
 9 A. There's not a policy about it, but no one
 10 can just walk in off the street and access anyone.
 11 There are fences, perimeter, a reception area,
 12 security protocol similar to what you go through at
 13 the airport in order to get into the facility and no
 14 one gets to just show up unannounced.
 15 Q. Do you -- do you believe that the doctors
 16 who prescribe medicines to inmates do so because
 17 they're using their best medical judgment or because
 18 they are somehow influenced by something that was told
 19 to them by a pharmaceutical sales rep?
 20 MR. LEONOUidakis: Objection.
 21 THE WITNESS: I could speculate, but certainly
 22 their medical judgment is part of it, but to what
 23 extent they may or may not talk to sales reps or other
 24 educators or anyone else that may influence their
 25 decision I don't know.

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1 Q. (By Mr. Cheffo) You have no knowledge one way
 2 or the other?
 3 A. I can tell you they don't access facilities.
 4 Q. They don't?
 5 A. The sales reps, no. I'd get a phonecall
 6 over that, so if someone showed up unannounced wanting
 7 to speak with a doctor in a facility.
 8 Q. It's not the most welcoming environment?
 9 A. It would be something unusual enough that it
 10 would raise a flag.
 11 Q. And I take it you as the person who
 12 ultimately has supervision over the chief medical
 13 officer at least administratively, you have confidence
 14 and faith in the medical staff that's treating inmates
 15 of this state that they're performing their function
 16 in an honorable and ethical way to the best of their
 17 abilities. Right?
 18 A. Yes.
 19 Q. I mean, if you believe that doctors were
 20 prescribing medicines to inmates when they didn't need
 21 them, that would be something that would of concern to
 22 you, wouldn't it?
 23 A. Yes.
 24 Q. And you would take action if you thought
 25 that there was some prescription that was written for

1 not a medically necessary purpose solely because of
 2 information that a third party gave a doctor. Right?
 3 MR. LEONOUKAKIS: Objection.
 4 THE WITNESS: As a just point of process, the
 5 only way I would likely know that is once the chief
 6 medical officer or the pharmacist knew it and brought
 7 it to one or the other's attention.
 8 Q. (By Mr. Cheffo) Excuse me. And similarly,
 9 you believe, right, that the chief medical officer if
 10 he believed that his staff was engaging in improper
 11 prescriptions or was somehow improperly influenced he
 12 would take action and probably would tell you about
 13 that. Right?
 14 A. Yes.
 15 Q. And that's never happened, has it?
 16 MR. LEONOUKAKIS: Objection.
 17 THE WITNESS: Not to my knowledge.
 18 Q. (By Mr. Cheffo) Okay. Just to be clear, I'm
 19 not -- I don't want to get into right now HR issues
 20 somewhat performance related, so I'll try and narrow
 21 the question --
 22 A. Okay.
 23 Q. -- so you may have an easier time with it.
 24 But in terms of you're not aware of any
 25 situation that was brought to your attention or

1 brought to the CMO's attention where a medical
 2 provider at the DOC facility was improperly writing
 3 opioid prescriptions?
 4 A. No. I am not aware of anything specific
 5 like that.
 6 MR. CHEFFO: Just give me a second. No reason to
 7 leave, let me just see if --
 8 THE VIDEOGRAPHER: Off the record. The time is
 9 3:26.
 10 (A recess was here had 3:26 to 3:28.)
 11 THE VIDEOGRAPHER: Back on, 3:28.
 12 Q. (By Mr. Cheffo) Sir, I've seen reference to
 13 something called operations memoranda.
 14 A. Yes.
 15 Q. Can you just tell me what those are?
 16 A. The OPs are the policies.
 17 Q. Okay.
 18 A. It's just a synonymous term for policies and
 19 procedures.
 20 MR. CHEFFO: Thank you. All right, I -- subject
 21 to any followup and issues that we may have with
 22 respect to scope and testimony which we can deal with
 23 at a later point, I have no further questions and
 24 thank you for your time today, sir.
 25 MR. LEONOUKAKIS: Just a few.

1 CROSS EXAMINATION
 2 BY MR. LEONOUKAKIS:
 3 Q. Mr. Castleberry, in preparation for your
 4 deposition today, looking at Exhibit 1, before today
 5 did you come to learn what the relevant time period
 6 was as it's used in Exhibit A?
 7 A. Yeah. I think I misstated that earlier
 8 during prep. It was from the mid '90s, '95, '96
 9 forward.
 10 Q. Okay. And did you come to learn at all what
 11 the term opioid alternative medications referred to as
 12 used in Exhibit A?
 13 A. I believe earlier I got that confused with
 14 the medicated assisted treatment. What I believe this
 15 specifically is referring to would be alternative
 16 types of pain management techniques or medications.
 17 Q. Okay. And does the Department of
 18 Corrections make a distinction between opioid
 19 medications and opioid alternative medications in the
 20 procedures that you've referenced today?
 21 A. I don't believe so, no.
 22 Q. Okay. And with respect to the relevant time
 23 period, did you -- did you do anything to collect
 24 documents to produce in this case?
 25 A. The policies and procedures that I requested

1 from our procedures unit that were the historical
 2 versions back to the point that they had those
 3 available.
 4 Q. [REDACTED]
 5 [REDACTED]
 6 [REDACTED]
 7 [REDACTED]
 8 Q. To the substance of those documents?
 9 A. Yes. Of course, more familiar with whatever
 10 their current form is.
 11 Q. Okay.
 12 MR. LEONOUKAKIS: No further questions. Thank
 13 you.
 14 THE WITNESS: Okay.
 15 REDIRECT EXAMINATION
 16 BY MR. CHEFFO:
 17 Q. So you said now that you are -- you thought
 18 the relevant timeframe was 1995 to -- or 1996 to the
 19 present?
 20 MR. LEONOUKAKIS: Objection.
 21 THE WITNESS: Yes.
 22 Q. [REDACTED]
 23 [REDACTED]
 24 [REDACTED]
 25 [REDACTED]

1 [REDACTED]
 2 [REDACTED]
 3 [REDACTED]
 4 [REDACTED]
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 15 [REDACTED]
 16 [REDACTED]
 17 [REDACTED]
 18 [REDACTED]
 19 Q. So how is it that you're -- are you then
 20 prepared to testify if you didn't review them?
 21 A. I'm prepared to testify based on the fact
 22 that the policy exists currently and what current
 23 practices are.
 24 Q. We talked a fair amount about the current
 25 practices [REDACTED]

1 [REDACTED]
 2 [REDACTED]
 3 [REDACTED]
 4 Q. Because you spent six to eight hours
 5 focusing on these, you didn't actually believe that
 6 you needed to look at the policies prior to the most
 7 recent. Isn't that fair?
 8 MR. LEONOUKAKIS: Objection.
 9 THE WITNESS: Fair.
 10 Q. (By Mr. Cheffo) And if I asked you any
 11 questions about any of those policies going back
 12 beyond what you've dealt with, we would essentially --
 13 strike that.
 14 If I asked you anything about policies or
 15 procedures other than what you've brought here today,
 16 you would tell me that you can't testify under oath
 17 with any level of specificity. Isn't that right?
 18 MR. LEONOUKAKIS: Objection.
 19 THE WITNESS: Yes, without those historical
 20 documents in front of me.
 21 Q. (By Mr. Cheffo) You would need to review
 22 those historical documents, collect them and get them,
 23 familiarize yourself and possibly talk to other people
 24 if you believe that you were supposed to have done
 25 that. Right?

1 A. Yes.
 2 Q. And if you were asked to do that you
 3 certainly would have. Right?
 4 A. Yes.
 5 Q. And in order to understand the context of
 6 any of those historical documents, you likely would
 7 have had to talk to a number of people because some of
 8 these are issues that are outside your area of
 9 expertise. Right?
 10 A. Yes.
 11 Q. And you didn't do that?
 12 A. No.
 13 Q. And with respect to alternative therapies,
 14 you've testified about what that means. Right?
 15 MR. LEONOUKAKIS: Objection.
 16 Q. (By Mr. Cheffo) Strike that.
 17 You testified what you understood
 18 alternative -- opioid alternative medications to mean?
 19 A. Yes.
 20 Q. But you can't, can you, can you tell me
 21 about any of the standards, practices or procedures
 22 related to the use or prescription of opioid
 23 alternative medications?
 24 A. There's not a specific existing policy that
 25 I'm aware of that makes a distinction between the type

1 of medication that a provider can prescribe.
 2 Q. But what are some opioid alternative
 3 medications?
 4 A. I don't know the specific names of any.
 5 Q. Well, can you give me one?
 6 A. Not off the top of my head, no.
 7 Q. So how is it that you could tell me about
 8 the procedures and standards and practices about them
 9 if you don't know what they are?
 10 A. I know what an opioid is and I know what an
 11 alternative pain medication is in general, but the
 12 specifics of what it's name is, we don't list the
 13 names of medications or their prescribed usage in the
 14 policies.
 15 Q. Okay. But are there policies that relate to
 16 opioid alternative medications whether they define the
 17 names of those or not?
 18 A. No. I believe earlier I thought you were
 19 talking about methadone treatment for pregnant
 20 females, but no, in terms of pain management or opioid
 21 use, no.
 22 Q. So, if somebody is in pain and they're not
 23 prescribed an opioid, are there alternatives to that?
 24 A. If they are listed in the formulary, if
 25 there are other drugs that could be potentially used,

1 their clinical judgment are allowed to provide
 2 treatment to the inmate population.
 3 [REDACTED]
 4 [REDACTED]
 5 [REDACTED]
 6 [REDACTED]
 7 [REDACTED]
 8 [REDACTED]
 9 [REDACTED]
 10 [REDACTED]
 11 [REDACTED]
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 19 [REDACTED]
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 21 [REDACTED]
 22 [REDACTED]
 23 [REDACTED]
 24 [REDACTED]
 25 [REDACTED]

1 yes, there is an alternative to that.
 2 Q. In many situations, right, people will often
 3 be prescribed less potent medicines, right, both in
 4 prison and outside of prison before they're prescribed
 5 the more serious medicines. Right?
 6 A. Yes.
 7 Q. So, someone might be prescribed aspirin or
 8 other things and then if they don't receive pain
 9 relief then they might ultimately be titrated to a
 10 more potent medicine. Right?
 11 MR. LEONOUidakis: Objection.
 12 THE WITNESS: Presumably.
 13 Q. (By Mr. Cheffo) But in connection with your
 14 preparation, because you weren't asked to do it you
 15 don't know what the standards or practices or
 16 procedures that the Department of Corrections applies
 17 for uses with respect to opioid alternative
 18 medications for persons in the care and custody of the
 19 Oklahoma Department of Corrections. Correct?
 20 MR. LEONOUidakis: Objection, misstates his
 21 testimony.
 22 THE WITNESS: I am familiar with the existing
 23 policies and procedures that detail how our
 24 pharmaceutical and therapeutics committee determine
 25 what's for use on formulary and then our providers in

1 [REDACTED]
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 25 [REDACTED]

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1 Q. Or none at all. Some could be significant.
 2 Right?
 3 A. Or none at all.
 4 Q. Right. But being a diligent person
 5 exercising your good faith obligation, you would want
 6 to actually have details and facts before you
 7 testified under oath about what the policies were,
 8 wouldn't you?
 9 MR. LEONOUKAKIS: Objection.
 10 THE WITNESS: Yes.
 11 Q. (By Mr. Cheffo) So you wouldn't want to
 12 speculate about whether there were no changes, any
 13 changes, detailed questions, you'd actually want to
 14 find that information. Right?
 15 A. Yes.
 16 Q. Okay.
 17 MR. CHEFFO: Thank you. I have no further
 18 questions.
 19 MR. LEONOUKAKIS: No questions.
 20 MR. CHEFFO: Thank you, sir.
 21 THE VIDEOGRAPHER: We're off the record. The
 22 time is 3:40. This concludes today's testimony of
 23 Clint Castleberry. The total number of units used was
 24 five. They will be retained by Veritext.
 25

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1 (Deposition concluded at 3:40 p.m.)
 2 (Signature required; witness excused.)
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1 CERTIFICATE OF DEPONENT
 2
 3 I have read the foregoing transcript of
 4 my deposition and except for any corrections or
 5 changes noted on the errata sheet, I hereby
 6 subscribe to the transcript as an accurate record
 7 of the statements made by me.
 8
 9
 10 _____
 11 CLINT CASTLEBERRY
 12
 13 SUBSCRIBED AND SWORN before and to me
 14 this ___ day of _____, 20__.
 15
 16 _____
 17 NOTARY PUBLIC
 18
 19
 20 My Commission expires:
 21
 22
 23
 24
 25

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1 ERRATA SHEET
 2 VERITEXT LEGAL SOLUTIONS
 3 330 OLD COUNTRY ROAD
 4 MINEOLA, NEW YORK 11501
 5 516-608-2400
 6 NAME OF CASE: STATE OF OKLAHOMA vs. PURDUE PHARMA
 7 DATE OF DEPOSITION: SEPTEMBER 5, 2018
 8 NAME OF DEPONENT: CLINT CASTLEBERRY
 9 PAGE LINE(S) CHANGE REASON
 10 _____
 11 _____
 12 _____
 13 _____
 14 _____
 15 _____
 16 _____
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 18 _____
 19 _____
 20 _____
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 22 _____
 23 CLINT CASTLEBERRY
 24
 25 SUBSCRIBED AND SWORN TO BEFORE ME
 THIS ___ DAY OF _____, 20__.

 (NOTARY PUBLIC) MY COMMISSION EXPIRES:

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CERTIFICATE

STATE OF OKLAHOMA)
) SS:
COUNTY OF OKLAHOMA)

I, David Buck, Certified Shorthand Reporter within and for the State of Oklahoma, do hereby certify that CLINT CASTLEBERRY was by me first duly sworn to testify the truth, the whole truth and nothing but the truth, in the case aforesaid; that the above and foregoing deposition was taken in shorthand and thereafter transcribed; that the same was taken on September 5, 2018, in Oklahoma City, Oklahoma; that I am not an attorney for nor a relative of any said parties, or otherwise interested in said action.

IN WITNESS WHEREOF, I have hereunto set my hand and official seal this 10th day of September, 2018.


David Buck, CSR #1585

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Oklahoma
Rule 12-3230
Depositions Upon Oral Examination

F. Review By Witness; Changes; Signing.

The deponent shall have the opportunity to review the transcript of the deposition unless such examination and reading are waived by the deponent and by the parties. After being notified by the officer that the transcript is available, the deponent shall have thirty (30) days in which to review it and, if there are changes in form or substance, to sign a statement reciting such changes and the reasons given by the deponent for making them. The officer shall indicate in the certificate prescribed by paragraph 1 of subsection G of this section whether any review was requested and, if so, shall append any changes made by the deponent during the period allowed.

DISCLAIMER: THE FOREGOING CIVIL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY. THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2016. PLEASE REFER TO THE APPLICABLE STATE RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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September 14, 2018

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Re: *State of Oklahoma ex rel. Mike Hunter v. Purdue Pharma, LP, CJ -2017-816*

Dear Counsel:

I write in regard to the September 5, 2018 deposition of a corporate representative to testify as to the Oklahoma Department of Corrections' policies and procedures for diagnosis and treatment of pain and for the use of opioid medications and opioid alternative medications during the Relevant Time Period, which Judge Hetherington has held to be 1996 to the present. The State's witness, Clint Castleberry, was clearly not prepared to testify on the subject for which he was designated. Purdue has serious concerns about the State's lack of preparation for depositions, which is impeding the discovery process. This

EXHIBIT D

lack of preparation cannot continue, especially with the compressed schedule and May 2019 trial date that the State insists on.

At the outset, the witness improperly limited his preparation to 2018 policies, and did not investigate prior policies during the relevant period of the litigation:

Q. So in your preparation you did not endeavor to find out any information prior to January 1st, 2018. Correct?

A: Yes.

Q. If you wanted to go prior to 2018 you certainly could have. Right?

A. Yes.

Q. Other than any conversations that you may have had with lawyers, did you have a discussion with anyone about whether you should actually look for information prior to January 1, 2018?

A. No.

Q. And irrespective of any conversations, you didn't do it in any event. Correct?

A. No.

Q. So if I wanted to know anything about standards, policies, procedures prior to 2018 with respect to the diagnosis and treatment of pain, you would not be prepared to talk about that, would you?

A. No, I wouldn't.

Castleberry Dep. at 74:23-76:6.

Nor did the witness review any DOC drug formularies prior to 2018 that contain opioid medications:

Q. Did you review the formularies prior to the most recent formulary in connection with your preparation today?

A. No.

Castleberry Dep. at 34:16-19.

The witness made no effort to even understand a prime subject of the deposition:

Q. So if you wanted to find out what opioid alternative medicines, medications meant or might have meant, you -- you would have talked to the chief medical officer about that. Right?

A. Potentially, yes.

Q. And/or the pharmacist. Right?

A. Potentially, yes.

Q. And you didn't do that?

A. No.

Q. So therefore you wouldn't be the right person for me to ask questions about opioid alternative medications because you're not familiar with that term. Fair?

A: Not beyond the two examples I gave you.

Castleberry Dep. at 81:19-82:12.

The witness did not educate himself on one of the leading prescription and illicit opioids in existence, which appears on the DOC's formulary, and repeatedly pointed to other DOC personnel as having the relevant knowledge:

Q. If you wanted to know about policies and procedures and standards regarding the use of fentanyl, you're not the most knowledgeable person about that, are you?

A. Correct.

Q. Who would -- who do you think would actually know some of those answers?

A. The chief medical officer and the agency pharmacist.

Castleberry Dep. at 124:21-125:5; *see also* 27:9-17; 37:3-13; 39:25-40:8; 48:4-9; 53:19-23; 56:20-57:1; 58:23-25; 87:4-10; 110:3-9; 134:24-135:8; 136:15-20; 154:3-16; 169:24-170:7; 260:3-261:25.

Indeed, the witness appeared to not know anything specific about opioid use at the DOC at all:

Q. [A]s you sit here today you don't know anything about what opioids were prescribed, do you?

A. Outside of any that are listed in the formulary other than we have the ability to prescribe them, no.

Q. Even, even the ones in the formulary, can you tell me anything about the frequency or the purpose for the prescriptions or the indications for which they were prescribed?

A. No.

Q. Can you even tell me that any of them were prescribed?

A. No.

Q. So, you would be speculating if you told me one or 10,000 or 500 because you have no idea as to whether opioids were prescribed or were not prescribed. Right?

A. Correct.

Castleberry Dep. at 172:17-173:14.

Q. Similar to the current opioids of which you don't know if any and how many opioid prescriptions were written, you have no information about the volume, scope or reasons for any opioid prescription written by a healthcare provider in

the Department of Corrections within the last ten years, do you?

A. No.

Q. That's information that's obtainable if you were asked to do that?

A. Yes, to an extent.

Castleberry Dep. at 176:1-12.

Although the witness was almost completely unprepared, he was able to identify numerous categories of responsive documents that are within the State's custody or control but have not been produced, despite being subject to Defendants' document requests. Purdue requests the State supplement its production with the following documents by September 28, 2018:

- All iterations of the DOC formulary from 1996 to present. *See* Castleberry Dep. at 27, 36-37; *see also* Purdue Frederick's First RFPs No. 1; Teva's First RFPs No. 4; Johnson & Johnson's First RFPs No. 6; Janssen's First RFPs No. 2;
- Prior versions of operational policies and MSRMs relating to opioids, drugs, and substance abuse. *See* Castleberry Dep. at 32-33, 254; *see also* Janssen's First RFPs No. 8;
- Records, notes, and minutes related to meetings of the Pharmacy & Therapeutics Committee. *See*, Castleberry Dep. at 39-40; 53; *see also* Purdue Pharma LP's First RFPs No. 2; Johnson & Johnson's First RFPs No. 2; Janssen's First RFPs No. 2;
- Records of drug dose wastage and diversion by DOC employees. *See* Castleberry Dep. at 45, 111-112; *see also* Johnson & Johnson's First RFPs No. 9; Janssen's First RFPs Nos. 4, 8;
- Educational programs the Pharmacy & Therapeutics Committee has promoted for safe and appropriate use of drugs. *See* Castleberry Dep. at 56-57; *see also* Johnson & Johnson's First RFPs No. 8; Janssen's First RFPs No. 8;

- Statistical reports prepared by the DOC's designated pharmacy services provider. *See* Castleberry Dep. at 58-59; *see also* Johnson & Johnson's First RFPs No. 5;
- DOC policies and procedures related to medically assisted treatment (MAT). *See* Castleberry Dep. at 62-63; *see also* Purdue Pharma LP's First RFPs No. 7; Teva's First RFPs No. 6; Janssen's First RFPs No. 8;
- Records of any DOC use of Narcan or Naloxone. *See* Castleberry Dep. at 67-68; *see also* Janssen's First RFPs No. 8;
- Records related to DOC substance abuse programs including but not limited to policies and contracts with the Department of Mental Health and Substance Abuse Services for substance abuse programs. *See* Castleberry Dep. at 68-69; 71-72; 143; *see also* Janssen's First RFPs Nos. 4, 8;
- Health records documenting inmate substance abuse histories and DOC medication administration records, including hard copies and digital records stored at the OU Health Science Center. *See* Castleberry Dep. at 73-74, 86, 97, 99-100, 102-105, 138, 243; *see also* Purdue Pharma LP's First RFPs No. 3; Johnson & Johnson's First RFPs No. 4; Janssen's First RFPs No. 8;
- American Correctional Association guidelines and best practices relating to opioids and substance abuse/treatment. *See* Castleberry Dep. at 89-90; *see also* Teva's First RFPs No. 8; Janssen's First RFPs No. 8;
- DEA drug requisition forms submitted by the DOC, and records of opioid prescriptions written for inmates. *See* Castleberry Dep. at 109-110, 163-167, 172; *see also* Purdue Pharma LP's First RFPs No. 3;
- Records of deaths of inmates caused or contributed by drug abuse or overdose. *See* Castleberry Dep. at 187-188; *see also* Janssen's First RFPs Nos. 4, 8;
- Records of all policies for or contracts with DOC network providers or claims administrators. *See* Castleberry Dep. at 198-200; *see also* Teva's First RFPs No. 3;

- Intake forms and treatment records of substance abusers received by the DOC from county jails. *See* Castleberry Dep. at 217; *see also* Janssen's First RFPs No. 8;
- Internal emails related to opioid treatment programs and training. *See* Castleberry Dep. at 234; *see also* Johnson & Johnson's First RFPs No. 8; Janssen's First RFPs Nos. 5, 8; and
- DOC medical provider requests for determinations of medical necessity. *See* Castleberry Dep. at 244; *see also* Purdue Pharma LP's First RFPs No. 8; Purdue Frederick's First RFPs No. 6; Teva's First RFPs No. 6.

Due to the witness's lack of preparation and the State's omission of relevant documents from its production, Purdue reserves the right to reopen the deposition once the documents are produced and the witness is properly prepared. As always, we are willing to meet and confer on these issues. Please let us know when you are available during the week of September 17, 2018.

Sincerely,

/s/ Mark Cheffo

Cc: Counsel of record for Defendants



Ross Leonoudakis
Attorney at Law
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September 17, 2018

ELECTRONIC MAIL

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Re: *State of Oklahoma ex rel. Mike Hunter v. Purdue Pharma, LP, CJ-2017-816*

Counsel,

I write in response to your September 14 letter concerning Purdue's deposition of Clint Castleberry as a representative of the Department of Corrections ("DOC"). Your allegations regarding Mr. Castleberry's preparation for and ability to testify on behalf of DOC are groundless and self-serving. The letter is particularly questionable considering Purdue's conduct in choosing and preparing its witnesses, such as Keith Darragh on August 30, 2018.

Unlike Mr. Darragh, who has only worked for Purdue for 4 months, Mr. Castleberry has worked at the DOC for eighteen years and was able to testify to the noticed topic in addition to the many other areas that Purdue explored outside the scope of the noticed topic. Unlike Mr. Darragh, Mr. Castleberry participated in the creation of many of the documents that were directly responsive to the noticed topic and was personally knowledgeable as to the substance of those documents. And most importantly, unlike Mr. Darragh, Mr. Castleberry did not perjure himself by swearing to the accuracy of information that he didn't write or know was accurate.

Q. So when you signed the verification in Exhibit 3, as to the accuracy of the information in Exhibit 3 that says The Purdue Frederick Company, Incorporated are combined in the audited financial statements for Purdue Pharma, L.P., you really didn't know for sure whether or not that was accurate or not, did you?

A: That's correct

Darragh Dep. At 57: 13-22.

Indeed, Mr. Castleberry was able to testify to the topic as written and was knowledgeable as to the documents produced on behalf of the DOC. Contrary to the self-serving isolated items you chose to put in your letter, the documents produced on behalf of the DOC consist of all current and prior versions of DOC operating procedures and MSRMs related to the use of opioids or opioid alternatives for the treatment of pain. Moreover, contrary to the self-serving snippets of out of text testimony you chose to include in your letter, Mr. Castleberry did not limit his preparation to the 2018 policies and procedures. Castleberry dep. 252:22 - 253:11. Indeed, many of the documents he testified about at the deposition were in effect before 2018. You knew that to be the case when you wrote your letter. But, you made the choice not to question Mr. Castleberry about any of the prior versions of the policies and procedures. You cannot credibly use your choice to limit your questions as a sword to challenge the witness' preparation for a deposition about topics before this time that he was indeed prepared for but of which you chose not to ask.

Finally, many of the self-serving examples you chose to list in your letter involve documents and testimony that are outside the scope of the noticed topic. (*e.g.*, documents related to diversion, statistical reports, medically assisted treatment, substance abuse programs, in addition to others.) Furthermore, certain examples in your letter involve information that would be unreasonable for a witness to try and memorize (*e.g.*, the volume of opioids prescribed by DOC providers.)

The State is currently still in the process of gathering internal DOC emails and prior iterations of the DOC formularies. Further, you have identified several individuals you want to depose that you believe have additional information. Therefore, our witness clearly identified any other people who would have knowledge of information you asked about in the deposition. The State is available to meet and confer on Friday, September 21st regarding those depositions and your other requests.

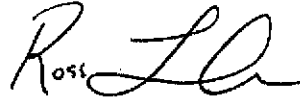
Now, back to Mr. Darragh. In addition to Mr. Darragh's inability to testify knowledgeably (or even truthfully) along with his sworn statement mentioned above, when we meet and confer regarding the DOC, the State requests that Purdue be prepared to discuss document production and testimony related to the following:

- Identity and purpose of companies listed in the audited financial statements produced by Purdue;
- Ownership of companies above Purdue Holdings L.P. and Purdue Pharma, Inc. up to the trusts held for the benefit of the Sackler Family;
- Distribution of revenue and profits above Purdue Holdings L.P. up to the trusts held for the benefit of the Sackler Family;
- Identity of past and current Board Members of Purdue;
- Unaudited and or audited financial statements for companies listed in Purdue Pharma L.P and associated companies and other companies listed in the audited financial statements produced by Purdue; and
- Unaudited and or audited financial statements for Purdue Holdings L.P.;

- Financial and ownership information related to other Purdue related companies that receive revenue for the sale of opioids including but not limited to Rhodes Pharma, Mundipharma, and Napp Pharmaceuticals.

Let us know when you are ready to discuss these matters and we will be happy to discuss anything you need further regarding the DOC deposition at the same time.

Regards,

A handwritten signature in black ink, appearing to read "Ross LA". The signature is written in a cursive style with a large, stylized "L" and "A".

Ross Leonoudakis

Cc: Counsel of record for Defendants