1041660819

IN THE DISTRICT COURT OF CLEVELAND COUNTY
STATE OF OKLAHOMA

STATE OF OKLAHOMA
CLEVELAND COUNTY, S.S.
FILED
OCT 04 2018
In the office of the
Court Clerk MARILYN WILLIAMS

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

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.

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[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.

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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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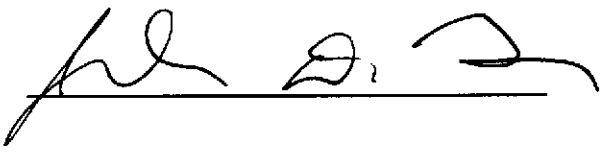
CERTIFICATE OF SERVICE

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

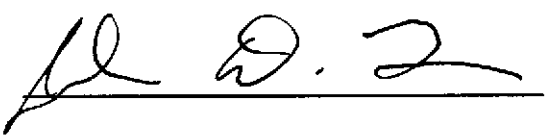
PURDUE'S MOTION TO COMPEL WITNESS TESTIMONY

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



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.



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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

Veritext Legal Solutions
866 299-5127

A

EXHIBIT A

three.

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

[redacted]. Now, there could be some situations where there are inpatient -- you know, there's an inpatient, you know, provision of an opioid medication, it's not a prescription per se, and we are looking at those records and anything related to that to see if there's anything there we can produce. As far as addiction treatment is concerned, another thing we are looking into to see how that's handled and we are going to provide any information there as well, [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**
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EXHIBIT B

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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.

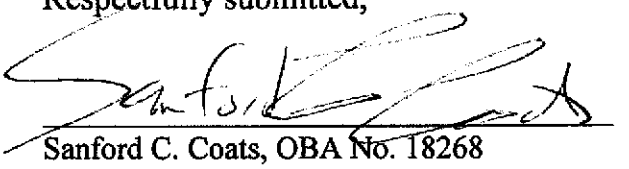
Pursuant to OKLA. STAT. TIT. 12, § 3230(C)(5), the State is hereby notified of its obligation to designate one or more officers, directors, managing agents, or other persons who consent to testify on the State's behalf about all matters embraced in the "Description of Matters on Which Examination is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

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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

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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Also Present: Michele Minietta

The Videographer: Bruce Rodgers

STIPULATIONS

IT IS HEREBY STIPULATED AND AGREED by and among the attorneys for the respective parties hereto that the deposition of CLINT CASTLEBERRY may be taken on behalf of the Defendants on the 5th of August, 2018, in Oklahoma City, Oklahoma, by David Buck, Certified Shorthand Reporter for the State of Oklahoma, taken pursuant to Notice.

IT IS FURTHER STIPULATED AND AGREED by and among the attorneys for the respective parties hereto that all objections, except as to the form of the question and the responsiveness of the answer, are reserved until the time of trial, at which time they may be made with the same force and effect as if made at the time of the taking of this deposition.

* * * * * *

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THE VIDEOGRAPHER: Good morning. We're going on the record at 8:57 a.m. Please note that the microphones are sensitive and may pick up whispering, private conversations and cellular interference. Please turn off all cellphones or place them away from the microphones so they do not interfere with the deposition. Audio and video recordings will continue to take place unless the parties agree to go off the record. This is media unit number one, video deposition of Clint Castleberry taken on behalf of the defendants in the matter of State of Oklahoma versus Purdue Pharma, L.P., et al filed in the District Court of Cleveland County, Case Number CJ-2017-816. The deposition is being held at Whitten & Burrage located at 512 North Broadway, Suite 300, Oklahoma City, Oklahoma. My name is Bruce Rodgers with the firm D & R Reporting. The court reporter is David Buck from the firm D & R Reporting. I'm not authorized to administer the oath, I'm not related to any party in this action nor am I financially interested in the outcome.

Counsel and all present in the room and everyone attending remotely will now state their appearances and affiliations for the record.

MR. LEONOUDAKIS: Ross Leonoudakis from Nix

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Patterson & Roach on behalf of the state.

MS. MINIETTA: Michele Minietta, Department of Corrections.

MR. MERKLEY: Nick Merkley, GableGotwals, for the Teva, Cephalon defendants.

MR. KINNEY: David Kinney with the Odom & Sparks Law Firm for the Johnson & Johnson defendants.

MR. TAM: Jonathan Tam from Dechert for Purdue.

MR. CHEFFO: Mark Cheffo from Dechert for Purdue.

THE VIDEOGRAPHER: Will the reporter please swear in the witness?

CLINT CASTLEBERRY,

after having been first duly sworn at 8:59 a.m. deposes and says in reply to the questions propounded as follows, to wit:

* * * * * *

DIRECT EXAMINATION

BY MR. CHEFFO:

Q. Good morning, sir. Will you please state your name for the record?

A. Clint Castleberry.

Q. And are you employed?

A. Yes.

Q. Where are you employed?

A. Oklahoma Department of Corrections.

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Q. You understand you're under oath today?

A. Yes.

Q. I'm sure your counsel had an opportunity to give you some ground rules, but if there's anything I ask you that you don't understand today, will you please just let me know and I'll try and rephrase it?

A. Sure.

Q. And if you need a break for some time I just ask that you answer the question that's pending and let us know and we'll take a break. Fair enough?

A. Okay.

Q. What -- how long have you worked at the Department of Corrections?

A. Eighteen years.

Q. And what's your current role?

A. I'm the director of health services.

Q. Can you just give us a little bit of a narrative if you don't mind your -- your kind of history at the Department of Corrections professionally in terms of when you started, what your roles were and your general responsibilities and take us up through today?

A. Sure. I started with the agency in November of 1999 as a psychological clinician at our assess -- assessment and reception center in Lexington,

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Oklahoma. I was there for approximately a year and a half, two years and moved to our programs division which had oversight for treatment programs, educational, vocational services and grants for the agency, worked as the individual who was over coordinating the grants that worked with our substance abuse treatment programs. Moved up the ranks there until I was the I think the title was chief administrator of program services for seven or eight years probably and then moved over to the director of health services role in July 2015, I believe.

Q. What is your role as the director of health services?

A. The administrative oversight for our medical and mental health units within the agency.

Q. When you say within the agency, does that cover all correctional institutions within the State of Oklahoma?

A. Yes and no. Private prisons where we house a certain percentage of our population have their own contracts and contract requirements. We have some oversight but not direct oversight of their medical and mental health services.

Q. Okay. What -- what portion of the inmate population are housed in private versus public

institutions?
A. I couldn't tell you today without a count sheet.
Q. Could you give me an estimate?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Four thousand to 5,000 inmates.
Q. (By Mr. Cheffo) In private?
A. Yes.
Q. And how many in public?
A. Twenty-two to 23,000 roughly.
Q. And you have direct responsibility as the department -- the director of health services for the -- all the inmates who are in the public and you have some responsibility for the private?
A. Yes.
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) Can you tell us what the nature of your responsibility is with respect to the private inmates, for the inmates housed in private facilities?
A. In terms of their medical care, there are contracts that the agency's region three develops that includes all the services that private prisons are required by that contract to provide. In terms of the medical care that is completely contracted out, the

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

Q. Do you have any involvement in that process?
A. I do not.
Q. Who is the chief medical officer?
A. Dr. Joel McCurdy.
Q. How long has Dr. McCurdy been with the Department of Corrections?
A. I don't know.
Q. Has it been more than two or three years?
A. Yes.
Q. And prior to joining the Department of Corrections can you tell us about your educational background?
A. I have a master's of applied psychology.
Q. Where did you get that?
A. Southwestern Oklahoma State University.
Q. And where did you go to undergrad?
A. Southwestern.
Q. And what was your degree in?
A. Bachelor of Science.
Q. And prior to November 1999 when you were employed by the Department of Corrections as a clinician, did you have other employment?
A. Yes.
Q. What did you do?
A. I worked at Wal-Mart.

Q. After your master's in between the Department of Corrections you worked at Wal-Mart?
A. While I was working on my master's while I was in college I worked there.
Q. And then after you received your master's was your -- was your first job with the Department of Corrections?
A. Yes.
Q. And you've been there ever since?
A. Yes.
Q. Who do you report to?
A. The director of the agency.
Q. And when you say the agency, it's the Department of Corrections?
A. Department of Corrections.
Q. And who does he report to or she report to?
A. He reports to the board of corrections.
Q. And who is the director, the current director?
A. Joe Allbaugh.
Q. And how long has Mr. Allbaugh been the director?
A. Under three years.
Q. And who was the director before Mr. Allbaugh?

A. Patent. I can't remember his first name.
Q. Mr. Patent?
A. Uh-huh.
Q. Was he there the entire time that you were there at least other than Mr. Allbaugh?
A. I'm not sure I understand the question.
Q. Sure. I'm trying to figure out, you probably know who the directors were from the time that you were at since 1999. I'm going --
A. I got you.
Q. -- to try to maybe short circuit it. Maybe you can just tell us, from 1999 until the present who have the directors been?
A. I believe when I started with the agency Mr. Sapple was the director, then Mr. Ward, Justin Jones, Patent and Allbaugh.
Q. Are these political appointments?
A. I have no idea.
Q. And has Mr. -- excuse me, has Dr. McCurdy been the CMO, chief medical officer, since you've been there in 1999?
A. No, not since 1999.
Q. Do you remember who it was before him?
A. Immediately before him it was Dr. Don Sutmiller.

Q. And how long was he there?
A. Don't know.
Q. And who was before Dr. Sutmiller?
A. Dr. Mike Jackson.
Q. And before him?
A. I don't know.
Q. Is the -- is the -- the Department of Health services for the Department of Corrections adequately funded?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I'm not sure how to answer that question.
Q. (By Mr. Cheffo) You know what I mean by that. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Can you rephrase the question?
Q. (By Mr. Cheffo) Sure. Does it have adequate funding to meet the needs that you believe are appropriate to provide services to inmates?
A. Yes.
Q. So it has the full funding that you believe it needs in order to function as a fully operational and appropriate health service organization?
MR. LEONOUDAKIS: Objection.
THE WITNESS: With the funding we have we meet

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

have all of the money and resources it needs to provide adequate healthcare services to the inmates in Oklahoma?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer if you know in your personal capacity.
THE WITNESS: I don't know that the agency in general is funded the way that it should be funded in my personal view.
Q. (By Mr. Cheffo) And what about the healthcare services component?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: From my personal view I would say it is a challenge with the funding that we are given to operate.
Q. (By Mr. Cheffo) Is it underfunded?
MR. LEONOUDAKIS: Objection.
You can answer in your personal capacity.
THE WITNESS: In some areas, yes.
Q. (By Mr. Cheffo) What about is it underfunded in terms of drug treatment?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: I don't have oversight for drug treatment.
Q. (By Mr. Cheffo) You were a psych -- clinician

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in psychology?
A. Uh-huh.
Q. And you started there?
A. Yes.
Q. Did you work with patients, inmates who were patients?
A. As a psych clinician in the assessment and reception center my job was to screen inmates for the next step in the corrections process.
Q. Do you believe that the Department of Corrections provides adequate drug treatment programs and therapy to inmates currently housed in the Department of Corrections facilities in the State of Oklahoma?
MR. LEONOUDAKIS: Objection.
You can answer.
THE WITNESS: I don't have any oversight for the number of treatment programs and the capacity of the programs that we currently have in existence.
Q. (By Mr. Cheffo) So you have no opinion?
A. No.
MR. LEONOUDAKIS: Objection.
THE WITNESS: I do not have an opinion.
Q. (By Mr. Cheffo) Who is responsible for those programs?

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A. Nate Brown is the individual who is the chief administrator of program services.
Q. And what is -- what is he responsible for?
A. He has oversight for all substance abuse, educational, vocational programs that are operated in the agency, volunteer services and grants.
Q. Okay. So, what -- what are your -- what are your specific roles as the director of health services that you've had since 2015?
A. The administrative oversight for our functional operation as a division for medical and mental health services within the agency.
Q. And what does it mean administrative oversight?
A. I supervise the chief medical officer and the chief mental health officer and then I have oversight for our budgetary goals.
Q. The chief medical officer reports to you?
A. The chief medical administratively reports to me.
Q. And the chief mental health officer reports to you?
A. Administratively, yes.
Q. And have either one of those individuals come to you and said that their funding was not

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

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not.
Q. Okay. So in connection with preparing for this deposition, what did you do?
A. Met with Ross.
Q. Anyone else?
A. I had conversations with our general counsel so that they were aware of what was going on since we were -- since I was being deposed and have asked some clarification questions to our chief medical officer and pharmacist.
Q. Who is the pharmacist?
A. Robin Murphy.
Q. And when were you first asked to appear for this deposition?
A. When it was scheduled this time?
Q. Or even initially if you recall?
A. I have no idea.
Q. Did you review any documents in connection with the preparation?
A. Outside of the ones in front of me, no.
Q. And you said you spoke with your -- Ross, your -- your lawyer, the doctor I guess, Murphy, the pharmacist, general counsel and the chief medical officer. Correct?
A. Uh-huh.

Q. Anyone else?
A. Not that I can recall.
Q. And -- and where did you get the documents that you reviewed?
A. They are from our policies and procedures website on the DOC web page.
Q. And did you -- did you physically go and pull them or did -- did someone give them to you?
A. A combination of the two.
Q. Did you -- did you do any independent searches?
A. Well, I have full access to all of the policies and procedures within the agency as all employees do.
Q. What I'm asking you though is in connection with this specific deposition did you specifically conduct any document searches in order to help prepare yourself for this deposition?
A. Only of our own policies and procedures --
Q. Which --
A. -- which I have in front of me.
Q. Only the documents in front of you. Yes?
A. Yes.
Q. Sorry, you need to do that on the record.
A. Got it.

Q. I'm not trying to harass you.
(Deposition Exhibit Number 1 marked for identification purposes and made part of the record.)
Q. (By Mr. Cheffo) Let me show you what we've marked as Exhibit 1 and ask you if you've seen this document before. I'll tell you this is the Notice of Deposition for you to be here today.
A. No.
Q. You were not shown that?
A. No.
Q. Do you know what the scope of your testimony is?
A. Yes.
Q. Have you seen that before?
A. I've heard this before, yes.
Q. Not seen it?
A. Not to my recollection.
Q. You said you had conversations with I assume is it Dr. Murphy, Robin Murphy, is she a doctor of pharmacy?
A. I believe she's a PharmD.
Q. Okay. So, what was the nature of your conversation with Dr. Murphy?
A. Just clarification of processes on pharmacy,

ops and controlled substance ops or MSRM.
Q. [redacted]
Q. [redacted]
Q. And you don't remember the general subject matter of what you wanted to ask her about?
MR. LEONOUDAKIS: Objection.
THE WITNESS: No.
Q. [redacted]
Q. And what did he tell you?
A. The process of what's really in policy.
Q. I certainly have no objection to you looking

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

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

as Exhibit 2.
(Deposition Exhibit Number 2 marked for identification purposes and made part of the record.)
Q. (By Mr. Cheffo) Does that appear to be the same document?
A. Sure is the same effective date. I believe it is.
Q. [redacted]
Q. Do you know the years that are involved in this lawsuit?
MR. LEONOUDAKIS: Objection.
THE WITNESS: No.
Q. (By Mr. Cheffo) Do you understand what the claims are in this lawsuit?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Not outside of the specific

question that's posed here, no.
Q. (By Mr. Cheffo) Have you ever read the Complaint?
A. No.
Q. I take it you have no information about any of the defendants or what they were alleged to have done?
MR. LEONOUDAKIS: Objection.
THE WITNESS: No.
Q. (By Mr. Cheffo) Am I correct that you don't even know who the defendants are?
MR. LEONOUDAKIS: Objection.
You can answer if you know.
THE WITNESS: Other than the entities that you all represent that you introduced yourselves as, no, if it's beyond that scope.
Q. (By Mr. Cheffo) Is the -- strike that.
Are the formularies that were written over or revised, are they accessible on the Internet?
A. We post our current formulary on the Internet. I don't know how far back they can go with formularies that have been amended.
Q. But you believe that if you wanted to find out what the formulary was in existence in two or three or five years, that would be something that

Dr. Murphy would have?
MR. LEONOUDAKIS: Objection.
You can answer.
THE WITNESS: I believe to some extent, yes.
Q. (By Mr. Cheffo) Have you retained any documents that you've been working with in connection with your job function?
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) Have you been told to retain any documents?
MR. LEONOUDAKIS: Objection.
You can answer.
THE WITNESS: I recall a conversation with general counsel about retaining documents, but whether or not it was pertaining to this, without the order in front of me I don't recall.
Q. (By Mr. Cheffo) Have you retained documents or segregated any documents?
MR. LEONOUDAKIS: Objection.
You can answer.
THE WITNESS: We've not disposed of any documents, if that's your question.
Q. (By Mr. Cheffo) You've not deleted any e-mails?
A. Not related to this topic, no.

Q. Related to healthcare system or opioids or your work function?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Certainly there are e-mails that we delete that are just day to day operational but not anything specific to opioids or --
Q. (By Mr. Cheffo) You just told my I think that you don't know what this lawsuit is about. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Well, I know this lawsuit is about opioids in general, yes.
Q. (By Mr. Cheffo) But the specifics of the claims you're not familiar with, are you?
A. I'm not familiar with the claims in their totality, no.
Q. So what types of information do you believe you are required to retain?
MR. LEONOUDAKIS: Objection, outside the scope of the noticed deposition.
You can answer in your personal capacity if you know.
THE WITNESS: I believe assuming that the retention was in relation to this, we were to retain any information that was relevant to opioid medication and opioid alternative medications.

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

Q. And is this something that is updated on a regular basis?
A. Yes.
Q. Is it fair to say that if we looked at Page 2, the effective date of this policy, 01/17/2018, there would have been a prior similar policy that may have been updated to some extent?
A. Correct.
Q. This wouldn't be the first time you ever had a policy on this, this issue, would it?
A. Correct.
Q. And as with the formulary, would there be a place that is maintained within the Department of Corrections that would show changes from one effective policy to the next?
A. Yes.
Q. And where would that be maintained?
A. That would be in policy and procedures.
Q. Did you review any of the prior policies and procedures?
A. No.
Q. Did you believe that that was part of the Deposition Notice which calls for 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, custody of the Oklahoma Department of Corrections?
MR. LEONOUDAKIS: Objection.
You can answer the question.
THE WITNESS: It's my belief that what are our current operational policies are are what we're bound to to operate under.
Q. (By Mr. Cheffo) I understand. But they do change from time to time?
A. They can. They are reviewed annually. That does not necessarily mean that any of them is changed.
Q. Do you -- did you review any policies prior to this year or the most recent versions in order to determine what the policies were and if there were any changes?
A. Yes.
Q. What did you review?
A. All of the medical policies and procedures are on a rolling annual review. As part of that I am a stakeholder along with other entities within the agency.
Q. When you say a stakeholder, does that mean that you actually participate in the review process when a new policy either comes out or a policy is

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ratified?
A. Yes for health services, no for every policy in the agency.
Q. Okay. What are some of the policies for health services that you review?
A. The ones that are here.
Q. So this, this policy that we're talking about, Exhibit 2, is one of the health services policies?
A. Correct.
Q. So, and it also has information here about the formulary. Correct?
A. Correct.
Q. That's listed at Page 3. Do you see that?
A. Yes.
Q. [redacted]
Q. And I think you told us you were aware generally of some of the opioid analgesics that are on the current formulary?
A. Yes.
Q. And which were those?
A. Morphine and Norco.

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Q. Okay. And can you tell us any -- can you tell us first whether there were -- those opioid analgesics were on prior formularies?
A. I don't know.
Q. Do you know whether other form -- other opioid analgesics were on prior formularies?
A. I don't know.
Q. And with respect to Exhibit 2, how far back do the prior versions go?
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) Do you understand my question?
A. Yes.
I don't know. That would be a policy and procedures question.
Q. What would you -- you've been at the com -- at the department for 18 years. Approximately how long do you think you'd expect to find it?
MR. LEONOUDAKIS: Objection.
THE WITNESS: During my role as the director of health services there's been one.
Q. (By Mr. Cheffo) Okay. So you would expect -- well, not only has there been one but is it maintained in a computer somewhere?
A. Yes, back to some point in time.

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Q. So what I'm just trying to find out is assuming your supervisor said I'd like to know what the policy said back in, you know, 2009 with respect to this policy, where would you go to try and find that?
A. Policies and procedures.
Q. Is that a department?
A. It is a department within the agency.
Q. And who is the person you would speak to?
A. Any number of people in procedures could find that for me.
Q. Who, who would be the person you would call up?
A. Penny Lewis is the person who was over procedures for the agency.
Q. And she would have the prior versions of both Exhibit 2 and the formularies and other informations regarding policies and procedures. Is that right?
A. She --
MR. LEONOUDAKIS: Objection.
THE WITNESS: She would not have formulary.
Q. (By Mr. Cheffo) Who would have formulary?
A. I believe Robin Murphy would.
Q. Okay. So, policies and procedures would be

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treated separately than formulary?
A. Yes.
Q. [redacted]
Q. Is that published somewhere, do you know?
A. I don't believe so.
Q. Does the Department of Corrections use any private companies for pharmacies?
A. We use Diamond Pharmacies, who is our supplier of medications.
Q. Is that -- that's the company who actually provides prescription medicines to the Department of Corrections?
A. Correct.
Q. With respect to the setting of the formularies, there's the P and T committee that you

told us about.
A. Uh-huh.
Q. Are they solely responsible for setting the formularies are do you engage some outside consultants?
A. I believe Diamond itself has a role in the P and T committee.
Q. And -- and what's the basis of that belief?
A. I think in conversation I had with Dr. McCurdy.
Q. And do you know what the role is?
A. No.
Q. Do you know how many members are on the P and T committee?
A. No.
Q. Are they all doctors?
MR. LEONOUDAKIS: Objection.
THE WITNESS: In the op itself the committee consists of medical providers and qualified healthcare professionals.
Q. (By Mr. Cheffo) Have you ever sat on the P and T committee?
A. No.
Q. Has the CMO sat on the P and T committee?
MR. LEONOUDAKIS: Objection.

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

[redacted]
Q. Prior to preparing to this -- for this deposition had you ever had occasion to look at medicines that were on the formulary?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) In what context?
A. Primarily checking to see what the latest version of the formulary was that was published on the website.
Q. And do you know whether Oxycontin was ever on the formulary?
A. I know it's not on the current formulary.
Q. Okay. My question was a little different. Do you know whether it ever was?
A. No.
Q. Do you know whether any opioid analgesics other than those that are currently on there were on

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

procedure?
MR. LEONOUDAKIS: Objection.
You can answer.
THE WITNESS: I believe in general terms that it depends on how the inmate was outside of our custody to a small extent. But if they are seen by an outside provider and they are prescribed something that is not on formulary, at the point in time they come back into our jurisdiction one of our providers reviews their medical condition and what they are prescribed and they can maintain the duration of that prescription since it's already been filled by an outside provider or they can alter that prescription to something different.
Q. (By Mr. Cheffo) It's not the Department of Corrections view that all opioid analgesics should be barred from use by inmates, is it?
A. I'm not a medical provider.
Q. It wouldn't be on the formulary, would it, if you didn't think it was appropriate to have opioid analgesics?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Certainly whatever is on the formulary the P and T committee has recommended for our medical providers to prescribe.

Q. (By Mr. Cheffo) And they also determine that they're safe and effective when appropriately prescribed. Isn't that the point of the formulary?
MR. LEONOUDAKIS: Objection.
THE WITNESS: The formulary takes into account what medications we can prescribe that are utilized to treat different conditions and that are cost effective to do so.
Q. (By Mr. Cheffo) What if a patient is on -- strike that.
What if an in might -- inmate had been prescribed a certain opioid analgesic for chronic pain prior to incarceration, would that inmate still have an ability to maintain his or her prescription?
MR. LEONOUDAKIS: Objection.
THE WITNESS: There are processes and policy in the pharmacy op that talk about how a provider can request non-formulary meds to be considered, but it's evaluated on a case by case basis by a medical professional.
Q. (By Mr. Cheffo) Why -- you did intake. Right?
A. Yes.
Q. If someone is on a medicine, right --
A. Uh-huh.

Q. -- could be a chronic pain medicine, it could be a heart medicine, blood pressure, right, they come in, they're incarcerated and they are on a medicine. Right? What happens in terms of continuing their healthcare?
A. So, from the intake process when they come into our system they're evaluated by a triage nurse. That triage nurse takes a listing of medications that they report that they're on or any physical medications that are received with them from the county jail. At that point in time they're scheduled to see a medical provider normally within 24 hours unless in the nurse's professional opinion it needs to be sooner. The exact medications that you come in on from the county jail are disposed of and new prescriptions are written. They can be for the same type of medication or they can be for something completely different based on the medical provider's professional opinion.
Q. So even if they had a full prescription that would be disposed of?
A. Correct.
Q. And I saw some procedures here regarding disposal. Is one of them to pour water on them in the sink or to pour them in a toilet?

MR. LEONOUDAKIS: Objection.
THE WITNESS: I'm looking at the controlled drug procedures.
Q. (By Mr. Cheffo) Can you tell us what document you're talking about?
A. I'm looking at controlled drug -- or ODOC-00001733. Under wastage, wasted dose, partial or full, must be recorded by a qualified healthcare professional on a spiral bound controlled drug record with a signature witness by a separate ODOC employee such as -- or e.g., ODOC Pharmacy Director, correctional officer. Wastage doses may be disposed by running water in sinks or toilets, and the placement in sharps containers are not permitted.
Q. You read that pretty quickly. Let me just ask you. So it says any wasted dose, partial or full, must be recorded by a qualified healthcare professional on a spiral bound controlled drug records with a signature witness by a private ODOC employee, and it says e.g., ODOC Pharmacy Director, correctional officer. Wasted dose may be disposed by running water in sink or toilets. The placement in sharps containers is not permitted. Right?
A. Correct.
Q. So that means you could put it into the sink

and run water over it or flush it down the toilet. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: This is the MSRM that's specific to the controlled drugs. So it's --
Q. (By Mr. Cheffo) That would be opioids, right, and other controlled substances?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Correct.
Q. (By Mr. Cheffo) So, for controlled substances like opioids and other controlled substances, a policy and procedure is to -- with wastage is to put them in the sink, run water over them or put them down the toilet. Correct?
A. In the same document --
Q. I'm sorry, is that correct?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Can you repeat the question?
MR. CHEFFO: Sure. Let's read it back.
(The record was read as directed.
"Q. So, for controlled substances like opioids and other controlled substances, a policy and procedure is to -- with wastage is to put them in the sink, run water over them or put them down the toilet. Correct?")

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

Q. (By Mr. Cheffo) So which ones gets returned and which ones gets poured down the sink?
A. I don't know.
[redacted]
Q. Does the Department of Corrections recognize chronic pain as a legitimate disease endpoint --
MR. LEONOUDAKIS: Object.
Q. (By Mr. Cheffo) -- or medical problem?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I don't know.
Q. (By Mr. Cheffo) Does the Department of Corrections inform its view about formulary medicines by any other policies or procedures that are applicable to other state agencies?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer.
THE WITNESS: I don't know.
Q. (By Mr. Cheffo) Do you know what SoonerCare is?
A. Yes.

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

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

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

on hand in case you need them even though it's not specifically called for by a patient like aspirin, like --
A. Correct.
Q. -- other things, morphine?
A. Correct.
Q. Are there protocols about how to prescribe controlled substances and any restrictions on the length of use?
MR. LEONOUDAKIS: Objection.
THE WITNESS: No.
Q. (By Mr. Cheffo) That's totally within the discretion of the healthcare provider?
A. Yes.
Q. So, once an inmate -- let me strike that.
Do you call them patients or inmates?
A. Inmates.
Q. Okay. Once an inmate is evaluated by a healthcare provider and he or she makes a determination, the only guidepost or restrictions are his or her medical judgment as opposed to any restrictions or guidelines specifically with respect to controlled substances. Is that right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Unless if it's specifically defined

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

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

Q. And if you flip to the next page, this is under the oversight of pharmacy services and pharm -- pharmacy operations section. Do you see that? I'm counting over from 1751 under IV.
A. Yes.
Q. It carries over to the next page. Correct? Yes?
A. Yes.
Q. And there are -- under B the heading is pharmacy and therapeutics committee. Right?
A. Yes.
Q. And that's what we call the P and T committee. Right?
A. Yes.
Q. And -- and the six points below that refer to the roles and responsibilities of the P and T committee. Is that right?
A. Correct.
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) And under six it says, the committee's tasks specifically include. And they're referring to the P and T committee. Right?
A. Correct.
Q. And there's tasks A through H. Right?
A. Yes.

Q. And E says, objectively evaluating scientific/clinical criteria regarding drugs proposed for inclusion in the formulary.
Do you see that?
A. Yes.
Q. So, one of the P and T committee's jobs in determining whether a proposed medicine should be in the formulary is to evaluate the scientific and clinical criteria regarding that drug. Isn't that what it says in 6 E?
A. Yes, that is what it says.
Q. And it's also the responsibility of the P and T committee to recommend removal/addition of drugs from the formulary under F. Right?
A. Correct.
Q. And G says promoting educational programs for the safe and appropriate use of drugs.
Do you see that?
A. Yes.
[redacted]

[redacted]
Q. And then H says periodically evaluating ADEs.
Do you know what ADEs are? Does it mean adverse drug events?
A. I don't know.
Q. Okay. And C on 1752 talks about pharmacy services provider. Do you see that?
A. Yes.
Q. Right below that.
A. Yes.
Q. Is that current pharmacy services provider Diamond Pharmacies?
A. Yes.
Q. And do you know how long Diamond Pharmacies has been the pharmacy services provider?
A. They've been the pharmacy provider as long as I've been in my position, but I don't know if that was -- I'm not sure when their actual contract went into place. It predates me.
Q. Have you heard the term off label usage?
A. No.
Q. If you flip to 1760 in Exhibit 2, Exhibit 2, the document we've been talking about, this is one of the documents you brought with you today and one of

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the documents that you reviewed in preparation for your deposition. Is that right?
A. Correct.
Q. Under B, reports, at the top of the page. Do you see that, sir?
A. Yes.
Q. If you go down to two. Are you with me?
A. Yes.
Q. It says, statistical reports will be prepared by the designated pharmacy services provider and are reviewed monthly by the facility CHSA, ODOC medical services through the director of pharmacy services and any administrator designated by the chief medical officer or the director of health services.
Do you see that?
A. Yes.
Q. And then it talks about reports include drug utilization analysis, usage patterns, medical errors and ADRs and it goes on?
A. Yes.
Q. Did you review any of those reports?
A. No.
[redacted]

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Q. Is there a protocol for treating inmates who have substance abuse?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Not in the medical policies.
Q. (By Mr. Cheffo) Is there a Department of Corrections protocol?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: Substance abuse treatment is handled under our programs division in terms of what policies and procedures they have in place for how and who they treat in substance abuse programs. I'm not incredibly familiar with those.
Q. (By Mr. Cheffo) Do you know if methadone is used?
A. Methadone is only used for pregnant females who are received into our custody actively receiving methadone.
Q. What if someone is on methadone before they become incarcerated, what happens to them and they're not a pregnant female?
MR. LEONOUDAKIS: Objection.
You can answer.
THE WITNESS: They are discontinued on it.
Q. (By Mr. Cheffo) Are they given something else?

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A. In many instances we may not even know that they're on methadone.
Q. Wasn't my question. If they -- you may know because they may have very significant withdrawal symptoms. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Only if they were received from county jail immediately upon sentencing. We --
Q. (By Mr. Cheffo) Sir, corrections officers sometimes look inside cells. Right?
A. Yes.
Q. You -- you -- you've been working in a corrections facility for a long time, you are familiar not even as an expert, just as a human that there are things called withdrawal symptoms. Right?
A. Yes.
Q. And you know that they can be severe in some people?
A. Yes.
Q. So, and methadone you know is used to prevent withdrawal symptoms?
A. Yes.
Q. That's why you allow it for pregnant women. Right?
MR. LEONOUDAKIS: Objection.

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THE WITNESS: We allow it for pregnant females because they were already prescribed it at the point in time they were received and the adverse potential results to the fetus if they were to be abruptly discontinued.
Q. (By Mr. Cheffo) So, when an inmate who is not a pregnant female comes in with a prescription of methadone and indicates that he is on methadone, your testimony is that he does not receive the methadone?
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) Is that right?
A. To my knowledge we've not received any one at the assessment reception center other than pregnant females that we have knowledge of that were actively on methadone immediately prior to their reception.
Q. If they were would they receive methadone?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I don't know.
Q. (By Mr. Cheffo) If they didn't receive methadone what alternative medicines, if any, would they receive?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I don't know. We do have a -- I don't know.
Q. (By Mr. Cheffo) Is there any medicines that

are provided in order to assist inmates who have abuse or dependence or addiction problems?
MR. LEONOUDAKIS: Objection.
You can answer.
THE WITNESS: If you mean medicated -- medication assisted treatment, no.
Q. (By Mr. Cheffo) You're -- you're familiar with that term. Right? It's called MAT?
A. Yes.
Q. What does it mean?
A. Medicated assisted treatment.
Q. And generally for laypeople how would you describe that?
A. That there is some medication that is used to assist with withdrawal symptoms from an addiction.
Q. Are there policies and procedures that you've seen regarding correctional institutions that talk about recommending the use for a medication to treat -- assist the treatment?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I've not seen any specific agency's policy around it, no.
Q. (By Mr. Cheffo) Are you aware of whether the Department of Corrections' a member of any organizations or that basically have as its members

other Department of Corrections that set policies and procedures?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Can you rephrase the question?
Q. (By Mr. Cheffo) Sure.
Are you aware of whether medically assisted treatment is a generally accepted medical concept?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I don't know.
Q. (By Mr. Cheffo) But it's your testimony that the Department of Corrections does not permit medically assisted treatment except in the case of pregnant females who are receiving methadone prior to incarceration. Is that right?
MR. LEONOUDAKIS: Objection, misstates the testimony.
THE WITNESS: Say it again, please.
Q. (By Mr. Cheffo) Sure.
I'll ask you. Who receives, if anyone, medically assisted treatment in the Department of Corrections facilities?
A. Only pregnant females who are received into our custody who are actively receiving methadone at the point in time they are received into DOC custody.
Q. Do you know what naloxone is?

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

they both -- how do you refer to them, are they policies, are they procedures?
A. The first one I referenced, 1720, is a policy or procedure. The second one is an MSRM, which is a Medical Service Resource Manual, that operate as attachments or additional reference material to the policies.
Q. I was just going to ask you that. So just can you give me a little more clarity what -- what the difference is between these two, the policies and procedures, because I've seen MSRMs and I've seen policy and procedures?
A. The MSRMs are designed to provide a little bit more direction to nursing staff and medical providers specifically.
Q. So are they -- they're -- they're a more specific guidance that's meant to be consistent with the policies and procedures. Is that fair?
A. Correct.
Q. And obviously you have a policy or the Department of Corrections has a policy and procedure and a MSRM because it's contemplated that naloxone is used in the confines of the Department of Corrections. Correct?
MR. LEONOUDAKIS: Objection.

THE WITNESS: Yes.
Q. (By Mr. Cheffo) Are -- are illicit drugs found in the Department of Corrections' prisons in Oklahoma like they probably are in every other correctional facility in the country?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) That would include both illegal medicines -- strike that.
That would include both illegal substances like methamphetamines or crack cocaine or illicit fentanyl. Right?
MR. LEONOUDAKIS: Objection, outside the scope of the topic.
You can answer in your personal capacity.
THE WITNESS: Certainly contraband gets into facilities. In terms of an all encompassing amount and of what I don't know.
Q. (By Mr. Cheffo) And I -- and contraband could include products that -- substances that are illegal for everyone like heroin. Right?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) And contraband could also include things like medicines that are legal to a

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

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

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

Q. (By Mr. Cheffo) Okay. Do you have information about programs?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Not anything in depth, no, other than we operate them.
Q. (By Mr. Cheffo) What did you do prior to this job?
A. I was the chief administrator of programs.
Q. How long ago was that?
A. Three years and some change.
Q. So when you had -- when you were the chief administrator of programs did you have a lot of knowledge about programs?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I had knowledge of the operations as they were when I was there.
Q. (By Mr. Cheffo) You had the same role that Nate Brown has now. Right?
A. Correct.
Q. And when I asked you about questions about programs for abuse and addiction you said Nate Brown would be the person that I should go to.
A. Correct.
Q. Right? And you held that same role prior to 2015.

A. Correct.
Q. Right? Let's talk about prior to 2015.
A. Okay.
Q. And when you held the role.
A. Okay.
Q. Tell us about the programs that were in place for treating inmates who had abuse and addiction.
A. There were substance abuse programs that existed at multiple security levels, majority of which were contracted through the Department of Mental Health and Substance Abuse Services to provide substance abuse treatment through cognitive restructuring, manualized type treatment programs to select offender population.
Q. Did any of them involve medically assisted treatment?
A. No.
Q. Was buprenorphine used?
A. Not to my knowledge, no.
Q. Was methadone used?
A. Not to my knowledge, no.
Q. Who were the outside agencies that you contracted with or outside entities?
A. The contract itself was with the Department

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

THE WITNESS: I don't understand that question.
Q. (By Mr. Cheffo) Someone could come into be incarcerated and have a prior history of abuse and addiction. Correct?
A. Yes.
Q. And what I'm asking you, are there situations where someone did not have that prior history and through incarceration and access to contraband developed an addiction or abuse issue?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: I have no idea.
Q. (By Mr. Cheffo) Who, who would know that?
A. I don't know that the agency keeps records in that way.
Q. Well, if someone was in -- who would have records about an inmate's profile and medical history with respect to addiction?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: If the inmate reports a history of substance abuse or addiction to a medical staff person at intake or at any point in time while they're incarcerated it would be documented in the electronic health record.
Q. (By Mr. Cheffo) And is there a certain code that would be assigned?

MR. LEONOUDAKIS: Same objection.
THE WITNESS: I don't know.
Q. (By Mr. Cheffo) Would you look back at Exhibit 1, which is the Notice? The first portion of it says, the standards, practices and procedures during the relevant time period.
Do you see that?
A. Uh-huh.
Q. What is the relevant time period?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Today and back, back to some point in time.
Q. (By Mr. Cheffo) 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?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Not to my recollection.
[redacted]

MR. LEONOUDAKIS: Objection.
[redacted]
Q. (By Mr. Cheffo) Did you ever ask anyone what the relevant time period should be that you should actually look at to prepare for the deposition?
MR. LEONOUDAKIS: Objection. Just caution the witness not to disclose any communications he had with counsel.
MR. CHEFFO: Yeah, let me strike that. I don't want to ask you any counsel.
Q. (By Mr. Cheffo) 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?
MR. LEONOUDAKIS: Objection.
THE WITNESS: No.
[redacted]

[redacted]
Q. (By Mr. Cheffo) So, what are the standards, practices and procedures between January 1, 2018 and the present for the diagnosis and treatment of pain?
MR. LEONOUDAKIS: Objection.
You can answer.
THE WITNESS: The diagnosis and treatment of pain is left up to the medical abilities of our medical providers in facilities.
Q. (By Mr. Cheffo) So is there any standard practice or procedure regarding the diagnosis and treatment of pain?
A. Not to my knowledge.
Q. They have -- the healthcare providers have free rein consistent with their medical and ethical obligations with respect to the diagnosis and treatment of pain. Is that your testimony?
MR. LEONOUDAKIS: Objection, misstates the testimony.
THE WITNESS: The medical providers within

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

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

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

MR. LEONOUDAKIS: Objection.
THE WITNESS: Outside of the pharmacy op which references just the formulary in general.
Q. (By Mr. Cheffo) What about standards, policies, procedures regarding opioid alternative medications for persons in the care and custody of the Oklahoma Department of Corrections?
A. Can you define what opioid alternative medication is?
Q. It's listed on Exhibit 1.
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) Right here. Well, no, let me be clear, sir. I don't know if there's a definition, but that's -- I took that term from Exhibit A. Right?
A. Okay.
Q. So when you were preparing for this deposition you endeavored to understand and find information about opioid alternative medications. Right?
MR. LEONOUDAKIS: Objection, form.
THE WITNESS: Insomuch as they related or used the same term within our agency policies and procedures.
Q. (By Mr. Cheffo) Right. So, so you did have an understanding of what it meant. Right?

A. No.
Q. Did you ask the chief medical officer?
A. No.
Q. Did you ask the pharmacist?
A. No.
Q. Did you ask any nonlawyer?
A. No.
Q. So you as you sit here today don't really understand what opioid alternative medications are?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Only insomuch as if you are referring to naloxone or methadone in terms of how those treat overdoses.
Q. (By Mr. Cheffo) Well, are those alternatives or are those treatments for overdoses?
A. Naloxone is treatment for overdoses. Methadone is a medicated assisted treatment for someone who is addicted.
Q. [redacted]

[redacted]

Q. (By Mr. Cheffo) The examples you gave me were naloxone. Right?
A. Yes.
Q. Is that an alternative or a treatment?
A. Naloxone is a treatment for overdose.
Q. So would you consider it to be an opioid alternative medication?
A. Probably not.
Q. Okay. Did you -- do you have any other examples of what you would consider to be an opioid alternative medication?
A. I believe that would be the methadone.
Q. Anything else?

A. No.
Q. And what did you do to understand the policies and standards and procedures regarding the use of methadone?
A. Reviewed the current policies that exist within our agency's website related to health services.
Q. That's it?
A. Yes.
Q. Did you speak to anyone about that?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Outside of the casual conversations with the pharmacist and Dr. McCurdy concerning P and T.
Q. (By Mr. Cheffo) That, that specific topic didn't come up, did it?
A. No.
Q. And -- and beyond what the current policies are, you don't know of any policies prior to that regarding opioid alternative medications. Right?
A. Correct.
Q[redacted]

[redacted]

Q. What -- can you please tell me more specifics about what your roles and responsibilities were in your -- in your position prior to your current position, the job that Nate, Mr. Nate Brown has?
A. Had administrative oversight for the agency's program services, which are substance abuse treatment, educational, vocational services, volunteer services, at one time victim services and at one time the grants division.
Q. Is -- tell me if I got this wrong, but is -- I think we talked earlier about if you wanted to know about certain policies and programs and you wanted to find out some historic information you would go to somebody in program services. Is that right?
A. If you want to know something historic about procedures you would go to procedures.
Q. Okay. That's different than program services?
A. That's different than programs. Policies and procedures is Penny Lewis.
Q. Okay. Does the Department of Corrections maintain an org chart that lists out various people and what their roles and responsibilities are?

A. Yes.
Q. Who, who would you go if you wanted that?
A. Human resources.
Q. Is it updated pretty frequently?
A. As far as I know, yes.
Q. Do you know what a PDMP is?
A. No.
Q. A monitor -- a monitoring database that physicians or healthcare providers can look at to determine if someone has a prescription medicine.
A. I have heard of that.
Q. Maybe called something else?
A. Yeah.
Q. OARRS, have you ever heard of that?
A. Not the exact term but I have heard of prescription monitoring database.
Q. You're not an expert in it but you're generally familiar with what it is?
A. I've heard of it.
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) When -- when an inmate is first received there's an intake you said?
A. Correct.
Q. And that includes probably many things including an assessment of psychological and physical

health?
A. Correct.
Q. And is there a form that's filled out?
MR. LEONOUDAKIS: Objection.
THE WITNESS: There are many forms that are filled out.
Q. (By Mr. Cheffo) Well, with respect to mental and physical health and medications, let's talk specifically about that. Is the inmate asked to fill out a form?
A. Yes.
Q. Something that says tell me all of your problems, your medical history, any medicines that you're on, things like that?
A. I would say they fill it out or if they're reporting it to a staff member and the staff member is documenting their information, one of the two or a combination of both.
Q. And not unlike an initial visit that someone might have with their doctor. Right?
A. Correct.
Q. And then that is maintained in the files of the DOC. Right?
A. Yes.
Q. And the Department of Corrections and its

healthcare providers have access to this physician database. Is that right?
A. I don't know.
[redacted]
MR. CHEFFO: Let's mark this as four, please.
(Deposition Exhibit Number 4 marked for identification purposes and made part of the record.)
Q. (By Mr. Cheffo) So, do you see this document we've marked as Exhibit 4?
A. Yes.
Q. This is off the Department of Corrections' website. Correct?
A. It looks like it.
Q. And it talks about accreditation? It says --
A. Yes.
Q. -- Oklahoma accreditation?
A. Yes.

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

facilities?
A. These are facility names.
Q. Okay. And were you aware that the department was accredited by any organizations or institutions?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I know the agency has been accredited by ACA.
Q. (By Mr. Cheffo) What is ACA?
A. The American Correctional Association.
Q. And does the American Correctional Association have certain guidelines and best practices?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) Are you aware of what the ACA guidelines are with respect to the prescription or administration of opioids in correctional facilities?
A. Not verbatim off the top of my head, no.
Q. Are you generally aware?
A. I believe ACA stands that they are supported -- supportive of medication assisted therapy.
Q. That is something that the Department of Corrections in Oklahoma does not subscribe to. Is

that right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Correct.
Q. (By Mr. Cheffo) So the American Correctional Association of which the department of Oklahoma is proud to be a part of recommends the use of medically assisted treatment but the Oklahoma Department of Corrections does not use medically assisted treatment. Is that right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Other than with those pregnant females that we discussed earlier, that's correct.
Q. (By Mr. Cheffo) Right. But -- and you understand that the American Correctional Association's recommendations and guidelines with respect to medically assisted treatment are broader than just for women who are pregnant who are dependent. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: It's my understanding the ACA standards are broad, general and considered best practice for corrections in a wide birth.
Q. (By Mr. Cheffo) And with respect to medically assisted treatment, they're not followed by Oklahoma. Correct?

MR. LEONOUDAKIS: Objection.
THE WITNESS: Other than as I stated that I know that they are supportive of it. I'm not sure what their -- if they have a detailed bullet point list of all that makes up their medication assisted treatment recommendations.
Q. (By Mr. Cheffo) Does Oklahoma follow any of them outside of pregnant women?
MR. LEONOUDAKIS: Objection.
THE WITNESS: The only ones that we treat are pregnant females who are received on methadone at the point in time.
Q. (By Mr. Cheffo) So the answer is no?
MR. LEONOUDAKIS: Objection.
THE WITNESS: No.
Q. (By Mr. Cheffo) Are there other guidelines or recommendations from the American Correctional Association with respect to the use of opioids or treatment of dependent or addicted inmates that the Department of Corrections of Oklahoma does not follow?
A. State it again, please.
Q. Sure.
We talked about medically assisted treatment as being a recommendation from the American Correctional Association. Correct?

A. Correct.
Q. Are there other recommendations with respect to either the administration or use of opioids or the treatment of inmates who are addicted or dependent on -- on substances that the State of Oklahoma Department of Corrections does not follow?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer in your personal capacity if you're aware.
THE WITNESS: I don't -- I don't know.
Q. (By Mr. Cheffo) Have you seen any data regarding the benefits of medically assisted treatment?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Unless there were -- I don't recall.
Q. (By Mr. Cheffo) In your 18 years some of what you were involved with, right, was you were an intake person doing clinical work. Right?
A. Correct.
Q. Then you were at program services, you were looking at grants and substance abuse treatment --
A. Correct.
Q. -- issues. Right?
Then you were the chief of the

administration of program services. Right?
A. Correct.
Q. In many of those roles you touched upon individuals who had or issues involving addiction and substance abuse. Fair?
A. Fair.
Q. And did you ever seek a grant or a -- or funding for medically assisted treatment?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: No.
MR. LEONOUDAKIS: You can answer in your personal capacity.
Q. (By Mr. Cheffo) Did you ever make that recommendation?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: Going back that far it is certainly possible that there were grant announcements that may have been around medication assisted treatment, but in my capacity at the time that would be outside of the scope of something that I could do just as the chief administrator of programs.
Q. (By Mr. Cheffo) Okay. Do you believe that medically assisted treatment is a beneficial program?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer in your personal capacity, if

you know.
THE WITNESS: I think treatment in general can be beneficial to people.
Q. (By Mr. Cheffo) What about medically assisted treatment?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: It certainly is possible.
Q. (By Mr. Cheffo) Do you believe that it's something that should be implemented at the Department of Corrections?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: No.
Q. (By Mr. Cheffo) Why not?
MR. LEONOUDAKIS: Same objection, outside the scope.
You can answer in your personal capacity.
THE WITNESS: Given the management, management concerns of how -- how it would be controlled, how it would be administered, the oversighting of it, delivery of it, it would create some new administrative wrinkles.
Q. (By Mr. Cheffo) Well, putting aside administrative, if it could be handled administrative do you agree that it would be beneficial for the patient population?

MR. LEONOUDAKIS: Same objection.
Q. (By Mr. Cheffo) The inmate population?
A. I don't know that I have a feel for what percentage or number of inmates in the population would meet that criteria for treatment.
Q. If even one benefited from it would it be beneficial?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: Sure.
MR. CHEFFO: Mark this as Exhibit 5.
(Deposition Exhibit Number 5 marked for identification purposes and made part of the record.)
Q. (By Mr. Cheffo) I haven't had a chance to go through all your documents but I believe it's probably in your collection. You'll tell me if -- one, if you could tell me what that document is and if you've seen it before.
A. It's a policy for inmate medical, mental health and dental care.
Q. Did you review that in connection in preparation for your deposition?
A. It's not one specifically in my stack today, but I have seen this policy before.
Q. Did you review it in preparation for your

deposition?
A. No.
Q. You would agree with me that it's a -- strike that.
What is this?
A. It's a health services policy for inmate medical, mental health and dental care.
Q. And this is an overall policy regarding inmate medical, mental health and dental care. Is that right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: It is the policy for inmate medical, mental health and dental care.
Q. (By Mr. Cheffo) If you look at Page 3 you'll note that there's page numbers on the top?
A. Yes.
Q. Do you see pharmaceutical services there?
A. Yes.
Q. And it says, appropriate management of pharmaceutical services will be available to all inmates.
Do you see that?
A. Yes.
Q. And it says, facilities, on Number 3, will provide secure storage and daily inventory of all

controlled substances, syringes and needles.
Do you see that?
A. Yes.
Q. How is that done?
A. In the pharmacy policy, pharmacy operations, which is 140130, it details the medication administration record, which is the document where inmate medications administered and issued by DOC, QHCPs are recorded. The medication administration record may either be a hard copy or an electronic health record format. And then the daily inventory process under E, Roman numeral IV E, general procedures and practices, contracted pharmacy service provider, procedures are outlined in the MSRM 140130-01 entitled pharmacy services which delineates the exact steps involved in medication management.
Q. Okay.
A. Procedures regarding along in there.
Q. Okay. I'll represent to you I -- my understanding is that it was pulled off the Department of Corrections' website and we see it's got an effective date of 03/07/17?
A. Yes.
Q. Would it be a fair assumption that if it's on the current website this is the most recent

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

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

Right?
A. Presumably, yes. Right.
Q. They're asked questions about their history. Right?
A. Right.
Q. Whether they have any issues with dependence?
A. Correct.
Q. What medicines they were prescribed. Right?
A. Correct.
Q. If they -- if they indicated yes, they have a dependence you would expect to see some followup questioning by the healthcare provider, right, when did that start, what drugs were you abusing, were they illegal, things like that. Right?
A. Correct.
Q. And that would all be maintained in the healthcare records of those, those prisoners?
A. To the extent those questions are asked and they are reported, yes.
Q. Outside of the correctional facility do you think that medically assisted treatment is a positive thing for people who have substance abuse issues?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer in your personal capacity if

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

Q. I'm on the third page, V B. Do you see that?
A. Yes.
Q. Healthcare records. The Oklahoma Department of Corrections will maintain comprehensive confidential healthcare records regarding all healthcare services provided to inmates. Right?
A. Correct.
Q. That's a requirement?
A. Yes.
Q. And that's complied with?
A. Yes.
Q. If you wanted to find out information and you were authorized to do that, have an inmate's medical healthcare information, how would you go about doing that?
A. For every inmate currently incarcerated or historically incarcerated there is a healthcare record on them. There's a point in time when they were not electronic and a point in time when they were converted to electronic. It depends what information we are looking for in the healthcare record.
Q. But -- but let's just talk about the basic IT.
A. Okay.

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

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

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

you to --
MR. CHEFFO: Yeah, with that, no cause for that but I'm sensitive to the issue.
Q. (By Mr. Cheffo) I don't want you to tell me any conversations, but did you provide documents or give access to any of your documents in connection with this litigation?
A. The only documents I've provided have been to my attorney.
Q. Were they documents other than --
A. Other than --
Q. -- what's produced here?
A. -- policies and procedures, no.
Q. So no one -- do you operate, do you use a computer in your office?
A. Yes.
Q. Are you aware of whether any of your documents were collected?
MR. LEONOUDAKIS: Objection. This is outside the scope of the topic.
You can answer in your personal capacity. I'd just caution the witness not to disclose any communications you had with your counsel.
THE WITNESS: If -- if there were any documents, e-mails that were obtained I believe central IT would

do that behind the scenes.
Q. (By Mr. Cheffo) So you don't know one way or the other?
A. So I wouldn't have knowledge if they went into my e-mail and extracted them.
Q. And I -- I would just say there's an ongoing you should just be guided, any question I asked you, as I think I've said, I never want you to tell me about conversations you've had with your lawyers. So, if you would need to do that in order to answer you should just tell me and your lawyer that you can't do that because it's based on a conversation. That's not my intention. Okay?
A. Okay.
(Deposition Exhibit Number 6 marked for identification purposes and made part of the record.)
Q. (By Mr. Cheffo) I've marked this document, sir, as Exhibit 6. When you've had a chance to look at it would you tell us what that is?
A. This is the MSRM for controlled drug procedures.
Q. Is that a document that you reviewed in preparation for the deposition?
A. Yes.

Q. Is that one of the documents that you have before you?
A. I think so. Yes.
Q. And the person who either promulgated or signed this document is Dr. Joel McCurdy. Do you see that? It's on the first page, sir.
A. Yes.
Q. Just for the record, when I see in this case Joel McCurdy, M.D. --
A. Uh-huh.
Q. -- chief medical officer, is that the equivalent of Dr. McCurdy signing this document as promulgating it?
A. That's -- the signature block on policies and procedures are the signature block on MSRMs where it says signature on file means that it has gone through its final review process. On the last page under action directs who is responsible for it whether it's the compliance with the procedure itself or any reviews or revisions. So, the signature block means, yes, he has completed all those requirements and his signature is on file as approving.
Q. Okay. And thank you. So I've seen that on the bottom of some of these policies it will say action and it talks about the person who is ultimately

responsible. That means that the kind of buck stops with them with respect to that policy?
A. Correct.
Q. What -- what's the purpose of this, this policy in general terms?
MR. LEONOUDAKIS: Objection.
THE WITNESS: As it states, it defines the process for control and accountability of controlled drugs distributed and administered by medical service providers to offenders in the Oklahoma Department of Corrections.
Q. (By Mr. Cheffo) Okay. If you look at the second page of this, 1734.
A. Uh-huh.
Q. It talks about stock controlled, I'm on the very bottom.
A. Yes.
Q. It's under ordering, stock controlled pharmaceuticals will be ordered on the controlled drug stock order schedules 3-5 only.
Do you see that?
A. Yes.
Q. And Schedule II controlled pharmaceuticals for starter stock must be ordered by a DEA 222 form specific for that DOC facility address.

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Do you see that?
A. Yes.
[redacted]
Q. Can you turn to 1737?
A. Okay.
Q. It's Page 5. There's a section here, nine, it talks about theft or loss of controlled substances.
Do you see that?
A. Yes.
Q. Are you aware of any circumstances of theft or lost of controlled substances?
A. Specific instances, no. But in general it's in policy because it does occasionally occur where staff divert medications and the process is in place so that we can initiate an investigation.
Q. What does it mean staff divert medications?
A. It means that qualified staff who have access to dispense those medications through the logbook when they check it out, instead of wasting or

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disposing of a med or administering the med they could potentially divert that and alter the logbook.
Q. And by diverting that means either taking it themselves or giving it to an inmate or selling it or doing something unlawful. Right?
A. It just means it did not wind up where it was supposed to go.
Q. Well, divert is a -- is not a policy that's condoned by the Department of Corrections, is it?
A. No, it's not.
Q. Divert either means take, steal, sell, do something that's illegal. Right?
A. It means not administering it as the way that it was supposed to be administered.
Q. And if someone diverts -- sorry.
A. Go ahead.
Q. If -- if one of the -- the DOC employees diverts a scheduled medicine, there can be and often would be serious ramifications for that person. Right?
A. Correct.
Q. And there have been situations where that's occurred?
A. Correct.
Q. And there are records of those?

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A. Records of --
Q. Of diversion?
A. Yes.
Q. And one of the things -- in this case you would file a serious incident report. Right?
A. Correct.
Q. Because it would be a serious incident?
A. Correct.
Q. If you'd please look to 1739. There's also a recordkeeping requirement. It says, by Oklahoma law all records for controlled substances, see listing below, must be kept for a period of five years. These records should be filled -- I'm sorry, filed and maintained by the facility CHSA in a secure location with limited access.
Do you see that?
A. Yes.
Q. What is the facility CHSA?
A. The Correctional Health Service Administrator.
Q. And to your knowledge is the Department of Corrections in compliance with this regulation?
A. Yes.
Q. Do they keep records more than five years?
A. I don't know.

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

A. As of March 2018.
Q. And the individuals who were part of the P and T committee who make the decisions include individuals designated by the chief medical officer?
A. Correct.
Q. And also there's participation by Diamond Pharmacy Services?
A. I believe that is correct.
Q. Are any pharmaceutical companies part of the P and T decisions?
A. No. Not -- not to my knowledge.
Q. Have you ever been aware that anyone associated with any pharmaceutical company has ever sat or been part of decisions made by the P and T committee?
MR. LEONOUDAKIS: Objection.
You can answer --
THE WITNESS: Not to my knowledge. I think it would be in the procedure if that was intended or allowed.
Q. (By Mr. Cheffo) And there's nothing in the procedure currently that would allow that, would it?
A. Nothing.
Q. And in your preparation did you find out how often the formulary is modified?

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

migraine. Right? And they're grouped a bunch of anti migraine medicines. Right?
A. They grouped a lot of medicines. I couldn't tell you if those are anti migraine medications or not.
Q. If they say anti migraine above them would you assume that they're anti migraine?
A. I would assume that they are.
Q. You have no reason to believe that this is a wholly inaccurate document, do you?
A. No.
Q. You have faith in this, don't you?
A. Yes.
Q. Because this is done at the direction of your CMO?
A. Correct.
Q. Who reports to you. Right?
A. Correct.
Q. And if you thought there was anything wrong with this process you would be talking to your CMO. Right?
A. Correct.
Q. Now, the next one is narcotic analgesics, right, and anti-pyretics.
Do you see that?

A. Yes.
Q. And there is a number of narcotic analgesics listed here, at least a number of dosage types. Do you see that?
A. Correct.
Q. And morphine?
A. Yes.
Q. Yes? Is that a controlled substance?
A. I believe so, yes.
Q. Am I correct that you have really no idea or no information about any policies or procedures with respect to how morphine is or should be administered or prescribed?
A. Correct.
Q. And you don't know how often it's used, do you?
A. No.
Q. You don't know under what circumstances it's used?
A. Other than what we discussed under palliative care or infirmary care, no.
Q. If -- if patients -- strike that.
If inmates receive morphine, for example, do they receive any type of package information or labeling?

MR. LEONOUDAKIS: Objection.
THE WITNESS: I don't know.
Q. (By Mr. Cheffo) Who would know that?
A. The chief medical officer.
Q. Do they receive any, any warnings or information about risks when they're prescribed morphine?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I don't know.
Q. (By Mr. Cheffo) There's no policy about that?
(A brief pause.)
A. Can you repeat the question again, please?
Q. Is there a policy about advising inmates about the risks of prescription medicines including narcotic analgesics?
A. Not that I'm aware of using that language specifically.
Q. Are you aware of anything, any policy, procedure or practice about providing any types of information or warnings of risks in connection with the administration of narcotic analgesics?
A. No.
Q. There's also a list here on -- there's also a list -- strike that.
It's also listed as it says Hydrocod. Is --

do you understand to be hydrocodone?
A. Yes.
Q. And that's also a narcotic analgesic. Right?
A. Yes.
Q. That's a scheduled medicine?
A. Yes.
Q. That's approved for use in the prisons?
A. Yes.
Q. As is morphine?
A. Yes.
Q. Do those medicines have the risk of addiction?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes.
MR. LEONOUDAKIS: You can answer if you can.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) Do they have the risk of abuse?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) It's fair to say they wouldn't be on this if -- if the P and T committee didn't believe that they provided some benefit to inmates who were prescribed them. Right?

A. Yes.
Q. That's what the point of the formulary is. Right?
A. Correct.
Q. Are you aware of any policy or practice that limits the amount of initial dose of opioid analgesics that a healthcare provider can provide to an inmate?
A. No.
Q. Are you aware that other prison systems have policies and procedures limiting the initial dose of narcotic analgesics?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer in your personal capacity.
THE WITNESS: No.
Q. (By Mr. Cheffo) Are you aware of whether there's any of those regulations with respect to other governmental organizations?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: No.
Q. (By Mr. Cheffo) So, is it fair to say that you don't know what information is provided to a patient, whether there's any limitations on the amount of initial prescriptions or refill prescriptions or for what purposes patients are prescribed, inmates are prescribed narcotic analgesics in the correctional

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

right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: For those and -- I term that in that that is the most common way that I hear them discussed is for palliative care, end of life care or again, postoperative care or short term to treat some condition.
Q. (By Mr. Cheffo) Okay. And whether they are prescribed for other purposes, you just don't know?
A. Don't know.
Q. Are there other medicines other than opioids that have a heightened sense of security in terms of the way that the Department of Corrections treats them to avoid diversion or abuse?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer if you know.
THE WITNESS: It would just be those that are listed as scheduled substances that are under the controlled drug procedure MSRM.
Q. (By Mr. Cheffo) Are there specific drugs listed?
A. There are not specific drugs, they're just scheduled, so anything that would fall under those categories.
Q. You have the formulary in front of you. Can

you identify any others?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer if you know.
THE WITNESS: I don't know.
Q. (By Mr. Cheffo) You don't know?
A. Don't know.
Q. Now, if you look at Page 1792.
A. Okay.
Q. Do you see that it says unclassified?
A. Yes.
Q. And if you flip the page and if you -- it's in alphabetical order. Do you see fentanyl?
A. Yes.
Q. Fentanyl is an opioid analgesic, isn't it?
A. Yes.
Q. So why isn't it listed in the opioid analgesic section?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I don't know. I don't know.
Q. (By Mr. Cheffo) So if it's listed as unclassified, does that mean that all of the procedures and policies with respect to opioid analgesics or scheduled medicines are not applicable to fentanyl?
MR. LEONOUDAKIS: Objection.

THE WITNESS: I don't know.
Q. (By Mr. Cheffo) You agree it is an opioid medication. Right?
A. Yes.
Q. And as part of your preparation for this deposition did you ask about any policies or practices or procedures for the use of fentanyl for prisoners in the facilities?
A. No, not fentanyl specifically.
Q. Do you know what Phentamine is?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer if you know personally.
THE WITNESS: No.
Q. (By Mr. Cheffo) Is it an animal -- is it also used as an animal tranquilizer?
MR. LEONOUDAKIS: Objection, same objection.
THE WITNESS: If you say so.
Q. (By Mr. Cheffo) You just don't know one way or the other?
A. Just don't know.
Q. [redacted]

MR. LEONOUDAKIS: Objection.
Q. [redacted]
Q. As you sit here today do you have any idea why fentanyl is on the same list as Castor Oil and BD Syringe/luer Tip Cap and Magnesium Oxide?
MR. LEONOUDAKIS: Objection, outside the scope.
Answer if you know personally.
THE WITNESS: I don't know.
MR. CHEFFO: Let's mark this next document.
(Deposition Exhibit Number 8 marked for identification purposes and made part of the record.)
Q. (By Mr. Cheffo) This is marked as Exhibit 8. This is another formulary. No. This is the August 2018?
A. Correct.
Q. So this, this is a few months after the one we were just talking about. Right?
A. Correct.
Q. And if we want to know what the changes are we would look on the second page?
A. Correct.

Q. Do you know from looking at the second page whether any opioid analgesics were added or deleted?
A. I do not.
Q. Does that mean you don't see any?
A. I don't know.
Q. Can you tell from looking at them?
A. I don't pretend to know every name of opioid analgesics.
Q. But do you recognize any?
A. No.
Q. And if you turn to the first page, this is number one, it's the A, analgesic and inflammatory agents?
A. Yes.
Q. Like the one we talked about, the March version, hydrocodone and morphine are listed. Right?
A. Yes.
Q. I was just looking to see if there's a section for unclassified in this version. Do you see one? Actually I'm told it's Page 27, sir.
A. Yes.
Q. And again, fentanyl is listed. Do you see that?
A. Yes.
Q. Am I correct you'd have the same answer,

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

acute pain?
A. I don't believe there's -- to my knowledge there's nothing in our policies that discuss acute pain specifically.
Q. What about chronic pain?
A. Either.
Q. If there is a statewide policy regarding the administration of opioids and use of opioids, would that bind the Department of Corrections?
MR. LEONOUDAKIS: Objection.
Answer if you know.
THE WITNESS: To my knowledge we're bound by what's in state law and statute and the policies and procedures that are promulgated for the agency.
Q. (By Mr. Cheffo) What about other agencies like the Department of Health or -- strike. Or like the Department of Health?
MR. LEONOUDAKIS: Objection.
THE WITNESS: To my knowledge only if it is specified in state law.
Q. (By Mr. Cheffo) Are there different procedures for inmates with respect to the administration of medicines than there are for people who are not inmates?
MR. LEONOUDAKIS: Objection.

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

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Q. Do you know who promulgates this document?
MR. LEONOUDAKIS: Objection.
THE WITNESS: No.
Q. (By Mr. Cheffo) Doesn't it say on the second page?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: Which part are you referring to?
Q. (By Mr. Cheffo) Right down here, sir, Oklahoma State Department of Health at the bottom right.
A. Yes.
Q. This is from the Oklahoma State Department of Health, isn't it?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I assume.
Q. (By Mr. Cheffo) Isn't that what it says?
A. It is a document that has their insignia on it, the Oklahoma State Department of Health.
Q. I'll represent to you we took it off the website.
And it says Oklahoma opioid prescribing guidelines. Do you see that on the first page?
A. Yes.
Q. And it says opioid treatment for acute pain. Do you see that?

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A. Yes.
Q. It says, avoid prescribing opioids to patients currently taking benzodiazepines, I'm in Number 4, or other opioids -- and/or other opioids.
Do you see that?
A. Yes.
Q. Is that a policy or procedure of the Department of Corrections?
MR. LEONOUDAKIS: Objection, outside the scope.
If you want to take time to read this before you answer questions, go for it.
Q. (By Mr. Cheffo) Let me ask you just a general question. You can -- you can read the whole thing if you'd like. Are -- can you testify here that any of these guidelines are or are not standards, practices or procedures that are employed or adopted by the Oklahoma Department of Corrections?
(A brief pause.)
A. The question again, please.
MR. CHEFFO: Can you read it back, please?
(The record was read as directed.
"Q. Let me ask you just a general question. You can -- you can read the whole thing if you'd like. Are -- can you testify here that any of these guidelines are or are not standards, practices or procedures that are employed or adopted by the Oklahoma Department of Corrections?")
THE WITNESS: At the top where it says these are general guidelines and they don't replace clinical judgment and appropriate care of patients, I believe the clinical judgment is what our providers use in adopting may be a tent -- intent of some of these, majority of these written in their care of our patient population.
MR. CHEFFO: Move to strike.
Q. (By Mr. Cheffo) My question is, do you know, can you testify from your knowledge and preparation as to whether any of these are or are not incorporated into policies, procedures or standards of the Department of Corrections?
MR. LEONOUDAKIS: Objection.
THE WITNESS: No.
MR. LEONOUDAKIS: Asked and answered.
Q. (By Mr. Cheffo) So you just read the entire document and you can't tell us, right, which of these are part of the policies or procedures and which are not because you're not familiar with the policies and procedures.
MR. LEONOUDAKIS: Objection --
Q. (By Mr. Cheffo) Is that fair?

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MR. LEONOUDAKIS: -- misstates -- misstates his testimony.
THE WITNESS: I'm familiar with the policies and procedures that make up the health services division for our agency, but I don't believe that these specifics, specific regurgitation of this information or references to the State Department of Health are carried in any of our existing policies.
Q. (By Mr. Cheffo) So, which standards, policies and procedures are there that the Department of Corrections maintains for the diagnosis and treatment of pain other than palliative care?
A. Other than palliative care there is not a specific policy or MSRM that I'm aware of that is specifically for pain management.
Q. So to the extent any of these recommendations or guidelines talk about pain management, they would not be in the Department of Corrections' policies or procedures or standards because you don't have any. Is that right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Correct.
Q. (By Mr. Cheffo) And are you aware of the standards, practices, procedures for the use of opioid medications other than for end of life or palliative

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care?
A. Outside of what's documented in the pharmacy op and controlled substances, which really makes a distinction based on schedule, not type of medication, that's as far as I know that it goes in the policy.
Q. So to the extent any of these guidelines from the Oklahoma State Department of Health talk about the standards or practices or procedures for the use of opioid medications, they are not part of any policy or procedure at the Department of Corrections because you don't have any?
MR. LEONOUDAKIS: Objection, misstates the testimony.
THE WITNESS: As it relates to an actual policy around opioid prescribing, no, we do not have a policy around opioid prescribing.
Q. (By Mr. Cheffo) So, do you see on opioid treatment for acute pain on the first page, sir?
A. Yes.
Q. It says by Ok -- I take it that the healthcare providers who work for the Department of Corrections are required to follow Oklahoma law?
A. Correct.
Q. [redacted]

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[redacted]
Q. You're not aware of any policy that says the healthcare providers who prescribe opioids actually have to follow Oklahoma law?
MR. LEONOUDAKIS: Objection, misstates testimony.
(A brief pause.)
Q. (By Mr. Cheffo) Let me withdraw the question. Let me just ask you this. Are you -- do you have any information about any policies or procedures that healthcare providers who work for the DOC undertake with respect to checking the Oklahoma prescription monitoring program?
A. No.
Q. And so you don't know whether they do it every 180 days or whether they don't do it or whether they do it more frequently or less frequently. Right?
A. Right.
Q. Do you know whether there is a policy or

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procedure, guideline that opioids should not be prescribed to patients taking benzodiazepines?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I do not. Although, again, the prescribing practices goes back to the clinical judgment of our providers when it comes to what they're prescribing and the interactions.
Q. [redacted]
Q. (By Mr. Cheffo) The CMO reports to you. Right?
A. Correct.
Q. You had complete access to them I suppose. Right?

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A. Sure.
Q. And if he was asked to testify he could have testified. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I suppose.
Q. (By Mr. Cheffo) Is there any policy that long acting or extended release opioids should not be prescribed for acute pain?
A. Not to my knowledge.
Q. And then for chronic pain, do you see that, sir, opioid treatment for chronic pain?
A. Yes.
Q. There's no dispute that there is such a thing called chronic pain, isn't there?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) Yes, you agree with me or --
A. Yes, there is such a thing as chronic pain.
Q. Thank you.
And under four it says, the health care provider should screen for risk of abuse or addiction before initiating opioid treatment.
Do you see that?
A. Yes.
Q. Is that -- is that a policy or procedure of

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

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

MR. LEONOUDAKIS: Objection, same objection.
THE WITNESS: To the extent that they apply to the population treated in our custody, yes.
Q. (By Mr. Cheffo) And you know from what we looked at the formulary that some population that are treated have access to opioid analgesics including morphine, fentanyl and hydrocodone?
MR. LEONOUDAKIS: Objection.
THE WITNESS: They're listed in the formulary, so yes, they can be prescribed.
Q. (By Mr. Cheffo) So this document that talks about opioid -- Oklahoma opioid prescribing guidelines would apply to at least some population of the individuals in custody in the Department of Corrections. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Well, at the top of this it says they're not intended as standards of care or as a template for legislation. They're recommendations.
Q. (By Mr. Cheffo) I understand that.
A. So --
Q. But they -- these guidelines would apply. They're not -- they're not requirements. Right?
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) They're guidelines. Yes?

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

Q. Okay. And do you have a -- do you know what tapering is?
MR. LEONOUDAKIS: Objection.
THE WITNESS: My understanding that's where they gradually decrease the amount of medication.
Q. (By Mr. Cheffo) And is that a policy of the Department of Corrections to taper dependent inmates?
A. As written.
Q. And as -- as -- as the healthcare provider determines is appropriate. Right?
A. Correct.
Q. You leave that decision to the doctor?
A. Correct.
Q. And then 15, healthcare provider should offer a range of evidence based treatment and it says usually medication assisted treatment with buprenorphine, buprenorphine or methadone in combination with behavioral therapies for patients with opioid use disorder.
Do you see that?
A. Yes.
Q. Is that something that the Department of Corrections provides?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Only to the extent we discussed

earlier with pregnant females who are received already on methadone treatment.
Q. (By Mr. Cheffo) Other than pregnant females, is this guideline put in place in the Department of Corrections?
MR. LEONOUDAKIS: Objection.
THE WITNESS: It is not.
Q. (By Mr. Cheffo) Do you have -- does the Department of Corrections have any interaction with the Oklahoma Department of Mental Health?
A. Yes.
Q. In what way?
A. Currently we have con -- historically we've had contracts in place with the Department of Mental Health proper. We also have some contracts in place through agencies that are certified by the Department of Mental Health and Substance Abuse Services to provide counseling groups.
Q. So does department -- the Oklahoma Department of Mental Health actually provide mental health services to inmates?
A. We make a distinction between mental health services and addiction services.
Q. Can you please tell me what those are?
A. So, we have our own in-house and mental

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

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

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

session conducted within the protocols and programmatic scheduling of the Department of Mental Health or the Department of Corrections or a combination?
MR. LEONOUDAKIS: Same objection, outside the scope of the noticed topic.
You can answer if you know.
THE WITNESS: I'm not sure what you mean by the scope of the Department of Mental Health.
Q. (By Mr. Cheffo) The program.
A. Yes.
Q. Right? There's a program?
A. Yes.
Q. Who -- whose program is it, is it theirs or yours?
A. The agency Department of Corrections views it as ours. It's our programming contracted those services out.
Q. Do you regulate the content and the methodology and the content of it --
MR. LEONOUDAKIS: Same objection.
THE WITNESS: To an extent, yes.
Q. (By Mr. Cheffo) Do they have any input?
A. Yes.
Q. The Department of Mental Health?

A. Yes.
Q. So --
A. Or they did historically again.
Q. Okay. If you look at this document that we've marked here, this two page Department of Mental Health.
A. Uh-huh.
Q. Amongst the many, many signatories, if you look under the second row, the first in the green, what is that organization?
A. It's the Oklahoma Department of Mental Health and Substance Abuse Services.
Q. That's the same organization that administers the program in the Department of Corrections for dependent or addicted inmates. Correct?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Some of the programs, yes.
Q. (By Mr. Cheffo) And you would agree that they've endorsed these guidelines?
MR. LEONOUDAKIS: Objection.
THE WITNESS: They've certainly -- their agency stamp is on the document, yes.
Q. (By Mr. Cheffo) What do you think that means?
MR. LEONOUDAKIS: Objection.

THE WITNESS: I'd assume that that means that they endorsed it.
Q. (By Mr. Cheffo) And can you tell some of the other organizations here that have endorsed these guidelines?
A. State Department of Health.
MR. LEONOUDAKIS: Objection.
THE WITNESS: Everything listed there, State Medical Association, Oklahoma Bureau of Narcotics, the Hospital Association, I'm not sure what the next one is, Board of Pharmacy, Oklahoma Medical Board, Pharmacy Association, the next one is small enough I can't read it, Department of Mental Health, Board of Dentistry, Pain Physicians, Veterinary Medical Examiners, Oklahoma Health Authority, Oklahoma Osteopathic Association, APA, College of Emergency Physicians, not sure what the next one is, American College of Osteopathic Family Physicians, Oklahoma Pharmacists Helping Pharmacists, PPOK, Oklahoma Pain and Wellness Center and AONP, whatever that is.
Q. (By Mr. Cheffo) In addition there's also listed below that the Oklahoma Society of Interventional Pain Physicians and Oklahoma Board of Nursing. Right?
A. Yes.

Q. Is an issue of drug dependence amongst the inmate population a significant issue in Oklahoma?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: Certainly inmates have dependence issues. As to what percentage of the inmates I couldn't tell you.
Q. (By Mr. Cheffo) Has that been the case since you've first joined the Department of Corrections?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Which?
Q. (By Mr. Cheffo) Issues with drug dependence amongst inmates?
A. Historically the recordkeeping system in the Department of Corrections doesn't do a good job of distinguishing between drug use and drug abuse in terms of just general intake. So in the broader category, a segment of the population, a large segment of the population indicates some history of drug use.
Q. With respect to drug use and abuse, has there been a population of inmates who have abused methamphetamine?
MR. LEONOUDAKIS: Objection.
THE WITNESS: In terms of a quantifiable number, no. But yes, in terms of anecdotally, yes, inmates profess to using methamphetamine.

Q. (By Mr. Cheffo) And the same would be true of heroin. Right?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: To some extent, yes.
Q. (By Mr. Cheffo) And illegal -- have you heard of fentanyl, illicit fentanyl and -- and carfentanil?
A. Yes.
Q. And you know that's a big problem?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I've seen the newspaper, yes, about other states that are experiencing that.
Q. (By Mr. Cheffo) And those are illegal medicines. Right?
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) Illegal drugs?
A. To my knowledge, yes.
Q. They're not used for any medicinal purpose, are they?
MR. LEONOUDAKIS: Objection.
Answer if you know.
THE WITNESS: I believe fentanyl can be.
Q. (By Mr. Cheffo) Fair enough. Illicit fentanyl is -- is unlawful, is an unlawful drug. Right?
A. Correct.

Q. Let's mark this. I think we're up to, what?
MR. TAM: Ten.
MR. CHEFFO: Ten? Thank you.
(Deposition Exhibit Number 10 marked for identification purposes and made part of the record.)
Q. (By Mr. Cheffo) Do you know what this document is?
A. Yes.
Q. What is it?
A. It's a medical services overview from the Department of Corrections website.
Q. Who prepares this document?
A. Generally the chief medical officer or his administrative staff.
Q. So, this is an overview. Right?
A. Yes.
Q. This is on your website?
A. Yes.
Q. It says, medical services provided -- provides medical and dental care for offenders in Oklahoma Department of Corrections ODOC facilities, work centers, contract facilities and DOC offenders in contract county jail beds.
Do you see that?

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

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MR. LEONOUDAKIS: Sure. Are you okay with that?
THE WITNESS: Yeah, fine.
Q. [redacted]
Q. And that's done on a regular basis?
A. Quarterly.
Q. ODOC clinical quality outcomes routinely exceed community benchmarks.
Do you see that?
A. Yes.
Q. Do you track whether inmates have recidivous behavior with respect to drug abuse after they leave?
MR. LEONOUDAKIS: Objection, outside the scope.

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You can answer if you know.
THE WITNESS: Recidivous behavior after they leave. So what their behavior is after they're no longer in the custody of the Department of Corrections?
Q. (By Mr. Cheffo) Right. So --
A. No. There's -- there's not a mechanism for us to capture that when they're no longer in our custody.
Q. You couldn't check medical or public health records? There's no -- there's no mechanism to do that?
MR. LEONOUDAKIS: Objection.
THE WITNESS: There's not a mechanism nor the staff to do that with.
Q. (By Mr. Cheffo) The American Correctional Association accredits all the medical services units along with their facilities.
Do you see that?
A. Yes.
Q. Are you accredited by the American Correctional Association?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer if you know.
THE WITNESS: I know we are maintaining all of

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the ACA standards and documents that are required for audits. As to when the last audit was done of any one facility, which would include their medical services, that would be a question for auditing and compliance.
Q. (By Mr. Cheffo) I think my question I think you know is a little different. Right? I asked you whether the ACA has accredited the facilities.
A. They have in the past, yes.
Q. Are you accredited right now?
A. Not to my knowledge.
Q. Do you know why this is on the website then?
MR. LEONOUDAKIS: Objection, outside the scope.
You answer in your personal capacity.
THE WITNESS: I don't know.
Q. (By Mr. Cheffo) Are some prisons in Oklahoma unaccredited?
A. I don't know.
Q. Well, if you know that you're not accredited, wouldn't it mean that you know that some of your facilities are not accredited?
A. I am not sure what the current stance is or where we are with regards to ACA accreditation. That's something the policy and procedure and auditing and compliance has oversight of. We maintain all documents that are necessary so that we could be

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audited today and internal audits are continually conducted using the ACA standards.
Q. So the last time when accreditation was possible were you accredited or not?
A. I don't understand what you mean by the last time it was possible.
Q. Is it done on an annual or periodic basis that they do a review and audit and then accredit?
A. It is on -- it is done on a periodic basis.
Q. And the last time that you underwent a review were the Department of Corrections' facilities accredited or not?
A. Yes, the last time that they were done I believe we passed all of those audits.
Q. So do you believe that you are accredited now or not or you don't know?
A. I don't know because I'm not sure how many of those with the -- with the periodic timeframe and not all facilities are done at once, I'm not sure how many of those may have lapsed beyond whatever that timeframe is and how many of them are still regarded as current.
Q. And -- and it says here in the second paragraph, the pharmacy and therapeutics committee composed of ODOC clinicians and pharmacist -- and

pharmacist monitors prescribing practices for cost efficiency and quality of care.

Do you see that?

A. Yes.

Q. That's accurate, isn't it?

A. Yes.

Q. And we talked a little bit about that earlier, that's ensuring that at least as to the formulary medicines that were deemed to be safe, effective and appropriate are on the formulary. Right?

A. Correct.

Q. Okay. I think, I think five -- if we go five minutes we can probably finish one more document and take a break, just a few questions. Let's just mark this one, please.

While we're doing that, sir, are you familiar with the National Commission on Correctional Health Care?

A. I'm familiar with them as an organization, but in terms beyond that, no.

(Deposition Exhibit Number 11 marked for identification purposes and made part of the record.)

Q. (By Mr. Cheffo) This is a position statement.

Do you see that?

A. Yes.

Q. Do you know one way or the other whether this is -- this position statement regarding the management of non cancer con -- concert pain -- cancer pain is consistent with any policy or procedure or regulation of the Department of Corrections?

A. Having never seen it before, no.

Q. Okay. And if you look back at the 10 just for a minute, hold on to that, I'm sorry, Exhibit 10, if you look on the bottom right hand first page.

A. Uh-huh.

Q. There's a reference to this organization. Right?

A. Uh-huh.

Q. On -- yes?

A. Yes.

Q. On the Department of Corrections' own website it basically lists or has a link to the National Commission on Correctional Health Care. Right?

A. Yes.

Q. And that's on the medical services page. Right?

A. Yes.

Q. And the document I just showed you as ten is actually from that same organization that's referenced on your medical page. Right?

A. Yes.

Q. So you would agree it's a legitimate organization. Right?

A. Yes.

MR. LEONOUDAKIS: Objection.

Q. (By Mr. Cheffo) And is it your testimony you don't know what the policy is with respect to the management of noncancer chronic pain?

A. It's my testimony that I don't believe we have a specific policy relating to the management of noncancer chronic pain.

Q. I was asking more about now Exhibit 10. You, you can't testify as to whether this policy is consistent or inconsistent with what is done at the Department of Corrections. Is that right?

A. Correct.

Q. If you look at Number 10 on Page 2, please.

A. Yes.

Q. It says, policies banning opioids should be eschewed. Opioids should be considered with caution after weighing all treatment options.

Do you see that?

A. Yes.

Q. That's consistent with your policies. Right?

MR. LEONOUDAKIS: Objection.

THE WITNESS: I believe so based on the fact that they are carried on the formulary.

Q. (By Mr. Cheffo) Right. There's absolutely no policy in place or one that you've ever seen or even suggested that would ban opioids, is there, for the Department of Corrections?

A. No, there is not.

Q. Are you aware of any intention to do that?

MR. LEONOUDAKIS: Objection.

THE WITNESS: Not to my knowledge.

Q. (By Mr. Cheffo) That would be inconsistent with the National Commission on Correctional Health Care. Right?

A. To the extent that that is their position in this paper, yes.

Q. That's what it says on Number 10. Right?

A. Yes.

Q. Okay.

MR. CHEFFO: Let's take a break. Thank you.

THE VIDEOGRAPHER: Going off the record. This is the end of Media Number 3. The time is 12:36.

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

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

and fill it. Right?
A. Correct.
Q. In the context of a correctional facility, is the process similar in the sense that there's an interaction between the inmate and a -- and a doctor and then the doctor actually writes a physical prescription that that gets filled by somebody in -- in the -- in the facility or is it -- does it operate in some other way?
A. When a provider, when a provider writes a -- or orders a medication it's done electronically. That is submitted electronically to Diamond offsite. Diamond fills the prescription and then ships it to the facility and then when it is received it is already packaged, carted to the individual inmate unless it is a stock medication and the ordering process for that is slightly different or a scheduled medication, that process is slightly different as we talked about earlier, and then it is logged into the medication room and into the electronic health record MAR system.
Q. So for stock medicines there's -- there's a space in the facility typically where they actually probably under lock and key --
A. Correct.

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

eligible for inmate possession subject to approval by a medical provider at the facility correctional health service -- or, excuse me, and the facility correctional health service administrator or CHSA.

Q. Okay. So, for example, I don't know whether this would be one or not, if someone had an asthma problem they might be able to keep their -- their inhaler --

A. Inhaler.

Q. -- with them. Right?

But I take it with scheduled medicines they can't keep those on their person?

A. Correct.

Q. They have to go to a pill line and actually be handed the medicine and then presumably somebody has to watch them ingest it?

A. Correct.

Q. To prevent diversion. Right?

A. Correct.

Q. And for people who receive opioids, morphine or hydrocodone today which is on your formulary, let's use that as an example, there would be a prescription written by a healthcare provider that would enable someone to go to the pill line and get their medicines. Right?

A. It would be a prescription written that would initiate the order for it to be received at the facility, logged in through appropriate chain and then administered either through pill line. The only exception to that would be if you are in the infirmary, in segregated housing for disciplinary reasons at which point in time our staff go to you and administer, observe, record the same as happens in pill line.

Q. Okay. But correct me if I'm wrong, the initial step of getting scheduled medicine like an opioid analgesic to an inmate requires an order and prescription by a healthcare professional, that's done electronically and then that starts the process?

A. Yes.

Q. And there would be records of that?

A. Electronically or, let's see, in terms of ordering under the MSRM about controlled drug procedures, if it's a stock medication it's handled slightly differently where there's a specific form that's used and faxed in to Diamond, but there is a record kept of that.

Q. And has that process been in place as long as you can recall?

A. As long as I can recall, yes.

[redacted]

Q. In fact, to -- to figure out whether opioid medicines were prescribed or used in prescriptions all

you would really have to do is go and ask the pharmacy person or the CMO and they would tell you no, we do use them under these circumstances. Right?

MR. LEONOUDAKIS: Objection.

THE WITNESS: They would say that we do use them because they're on formulary.

Q. (By Mr. Cheffo) And -- and they would be able to talk about the circumstances in which they are used. Right?

A. I believe.

MR. LEONOUDAKIS: Objection.

Q. (By Mr. Cheffo) Now, for any of the policies that you've looked at in preparation for this deposition, is there anything -- did you see any hint or learn of any information whatsoever that any pharmaceutical company had anything to do with any of those policies?

A. Not to my knowledge, no.

Q. That would strike you as unusual, wouldn't it?

A. Yes.

Q. Now, if I were to ask you -- well, strike it. Let me ask you a few of them.

[redacted]

[redacted]

Q. And would -- would you assume that they would be able to identify certain databases or documents that would have utilization information?

A. I believe that there is a method that they could get to that information, yes.

Q. And they could probably also consult with the Diamond Pharmacy people. Right?

A. Correct.

Q. Because ultimately -- are they the sole supplier for pharmaceutical products?

A. Yes. The only exception to that is in the contract we require that there is a backup pharmacy for anything that occurs after hours or in an emergency situation. In those instances we have articulation agreements with the backup pharmacy and specific facility so that when we fill that med that backup pharmacy bills Diamond and then Diamond bills us.

Q. And how long has Diamond, Diamond been your, when I say your I'm talking Department of Corrections --

A. I understand.

Q. -- your primary pharmacy provider?

A. Since I began in this position in 2015 and I -- for some time period prior to that.

Q. Have you ever had occasion either yourself or through your department to ask for reports or information such as things like utilization from Diamond?

MR. LEONOUDAKIS: Objection, outside the scope.

THE WITNESS: I have not -- I have not personally asked for utilization reports. My focus is more on the budgetary end.

Q. (By Mr. Cheffo) And in terms of your focus, is that providing budgets for the types of medicines and the nature of medicines that are provided to the facilities?

A. Not necessarily the types and nature. That's more what the P and T committee does when they're looking at it. Mine is just the bottom line dollar amount on what we're expending month to month versus the agency budget and what we're given to operate on.

Q. And are there audits done in order to validate that what you're receiving is what you're paying for?

A. There are -- I know financially there are audits that occur that are spot checks to make sure that the invoices that we receive match the quantity and amounts that are received. Beyond that in terms of any other type of audit that's done I'm not aware.

Q. And you would expect though that if you wanted to know how many prescriptions, for example, of Oxycontin were written for 10 milligrams in 2017, that would be something that you could call up Diamond and say give us a printout and they would be able to supply that information?

MR. LEONOUDAKIS: Objection.

THE WITNESS: I believe so, yes.

Q[redacted]

[redacted]

Q. (By Mr. Cheffo) Isn't that a question you would ask the CMO?

A. In terms of utilization we primarily for my purposes focus on the budgetary constraints and looking at what pharmaceuticals are costing us. Through the CMO in his function as the chief medical officer that's something that his role within pharmacy and therapeutics.

Q. And I'm not being critical, sir, but your -- your role here is beyond your own personal role, your role here is as -- as a corporate designation,

designee, right, to talk about broader areas? You understood that. Right?
A. Sure.
Q. And if, in fact, there were no prescriptions written for opioids, wouldn't that fall within practices or procedures regarding the treatment of pain for the use of opioid medications?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Well, the practice and the procedure when -- when that's applied to just general correctional terms, the practices and procedures are normally what's in front of us in terms of the exhibits that are here. Those are procedures for general operating guidelines, which is what I focused my efforts on reviewing those.
Q. (By Mr. Cheffo) Well, I agree practices and procedures are what's in front of you, but it depends on what you put in front of you in order to have that information. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: True.
Q. (By Mr. Cheffo) So if you wanted to understand how many prescriptions of a particular opioid were written, that's something that you had access to do if you wanted to or you were asked to do

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

[redacted]
Q. (By Mr. Cheffo) Now, I think I asked you briefly and I just want to make sure that I -- I understood what you testified earlier. The concept of abuse of illegal drugs is something that is a problem and a longstanding issue for correctional facilities like the Department of Corrections in Oklahoma. Right?
A. I believe I said use and abuse of illegal drugs is something that is commonly reported to us by inmates who are in our custody.
Q. And -- and you know that use and abuse of illegal drugs including opioids is something that's a societal problem going back many, many years?

MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes, I know that illegal drugs are an issue for society.
Q. (By Mr. Cheffo) And you -- you know probably from either seeing on TV or reading in the history books that abuse of heroin was an issue after the Vietnam War. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I know that there is a history of abuse of heroin in the general population, yes.
Q. (By Mr. Cheffo) And heroin's an opioid. Right?
A. Yes.
Q. And that goes back to the Vietnam War if not before. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Sure.
Q. (By Mr. Cheffo) And you know that there was a history of drug abuse in -- with opioids even after the Civil War with soldiers who were administered battlefield issues? Are you aware of that?
MR. LEONOUDAKIS: Objection to this line of questioning as outside the scope of the topic.
THE WITNESS: I don't recall ever seeing anything about drugs and abuse in the Civil War.

Q. (By Mr. Cheffo) So you would agree with me at least that the problems of drug abuse in America, particularly with opioids, didn't start in 1995 or 1996 or 1999. Right?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: I agree that there were drugs being abused in those timeframes and before.
Q. (By Mr. Cheffo) So, so the answer is yes?
A. Yes.
MR. LEONOUDAKIS: Objection, misstates the testimony.
Q. (By Mr. Cheffo) Is -- are the concept of -- strike that.
You, you mentioned the terms I think use and abuse?
A. Yes.
Q. Do you draw a distinction between those two?
A. Not one that's listed in policy, no.
Q. Are use, abuse and addiction, are those related, can they be related to prescription of Schedule II medicines?
MR. LEONOUDAKIS: Objection.
THE WITNESS: There's nothing that limits it in anything in writing or practice that I'm aware of in the agency to just illicit drugs.

Q. (By Mr. Cheffo) But they are -- the concepts of addiction and abuse, they are related to or can be related to the use of opioids. Right?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: Yes.
MR. CHEFFO: Well, I don't think it's out -- any of it's outside the scope, but you can make the objections.
Q. (By Mr. Cheffo) What I'm trying to understand -- let's look at Exhibit 1.
MR. LEONOUDAKIS: The Notice.
Q. (By Mr. Cheffo) Yes, the Notice. I -- I think I have it. I'm sorry.
A. Okay.
MR. CHEFFO: Do we have another copy, John?
Q. (By Mr. Cheffo) So I'm just trying to understand because there's been a number of objections that this is outside the scope. But do you -- do you see the concepts of -- let me start with abuse. Is that unrelated to the prescription or use of opioid medicines?
A. Are you asking me the question?
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) Yeah.
MR. LEONOUDAKIS: Objection.

THE WITNESS: When you use the term abuse, I think it covers anything that has an addictive potential.
Q. (By Mr. Cheffo) Okay. Would it include potentially opioids?
A. Potentially.
Q. So it's not exclusive to opioids. Right?
A. No.
Q. Abuse can be alcohol. Right?
A. Correct.
Q. Cigarettes, cocaine. Right?
A. Correct.
Q. Methamphetamines?
A. Correct.
Q. It could also include unlawfully obtained opioids. Right?
A. Yes.
Q. So, the concept at least of abuse is related to treatment of pain using opioid medicines. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Repeat that back.
Q. (By Mr. Cheffo) Sure.
The concept of abuse can be related to the treatment of pain with opioid medications?
MR. LEONOUDAKIS: Objection.

THE WITNESS: The concept of abuse can be related to the medication however the medication is obtained.
Q. (By Mr. Cheffo) Okay. So my an -- the answer is yes then. Right?
MR. LEONOUDAKIS: Objection, misstate the testimony.
THE WITNESS: No.
Q. (By Mr. Cheffo) Let me restate it. The concept of abuse can be related to the use of opioids medicines for the treatment of pain?
MR. LEONOUDAKIS: Objection.
THE WITNESS: No, that's not what I said.
Q. (By Mr. Cheffo) I'm asking the question. Do you agree with it?
A. Repeat it one more time.
MR. CHEFFO: Sure.
(The record was read as directed.
"Q. The concept of abuse can be related to the use of opioids medicines for the treatment of pain?")
MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) And the concept of addiction can be related to the use of opioid medicines for the treatment of pain?
MR. LEONOUDAKIS: Objection.

THE WITNESS: Not singularly, but yes, it is one, one avenue.
Q. (By Mr. Cheffo) And the concept of dependence can be related to the use of opioids for the treatment of pain. Correct?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Again, not singularly as one form of drug, but yes.
Q. (By Mr. Cheffo) You would also agree that there can be and you have seen it in connection with the Department of Corrections population, there can be widespread abuse of chemical substances even without any advertising by a pharmacy manufacturer. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I have no idea what form of advertising any one single segment of our population is or isn't exposed to.
Q. (By Mr. Cheffo) Well, certainly no one advertises heroin. Right?
A. Well, no.
Q. Right.
A. Other than other inmates possibly.
Q. Right. But -- and there still can be a heroin crisis. Right?
MR. LEONOUDAKIS: Objection.

THE WITNESS: Sure.
Q. (By Mr. Cheffo) And the same, you haven't seen any advertisements for methamphetamines. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Not to my knowledge.
Q. (By Mr. Cheffo) And there still can be a methamphetamine crisis. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Sure.
Q. (By Mr. Cheffo) And you haven't seen any advertisements for crack cocaine, have you?
A. No.
Q. And there still could be a crack cocaine crisis. Right?
MR. LEONOUDAKIS: Same objections.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) And you haven't seen any advertisements for marijuana. Right?
MR. LEONOUDAKIS: Objection.
Q. (By Mr. Cheffo) Outside of Colorado perhaps?
A. No, here too.
Q. That's -- that's a fair point, under your recent law. So let me --
A. Yes.
Q. Let me withdraw that. I need to be more --

more in tune with -- with recent legislation.
You haven't seen any advertisements for regular cocaine, have you?
MR. LEONOUDAKIS: Objection.
THE WITNESS: No.
Q. (By Mr. Cheffo) And there still could be a cocaine crisis. Right?
A. Yes.
Q. And the drug cartels from Mexico and -- and China, they don't advertise illegal carfentanil or fentanyl analogues. Right?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: I have no idea what illegal cartels do or don't do. Certainly no commercials I've seen for them.
Q. (By Mr. Cheffo) But illegal, illegal fentanyl and fentanyl analogues are a major problem in -- in prisons, aren't they?
MR. LEONOUDAKIS: Objection.
THE WITNESS: To my immediate knowledge they are a growing problem within correctional entities. I believe our exposure to date has been very few.
Q. (By Mr. Cheffo) And what -- help me understand that distinction.
A. Based on death reports, inmate deaths, what

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

Q. And is there an autopsy done if there is a suspicion of an overdose death?
A. The medical examiner is contacted in every instance of death, but the ME determines whether or not they take the body and perform an autopsy.
Q. And there are situations where someone in prison dies of an overdose even though that person is not supposed to be receiving any type of medicine that would cause an overdose?
MR. LEONOUDAKIS: Objection, outside the scope.
Q. (By Mr. Cheffo) Do you understand my question? In other words, there are situations where someone, inmates are dying of overdose from illicit fentanyl where they're not getting that obviously from doctors?
MR. LEONOUDAKIS: Object, same objection.
THE WITNESS: In that exact instance, yes.
Q. (By Mr. Cheffo) What do you mean in that exact instance?
A. Is your question specific to fentanyl itself?
Q. No, it's -- it's broader. It could be fentanyl, it could be even a prescription medicine, it could be something else. My question is, is there situations where inmates are being exposed to either

lawful medicines illegally or illegal drugs and overdosing in prisons?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: The information that I've seen on any reports from the medical examiner will simply state cause of death or manner of death and a toxicology report if one is performed. Beyond that the chief medical officer and his staff review what medications they may or may not be on.
Q. (By Mr. Cheffo) Is there any type of survey or document or analysis of the amount of illegal drugs that are being used or brought into Oklahoma correctional facilities?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: If there is I have no knowledge of it. It would not be something that my division would handle.
Q. (By Mr. Cheffo) If someone died in prison in Oklahoma and the cause of death was an overdose, we would be able to run a report or ask someone to say identify all of those deaths that were attributable to an overdose based on either a medical examiner evaluation or, you know, a treating physician. Right?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: For any death that occurs while in

custody if the medical examiner assumes the body and whatever reporting they do, if they do a full autopsy, toxicology, whatever, that report is furnished to the Department of Corrections. So the medical examiner's office I would assume is the repository of that information.
Q. (By Mr. Cheffo) What about you -- let's say John Smith unfortunately expires and -- and there's no autopsy done. Someone has to I assume do some type of an analysis or conclusion as to what the most likely cause of death is?
A. We make a distinction in policy between attended and non-attended deaths. Attended deaths can be those that fall in the category of expected deaths. So elderly inmate who may be receiving palliative care in an infirmary who has stage four cancer as a generic example, more than likely that would be an attended death and the ME would probably not take the body, we'd contact family and determine what the next steps were.
Q. Understood.
A. Anything that is determined to be unattended, the normal process is that chain of commands are alerted and the ME is contacted for their determination whether or not they will take the body

to determine if they will do an autopsy or toxicology review. But then yes, internally the chief medical officer or an external panel we have the ability to send it to for review in terms of care.
Q. With -- with every, every inmate death is there someone or somebody who does a cause of death analysis?
MR. LEONOUDAKIS: Objection, outside the scope.
You can answer.
THE WITNESS: I'm not sure if the terminology is the same in terms of cause of death, but when there is a death that occurs, yes, there is a review of that death that is conducted at a minimum internally by the chief medical officer.
Q. (By Mr. Cheffo) Whether it's from the outside ME or the chief medical officer or some outside panel, there would be some documentation for every death that occurred that it would at least identify whatever conclusions were drawn by folks. Correct?
MR. LEONOUDAKIS: Same objection.
THE WITNESS: There is -- there is a recording of every death. To the extent as to how in depth someone went in terms of examining it, that would vary.
Q. (By Mr. Cheffo) As part of the corrections umbrella of various programs and facilities, do you

have any type of outpatient or halfway house type facilities where you provide substance abuse counseling and guidance?

A. We don't have -- we have halfway houses. I don't believe -- it depends on what your definition is of outpatient services. I don't believe we have anything that would -- would qualify as that. The programs that we discussed earlier from a historical concept all happen while incarcerated. In terms of halfway houses, we are still responsible for their healthcare, which is medical and mental health services. Most of that is performed by a host facility, so the halfway house is transporting back to a facility so that our in-house staff provide those services with the rare instance of a couple of halfway houses that are in the Tulsa area where we contract out the medical and mental health services.

Q. In -- in those situations where the Department of Corrections contracts out to other entities to assist with healthcare for a certain population wherever that may be, do any of them provide medically assisted treatment?

A. No.

Q. Is that a policy of the Department of Corrections that no one shall provide medically

assisted treatment?

A. Not to my knowledge, no.

Q. So do you have a reason as to why it is that no doctor associated in any way with the Department of Corrections provides or prescribes medically assisted treatment for people who have addiction or abuse disorders?

MR. LEONOUDAKIS: Objection.

THE WITNESS: Say it again.

Q. (By Mr. Cheffo) Sure.

Do you have an explanation as to why no healthcare provider in any way associated with the Department of Corrections prescribes medically assisted treatment for inmates who have abuse or addiction disorders?

MR. LEONOUDAKIS: Objection.

THE WITNESS: Because we've not created policies, processes or contracts around it, nor has the chief medical officer pursued that as an avenue.

Q. (By Mr. Cheffo) Are you aware of anybody who has prescribed it who has been rejected?

A. An inmate who has been prescribed it while incarcerated?

Q. Incarcerated, halfway house, contract.

A. Not to my knowledge. I don't know anybody

that's been prescribed it.

Q. So is there a prohibition against it or you just don't have policies in place to administer it?

A. It's just not an avenue of treatment that the agency has undertaken at this point by developing policies or practices around it.

Q. Right. But I thought you told me that the agency doesn't set medical guidelines, that's up to doctors?

A. Right.

MR. LEONOUDAKIS: Objection, misstates the testimony.

Q. (By Mr. Cheffo) So if a doctor wanted to prescribe medically assisted treatment, could he or she?

A. As I said earlier, I think that would be up to the chief medical officer to design whatever that process would look like if that was his interest.

Q. No, no, let's assume someone went to see a staff doctor, I'm not being pejorative, just a regular treating physician at a facility, and could that doctor say I think inmate X, Y, Z would benefit and I think it's medically necessary for them to have this medically assisted treatment, I'm going to prescribe that, could they do it?

A. I believe there's a distinction between DEA licenses where you have to have a specific DEA license for pain management versus addiction treatment. I seem to recall that none of our existing physicians have the addiction treatment specialty which may be why they don't prescribe that nor is it a requirement of their employment with the agency.

Q. So is it that they're just not licensed to prescribe it and that's why it doesn't happen or is it that you would formally prevent someone from receiving medically assisted treatment?

A. It's a chicken or the egg.

Q. I guess if you don't hire people who could actually do the job then you -- let's assume hypothetically someone got up tomorrow and said I'm a doctor for the Department of Corrections, I read this article, this looks like it's a really good thing, there's this council out there that says this is best practices, gosh, I'm going to go and get a license to prescribe. Right?

MR. LEONOUDAKIS: Objection.

Q. (By Mr. Cheffo) If that person did that could they then prescribe and would it be fulfilled?

A. I believe administratively they would have to have the support of the chief medical officer and

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

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

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

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

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

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

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

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

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

A. Uh-huh.

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

A. Correct.

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

MR. LEONOUDAKIS: Objection.

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

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

A. Yes.

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

Do you see that?

A. Yes.

Q. And is that the -- the administrator?

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

Q. January 1 of 2018?

A. Yes.

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

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

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

A. No. They are a contractor for EGID.

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

Do you see that?

A. Yes.

Q. What does that mean?

A. It means they are to follow our formulary.

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

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

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

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

A. No.

Q. You're familiar with it though?

A. Cursorily.

Q. Do you know what it is?

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

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

(A brief pause.)

A. Sorry, ask your question again.

MR. CHEFFO: Sorry. Please read it back.

(The record was read as directed.

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

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

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

inmates?
A. Yes.
Q. And is this typically a contract that would be for entities or individuals outside the physical confines of a correctional facility?
A. Yes.
Q. So if there was a network provider that just as an example provided dialysis services and that wasn't available in the facility, maybe that was a bad example, but is that the type of thing that there would be a contract for or is it more specific to specialty?
A. A little of both and it's hard to distinguish the two. And when you say dialysis, we do have an on site contract dialysis provider.
Q. That's why -- I figured you might. So --
A. So there is a distinction within state law that allows us to do professional service contracts and then those that allow us to do the network provider contracts. The intent of the network providers are generally for services that are outside the scope of the facilities. I need to go back and look at the specific ones.
Q. So, so as a general matter this is for entities that are outside the scope of the facilities?

A. For general, yes.
Q. There could be exceptions?
A. Right.
Q. But that's the general understanding?
A. The general purpose of it is to, again as we discussed, develop a network of providers that can be accessed.
Q. And -- and it -- and the contract probably does many things, but one of the things that I'm looking at the definition of covered services, it means that covered services are medically necessary services delivered by a facility pursuant to this contract. Right?
A. Yes.
Q. That's basically saying the DOC will cover certain surfaces -- services to the extent that they are medically necessary under this contract?
A. Yes.
Q. And then if you look on the next page, 2.13, it says -- it says medic -- I'm in the medically necessary.
A. Yes.
Q. And that's a definition from the Department of Corrections as to what is medically necessary?
MR. LEONOUDAKIS: Objection.

Q. (By Mr. Cheffo) Correct?
A. This contract is developed in conjunction with EGID. To what extent this is our verbatim language I don't know.
Q. Whether it's -- it's not your verbatim language or not, this is something that is used when you, the Department of Corrections, and your looks like chief medical officer enter into contracts with outside entities. Is that right?
A. Correct.
Q. So when someone -- when you -- when you contract with other outside entities and create a contractual relationship, this is the document that's used and this medically necessary definition is incorporated into that contract. Right?
A. It is in that contract.
Q. And it's one of many contractual terms, right, that's listed here?
A. Yes.
Q. And one of the things it says in 2.13, it's medically necessary means services or supplies which are provided for the diagnosis and treatment of the medical and/or mental health slash substance abuse condition and applies with criteria adopted by the DOC.

Do you see that?
A. Yes.
Q. So there's criteria that the DOC adopts and -- and that helps define what medically necessary is. Right?
A. Yes.
MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) Then it goes on, direct care and treatment are within standards of good medical practice within a community and are appropriate and necessary for the symptoms, diagnosis or treatment of the condition. Right?
A. Yes.
Q. And that's part of this defined contractual term that the DOC uses in its normal business practices. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: It's part of what we use in relation to a specific network contract.
Q. (By Mr. Cheffo) And that's a business practice, isn't it?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) Before entering into this

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

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

makes the determination. Right?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) And that person is the chief medical officer?
A. Yes.
Q. That doesn't require any out -- you don't go to any outside experts, do you?
MR. LEONOUDAKIS: Objection.
THE WITNESS: We have the ability to request an authorized second opinions if there was a necessity for that.
Q. (By Mr. Cheffo) But you don't need to, do you?
MR. LEONOUDAKIS: Objection.
THE WITNESS: I wouldn't want to hazard a guess.
Q. (By Mr. Cheffo) But it's typically done all within the confines of the relationship and the Department of Corrections' healthcare providers. Right?
MR. LEONOUDAKIS: Objection, misstates the testimony.
THE WITNESS: If -- if there's something that there is a question about the medical necessity of it is the process that I described, go back to the

facility and potentially the chief medical officer from there if there was a concern.
Q. (By Mr. Cheffo) So if I were to say that it's beyond the scope of the state through its contractual ability to determ -- to determine medical necessity, you would disagree with me. Right?
MR. LEONOUDAKIS: Objection, scope.
You can answer in your personal capacity if you know.
THE WITNESS: Ask it again, please.
Q. (By Mr. Cheffo) Sure. I'm asking our court reporter to read it because I can't remember that far back.
(The record was read as directed.
"Q. So if I were to say that it's beyond the scope of the state through its contractual ability to determine medical necessity, you would disagree with me. Right?")
MR. LEONOUDAKIS: Objection, scope, calls for a legal conclusion.
THE WITNESS: I would disagree.
Q. (By Mr. Cheffo) And you would agree with me that this process of what's medically necessary or not medically necessary and that whole determination, a pharmaceutical company has no role in that process or

evaluation or determination. Isn't that right?
MR. LEONOUDAKIS: Objection, outside the scope.
THE WITNESS: Yes.
Q. (By Mr. Cheffo) While we're looking for the next document, sometimes people need a shorter break after lunch than before lunch, so if that's the case you'll let me know if that happens.
THE WITNESS: I'm doing fine. I'm doing fine.
(Deposition Exhibit Number 14 marked for identification purposes and made part of the record.)
Q. (By Mr. Cheffo) This is Exhibit 14, sir. We've marked this as 14. Is that one of the documents that you reviewed in connection with your preparation?
A. Yes.
Q. I'll give you a chance to take a look at it and maybe you can tell us what this is.
A. This is the MSRM guide for detoxification.
Q. And just for the record is clear, the MSRM is a essentially addendum to a procedure and policy?
A. Correct.
Q. Provides a little more detail and information to build out a policy. Is that generally fair?
A. Specifically for healthcare staff.

Q. And this one is labeled detoxification?
A. Yes.
Q. And what is the purpose of this MSRM?
A. It's to provide guidance on the safe withdrawal from drugs of dependence and enable individuals to become drug free. The detox services that are designed to administer are the severity of the inmate's level of physical dependence, achieve a safe and supportive withdrawal for alcohol or drugs and effectively facilitate the inmate's transition into ongoing services, including referral to mental health services.
Q. And it talks about detoxification from alcohol, opiates, hypnotics, benzodiazepines, other stimulants and sedative, hypnotic drugs may be conducted in a variety of inmate housing settings and may include an infirmary setting in a DOC facility or a hospital as ordered by the attending psychiatrist, healthcare provider.
Do you see that?
A. Yes.
Q. And those are all kind of substance of abuse, right, alcohol, opioids, hypnotics, benzodiazepines, stimulants, sedatives, hypnotic drugs?

A. Yes.
Q. In the next paragraph it actually says that all chemical dependencies require monitoring and treatment.
Do you see that?
A. Uh-huh.
Q. Does the DOC provide that?
A. In terms of monitoring, the intent of the language here, chemical dependencies require monitoring as it relates to the detox process and treatment as it relates to the detoxification.
Q. So what does -- what does that mean in practical terms?
A. In practical terms it's instructing the staff to agree that they're in charge of monitoring and providing the treatment during the detoxification process.
Q. What is the treatment?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Under six where it says withdrawal management, the initial evaluation, every effort made to ease the discomfort of detoxification, but essentially there's not a specific treatment regimen that is prescribed. It's left -- left up to the qualified healthcare professional to determine what

that detox plan looks like.
Q. (By Mr. Cheffo) And as we discussed, that detox plan cannot currently include medically assisted treatment like methadone or buprenorphine?
MR. LEONOUDAKIS: Objection, misstates the testimony.
Go ahead.
THE WITNESS: As I -- as I said, I don't believe our current practitioners have the appropriate licensure to prescribe it.
Q. (By Mr. Cheffo) And even if they did you told us they'd have to go and get some kind of approval from the CMO?
A. There would have to be --
MR. LEONOUDAKIS: Objection.
THE WITNESS: -- some policy, rule or regulation promulgated around that.
Q. (By Mr. Cheffo) And we know that because that was required when you wanted to give methadone to pregnant mothers, pregnant women?
A. It was created when we received a pregnant female already on methadone.
Q. It says alcohol, benzodiazepines and barbiturates are associated with the highest risk of severe withdrawal symptoms.

Do you see that --
A. I do.
Q. -- on the first page?
You believe that to be true, right, if it's in the policy?
A. I believe that to be the way the policy is written, yes.
Q. You don't disagree with it, do you?
A. Don't disagree.
Q. Probably outside your area of expertise. Right?
A. Yes.
Q. And then there's various provisions here about intake assessment, withdrawal management, right, on the next page?
A. Yes.
Q. And on Page 3 there's a section for medium and high risk symptomatic inmates. Do you see that?
A. Yes.
Q. And I take it from this that there's certain potential situations where an inmate may be required to be hospitalized outside of a facility?
A. Correct.
Q. And if that's the case there's a specific receiving hospital, the Lindsay Municipal Hospital?

I'm in the second paragraph under C, second sentence. Right here, sir. (Indicating.)
A. Yes, yes.
Q. When appropriate, inmates requiring hospitalization will be admitted to Lindsay Municipal Hospital.
A. Yes.
Q. Is that the only hospital to take outpatient DOC inmates?
A. It is not. This is written in such a way as it primarily refers to intake and assessment. Lindsay is the closest hospital to the assessment reception center. But certainly it is possible that you can become hospitalized through an emergency setting at any hospital in the state.
Q. I see. So, this is more written for if someone is kind of in a crisis situation or at high risk during the intake the closest hospital would be Lindsay Municipal but if they were outside of that situation of intake they could go to some other hospitals?
A. Correct.
Q. Is Lindsay Municipal Hospital able to use medically assisted treatment if the doctors in that hospital determine that it's appropriate?

MR. LEONOUDAKIS: Objection.
THE WITNESS: I don't know that there's anything that prohibits them from it but I don't know that that's ever been anything that they have done.
Q. (By Mr. Cheffo) Do you know one way or the other how they treat the patients that are sent there?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Well, the Lindsay Municipal Hospital is a hospital that primarily cares for DOC inmates for a variety of health purposes. We -- we rarely have inmates who are received into our system who are actively in withdrawals because they sit so long in county jail before they are received into our custody.
Q. (By Mr. Cheffo) And does the DOC have any jurisdiction or oversight over county jails?
A. Only insofar as if we contract bed space with them, otherwise we have no oversight for inmates who are in county jail. If they are sentenced to our custody and the sentencing documents have been received by population, then they are the responsibility for us in terms of the cost of their medical care that's provided or arranged by the county.
Q. So that's a good distinction. I'm glad you

raised that. So am I correct that if somebody is arrested and is a drug abuser and has an addict, first they're going to likely be in county jail. Right?
A. Yes.
Q. And if -- if their experience -- if they're there for a day or two or three days, if they're experiencing significant withdrawal it's more likely to happen in the county jail. Is that right?
MR. LEONOUDAKIS: Objection.
Answer if you know.
THE WITNESS: I don't know but I would assume.
Q. (By Mr. Cheffo) With respect to any of those treatment records or intake forms or evaluations that are done at the county level, does the Department of Corrections, the State Department of Corrections have access to those, that information?
A. We have access to the documents that we receive from the county. In the -- in the situation that you specifically described of someone who may have been picked up on charges, be there four or five days, DOC would have no record of them ever being in county jail. We would only have record of people who are sentenced to our custody.
Q. Okay. I'm sorry. I didn't mean to cut you off.

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

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

See that on nine?
A. Right.
Q. Eight, sorry.
Medical provider will enter a note on each working day.
Do you see that?
A. Yes.
Q. And the QMHP and psychiatric provider will enter a note weekly.
Do you see that?
A. Yes.
Q. What's the QMHP?
A. Qualified mental health provider.
Q. And all these notes and records weekly, daily, you know, or more or less, where are they all maintained?
A. Electronic health record in DOC.
Q. For the patient, for the inmate?
A. Yes.
Q. So we talked a little bit about this but I think this is the policy, if you turn to Page 5, methadone treatment for pregnant inmate.
A. Yes.
Q. It says, the federal Narcotic Addict Treatment Act of 1974 restricts the use of methadone

in the treatment of opioid dependence to facilities that are appropriately licensed as a narcotic treatment program for maintenance of detox -- or detoxification with methadone.
Do you see that?
A. Yes.
Q. And that's I believe what you told us that you need to send out or get consult from an outside entity because the physicians or healthcare providers in the facilities are not licensed to prescribe methadone?
A. Correct.
Q. But your policy does go on. Right?
A. Uh-huh.
Q. It says, methadone can be provided without an institutional license for up to three days while arranging for an appropriate referral of the inmate to a licensed facility.
Do you see that?
A. Yes.
Q. And that would apply to men and women. Right?
A. Correct.
Q. So there is an ability for a physician to write methadone prescriptions for three days?

A. It's my understanding that based on the act that this section of policy was developed on, yes, that is correct.
Q. But in practice that never happens in the Department of Corrections' facilities, does it?
MR. LEONOUDAKIS: Objection.
THE WITNESS: To the best of my knowledge, no, it does not, unless they are pregnant females.
Q. (By Mr. Cheffo) And is there a certain rule that says healthcare provider, don't ever do this, or is it an unwritten rule around the institutions?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Again, without a policy or direction from the chief medical officer, I think it's something that we as an agency has not adopted as practice.
Q. (By Mr. Cheffo) I'm just trying to understand. You know, on the one hand, and help me understand this, you -- I think it's been the position that the Department of Corrections doesn't practice medicine and that you trust the judgment of your -- your doctors and your health care providers. Right?
A. Yes.
Q. And the ability for a healthcare provider to prescribe methadone for at least three days is not

restricted by law. Right? Correct?
A. Yes.
Q. Yet it's been your repeated testimony that there would have to be some change in policy or approval or recommendation by the chief, CMO or somebody else in order for a doctor or healthcare provider to do what they're able to do under law in their medical judgment and I'm trying to understand why that is.
MR. LEONOUDAKIS: Objection.
THE WITNESS: Well, just in terms of the way the policies, MSRMs are meant to be guidelines that better explain or expand certain practices. We don't have providers nor is the chief mental health officer -- excuse me, the chief medical officer engage in brain surgery. I'm sure there's probably regulations as to why they wouldn't do that. But in terms of having something like this, some type of medication assisted treatment where you're talking about medications of this type, historically the agency has adopted some framework of how that would work and not just all over the place for three days.
Q. (By Mr. Cheffo) This isn't brain surgery though. Right?
A. No.

Q. I mean, this is just methadone of which your healthcare providers are doing this for pregnant women. Right?
A. Our healthcare providers are not doing it for pregnant women. We're contracting that service out.
Q. Okay. But, I mean, do they -- do they literally leave the facility, the pregnant women?
A. Yes.
Q. And they go off site?
A. Yes. Two officers, transport, off site, medical care provided by the contractor, transported back to the facility, notes provided to the provider.
Q. And it can't be done inside the prison?
A. I don't believe it can be done based on the licensure issues that we discussed earlier. I believe our providers have the licensure to do it beyond the scope of the three days we're talking.
Q. But so, so what I'm hearing you say is that even though it says this here in terms of they can prescribe for three days, in fact, they really can't?
MR. LEONOUDAKIS: Objection, misstates the testimony.
THE WITNESS: They -- they don't.
Q. (By Mr. Cheffo) Even though they could for

three days. Right?
A. Methadone can be provided. In essence what we have done to date I believe is we are receiving the methadone from the clinic that the female has been attending while in county jail and that is administered by our staff for up to three days until we can coordinate the appointment with the contractor at which point in time they take over the dosing.
Q. Somebody said -- who ultimately, who would be the person to make the decision? If -- if you wanted to evaluate or the institution wanted to say we know other institutions are doing this, right, we don't historically do it, we know that there's certain guidelines out there including for some organizations that we are a member of and support, we'd like to evaluate this and change our policy, who would be the person to do that? Would it be the CMO?
A. It would be the chief medical officer and the chief mental health officer would both be expected to weigh in on that and provide input, insight into the development of a policy recommendation and a proposed budget in terms of what that program looks like, what segment of the population it would target.
Q. And how, how could something like that get on the desk of the CMO? Could a bunch of prisoners

ask that it be considered, would it be an outside law -- lawsuit, could it be public concerned citizens? How would it --

MR. LEONOUDAKIS: Objection.

THE WITNESS: Conceivably anyone can make that type of recommendation for his consideration.

Q. (By Mr. Cheffo) Okay. And are you -- have you ever had a conversation with him about whether that should be implemented?

A. No. Not in terms of specifics of should we adopt it and what it would look like.

Q. What have you -- have you talked to him at all about it?

A. In the context of preparation for this we know that other states certainly do offer it, some do, some don't, some do it outpatient as part of reentry, some do it earlier while incarcerated or during the period of incarceration and some like us don't do it at all.

Q. Did he give you any reason as to why he thinks from a medical perspective it would be a bad idea?

A. We didn't go that far into conversation.

Q. Did he say it would be a good idea?

A. No. We, again, didn't have that type of

conversation.

Q. Do you think that it would have a positive impact on people who are released from prison and reenter into the community if they had a way of addressing their abuse and addiction issues?

MR. LEONOUDAKIS: Objection, outside the scope.

You can answer.

THE WITNESS: Just from my personal perspective, sure, any type of treatment or educational services in general is designed to assist with reentry.

Q. (By Mr. Cheffo) So being a student of other policies, obviously you're not bound by them or guided by them, but other states, what are some of the experiences from the states that have done it that you think are lessons learned in a positive way?

MR. LEONOUDAKIS: Objection, it's outside the scope.

You can answer in your personal capacity.

THE WITNESS: And I don't know that I specifically read any specific research articles around it or reviewed anyone's specific policies. I know there are a couple states that have -- like I said, they do it from anywhere from thirty days to six or nine months prior to discharge. Some of them manage it in-house, some of them contract it out, some

of them do nothing more than set up the appointment or referral for the date of discharge. There seems to be a wide variety of how it's done. I don't know that I've seen or heard anyone really talk about longitudinally what -- what the overall impact is in terms of reducing opioid related deaths with segments of previous incarcerates. That's probably in the works somewhere but I don't know that I've seen it.

Q. (By Mr. Cheffo) With regard to any of those, the short term, the long term, Oklahoma doesn't do any of those. Right?

A. Not while incarcerated, no, or not as part of a reentry service.

Q. Would you say there's a trend towards medically assisted treatment in the states or a trend against it?

MR. LEONOUDAKIS: Objection, outside the scope.

THE WITNESS: Just from a -- a personal perspective, I'd say that there is more of a trend in the treatment community in general, not necessarily in the state, but towards medication assisted treatment.

MR. CHEFFO: Let's mark this, please, as -- I've marked it as 15.

(Deposition Exhibit Number 15 marked for identification purposes and made part of

the record.)

Q. (By Mr. Cheffo) I believe this is one the documents you may have referenced earlier?

A. Yes.

Q. Can you just tell us what it is?

A. This is an MSRM that was developed for the use of naloxone and Narcan.

Q. And what's the purpose of this document?

A. The intent is to provide some guidance for how to respond using naloxone or Narcan if an opioid overdose is suspected.

Q. Do you have any sense of how often Narcan is administered in the DOC facilities?

MR. LEONOUDAKIS: Objection.

THE WITNESS: Anecdotally I could tell you it's been used a couple of times. In terms of an actual number of count or actual count of the number, naloxone kits that are being used, those are reported to the Department of Mental Health and Substance Abuse Services. We received our nasal Narcan and training on how to use them from the Department of Mental Health and Substance Abuse Services. Prior, prior to that our naloxone was the injectable form.

MR. CHEFFO: It's warm in here, isn't it?

THE WITNESS: It's getting that way.

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

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

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

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

or e-mails with colleagues about ways to address opioid abuse or illicit fentanyl or carfentanil abuse in the prison system?

MR. LEONOUDAKIS: Objection, outside the scope of the testimony.

Answer in your personal capacity.

THE WITNESS: The only thing that immediately comes to mind are e-mails that I have had with internal staff as well as a staff member from Department of Mental Health and Substance Abuse Services through coordinating with them to go through naloxone training for our direct care staff and some nonuniform staff in facilities.

Q. (By Mr. Cheffo) You mentioned or you testified that the nalox -- I'm sorry, the methadone program for pregnant inmates began with essentially a real life person, a woman who I guess was incarcerated who was pregnant and that caused you to evaluate your policies or programs with respect to drug assisted treatment for pregnant women. Is that right?

A. Correct.

Q. How long ago was that?

A. Within the last 12 months or so.

Q. So that policy we read earlier was new, the one about drug assisted treatment for pregnant women?

A. Are you referring to Exhibit 14?

Q. Yes, sir.

A. The portion about the methadone treatment for pregnant inmates was specifically new there.

Q. And I don't need any details about the specific patient or inmate, but just tell me what -- help me understand how that process came to be as best as you can recall it. In other words, she -- she came to a facility, she either made it known that she was pregnant or it was obvious and she was I guess abusing medicines or taking methadone?

MR. LEONOUDAKIS: Objection.

THE WITNESS: We -- we have a provider who works at the Mabel Bassett assessment and reception center, which is our site for female receptions in the state, that's where everybody goes to when they're coming into our custody, who was also at the time working part time in the county jail from which she was received. So, he had knowledge of the fact that she was slated to come into our custody a few days prior to her reception and that she was actively receiving methadone treatment through some program prior to her sentencing and shipment.

Q. (By Mr. Cheffo) And then that started the process?

A. That started the conversation because he had a conversation with the chief medical officer who alerted me and then the roundtable discussions of how that could be dealt with.

Q. Who else was involved in the decision to implement that program or policy?

A. The chief mental health officer had input into it as well.

Q. You, the CMO and the chief mental health officer?

A. Yes.

Q. Anyone else?

A. If you're talking specifically about the medical service resource manual since that serves as sort of an addendum and attachment, it did not have to circulate outside for a full stakeholder review. So, yes, it was primarily in-house in health services division.

Q. Okay. Can you just look at the document? The American Correctional Association and the American Society of Addiction Medicine, are you familiar with that organization?

A. ACA, yes, ACAM, yes.

Q. Okay. And this is a relatively recent document, March 20th, 2018?

A. Yes.

Q. Do you see the one, two, the third paragraph below the heading, it says in quotes, ACAM is pleased to join ACA in releasing this important statement which makes clear that justice involved individuals should have access to the same evidence based treatment options that are available in traditional healthcare settings? Do you see that?

A. Yes.

Q. Do you agree with that?

MR. LEONOUDAKIS: Objection.

THE WITNESS: It's a policy statement that was adopted by ACA and ACAM. I don't -- I don't have an issue with the statement.

Q. (By Mr. Cheffo) Okay. Do you agree with it?

A. Sure.

Q. Do you think that the DOC complies with that statement?

MR. LEONOUDAKIS: Objection.

Q. (By Mr. Cheffo) Strike that.

Do you think the DOC has policies and procedures that are fully consistent with that statement?

MR. LEONOUDAKIS: Objection.

THE WITNESS: I think the DOC has policies and

procedures that govern the deliverance of a constitutional level of care to all the inmates in our jurisdiction. I believe we specifically have a policy that addressed methadone treatment for pregnant females.

Q. (By Mr. Cheffo) And the next page, there's a joint public correctional policy on the treatment of opioid use disorders for justice involved individuals. Do you see that?

A. Yes.

Q. It says 17 to 19 percent of individuals in America's jails and state prison systems have regularly used heroin or opioids prior to incarceration. While release from jail and prison is associated with a dramatic increase in death from opioid overdose among those with untreated opioids use disorder, there are considerably -- considerable data to show the treatment with opioid agonists and partial agonists reduce deaths and improve outcomes for those with opioids use -- opioid use disorders.

Do you see that?

A. Uh-huh.

Q. Preliminary data suggests that treatment with an opioid agonist could also reduce overdose. As a result, a 2017 bipartisan Presidential Commission on

Combating Drug Addiction and the Opioid Crisis has recommended increased usage of medications for addictive treatment, MAT, in correctional settings.

Do you see that?

A. Yes.

Q. These are both legitimate well recognized organizations, aren't they?

A. Yes.

Q. Do you agree with the introduction paragraph I just read?

MR. LEONOUDAKIS: Objection.

THE WITNESS: Yes.

Q. (By Mr. Cheffo) Is it consistent with the policies of the DOC?

MR. LEONOUDAKIS: Objection.

THE WITNESS: In such that we've adopted a procedure to address pregnant females, yes.

Q. (By Mr. Cheffo) Is that what you think this means?

A. Well, certain there are -- there -- both organizations provide policy statements on what they recognize as best practices in the field.

Q. So you would agree with me that if we were to talk to the people who wrote this that this is broader than applying methadone to pregnant women.

Right?

A. Yes.

MR. LEONOUDAKIS: Objection.

Q. (By Mr. Cheffo) So in that regard it would be inconsistent with the current policies and procedures of the Oklahoma Department of Corrections?

A. I do not believe that the Department of Corrections has a policy that is as broad as the policy statement and recommendations made by the ACA and ASAM.

Q. The only consistency and overlap would be with respect to pregnancy inmates. Right?

A. Yes.

Q. And then there's also on the next page, I'm sorry, two pages, sir, C.

A. Yes.

Q. Do you see the reentry and community supervision considerations?

A. Yes.

Q. Can you just read to yourself, take as much time as you need, one, two and three and let me know if the DOC has policies that are consistent with those considerations?

MR. LEONOUDAKIS: Object to this as outside the scope.

But you can answer.

THE WITNESS: With respect to reentry in general and to the extent that the inmate tells us legitimately where they are discharging to, any type of referral can be made. To the extent community supervision occurs it is still possible within the State of Oklahoma to release without any type of community supervision. So you can flat discharge a sentence. When that occurs there is limited oversight or coordination that DOC can provide. So, with those two caveats stated, repeat the question for me one more time.

Q. (By Mr. Cheffo) I was basically just asking you if looking at these you believe that the DOC current policies and procedures are fully consistent with one, two and three of the recommendations of the organizations that we've been talking about?

MR. LEONOUDAKIS: Objection, outside the scope.

You can answer in your personal capacity.

THE WITNESS: The existing policies that I am familiar with that are within regard to reentry do not get this specific as they pertain to this type of treatment.

(Deposition Exhibit Number 17 marked for identification purposes and made part of

the record.)
Q. (By Mr. Cheffo) This is my second to last document, sir. This is 17. Have you seen this document in connection with your preparation?
A. Yes.
Q. What is it?
A. It's the operational policy for care of the actively dependent inmate.
Q. And in Section B it's medical detoxification and tapered withdrawal. Do you see that?
A. Yes.
Q. Do you know what tapered withdrawal means?
A. It means they are decreasing the amount of medication that's being prescribed.
Q. Does -- does the DOC engage in medical detoxification and tapered withdrawal?
A. We specifically do with pregnant females. Once the female has delivered they are tapered in conjunction with the contract provider and the chief medical officer. Beyond that if we received someone who was actively detoxing the process would be similar with the chief medical officer and attending physician would determine what was necessary and relating back to the MSRM that's referenced they could be sent out for hospitalization if necessary.

Q. And to the extent that that happened there would be records of that. Right?
A. In the electronic health record.
Q. Okay.
(Deposition Exhibit Number 18 marked for identification purposes and made part of the record.)
Q. (By Mr. Cheffo) This is 18. Have you seen this document in connection with your preparation?
A. Yes.
Q. And what is it?
A. It's the policy for outside providers for healthcare management.
Q. What -- what's the purpose of this document?
A. When medical needs require -- when an inmate's medical needs are -- excuse me, inmate whose medical needs require health related services not available at the DOC or primary medical contract provider will have treatment and/or hospitalization made through an outside community provider. When referral for community specialist care is warranted, the indication will fall within the four levels of care described below.
Q. One of the levels is on Page 4, medically necessary. Do you see that?

A. Yes.
Q. And the determination of medical necessity is a determination that's made internally by the medical staff. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: By the facility medical provider.
Q. (By Mr. Cheffo) Who would -- is that typically? Is it a doctor or --
A. It can be a midlevel or a doctor.
Q. When you say midlevel --
A. Physician's assistant or doctor.
Q. So, if there's a question about med -- whether something is medically necessary, either a physician's assistant or a staff physician makes that determination. Right?
A. Yes.
Q. And if there's a question I guess they could seek consult from the chief medical officer?
A. Well, essentially they by policy initiate a request electronically. And then that request is sent to the regional physician who supervises that physician within 24 hours for approval or disapproval.
Q. The idea of -- of determining medical necessity is something that's pretty common for healthcare professionals in the Department of

Corrections, isn't it?
MR. LEONOUDAKIS: Objection.
THE WITNESS: To the extent we have policy written on it, yes.
Q. (By Mr. Cheffo) And, I mean, it's something that they're expected to know and be able to make judgment calls and implement on a daily basis as necessary. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: It's certainly something that we expect them to assess and provide services.
Q. (By Mr. Cheffo) And they're able -- they should be able to do that within the scope of their general responsibilities. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: And within the scope of what their licensure allows.
Q. (By Mr. Cheffo) Okay. And they to your knowledge they do that with frequency without ever having to consult the CMO. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Can you rephrase the question?
Q. (By Mr. Cheffo) Sure.
Nurse practitioners, physician's assistants, doctors, they make determinations about what's

medically necessary and what's not medically necessary on a regular basis as part of their regular job function without having to consult with the chief medical officer?

MR. LEONOUDAKIS: Objection.

THE WITNESS: Within the scope of how the policy is worded. If it's routine treatment provided to maintain a chronic or non -- nonlife threatening condition that can be reasonably delayed without risk of further complications, serious deterioration, significant pain or discomfort, yes.

Q. (By Mr. Cheffo) They -- they could also make a determination as part of their daily work as to whether a prescription is medically necessary. Right?

MR. LEONOUDAKIS: Objection.

THE WITNESS: Their prescribing capabilities are more closely tied to what's in the pharmaceutical op and what is in formulary.

Q. (By Mr. Cheffo) Okay. But assuming it's on formulary, the determination of whether a prescription is medically necessary for a patient is something within the sound discretion of the staff or line doctor or healthcare provider in a facility. Right?

MR. LEONOUDAKIS: Objection.

THE WITNESS: I would agree in general, yes.

Q. (By Mr. Cheffo) That's not something that requires CMO or outside panels or experts, right, that's something they do every day?

MR. LEONOUDAKIS: Objection.

Q. (By Mr. Cheffo) Is that right?

A. Are you talking generalities or are you talking specific?

Q. I'm talking generally. I'm not -- I'm not even talking about that document, I'm just talking generally.

MR. LEONOUDAKIS: Same objection.

THE WITNESS: State it again, please.

MR. CHEFFO: Sure.

Could you read it?

(The record was read as directed.

"Q. Okay. But assuming it's on formulary, the determination of whether a prescription is medically necessary for a patient is something within the sound discretion of the staff or line doctor or healthcare provider in a facility. Right?

MR. LEONOUDAKIS: Objection.

THE WITNESS: I would agree in general, yes.

Q. (By Mr. Cheffo) That's not something that requires CMO or outside panels or experts, right, that's something they do every day?")

THE WITNESS: Prescribing what's within the scope of their practice, licensure and based on what's on the agency formulary, yes, is within the scope of their practice.

Q. (By Mr. Cheffo) Does the -- does the Department of Corrections have a policy about allowing pharmaceutical sales reps to come into the facilities to talk to doctors or detail?

A. There's not a policy about it, but no one can just walk in off the street and access anyone. There are fences, perimeter, a reception area, security protocol similar to what you go through at the airport in order to get into the facility and no one gets to just show up unannounced.

Q. Do you -- do you believe that the doctors who prescribe medicines to inmates do so because they're using their best medical judgment or because they are somehow influenced by something that was told to them by a pharmaceutical sales rep?

MR. LEONOUDAKIS: Objection.

THE WITNESS: I could speculate, but certainly their medical judgment is part of it, but to what extent they may or may not talk to sales reps or other educators or anyone else that may influence their decision I don't know.

Q. (By Mr. Cheffo) You have no knowledge one way or the other?

A. I can tell you they don't access facilities.

Q. They don't?

A. The sales reps, no. I'd get a phonecall over that, so if someone showed up unannounced wanting to speak with a doctor in a facility.

Q. It's not the most welcoming environment?

A. It would be something unusual enough that it would raise a flag.

Q. And I take it you as the person who ultimately has supervision over the chief medical officer at least administratively, you have confidence and faith in the medical staff that's treating inmates of this state that they're performing their function in an honorable and ethical way to the best of their abilities. Right?

A. Yes.

Q. I mean, if you believe that doctors were prescribing medicines to inmates when they didn't need them, that would be something that would of concern to you, wouldn't it?

A. Yes.

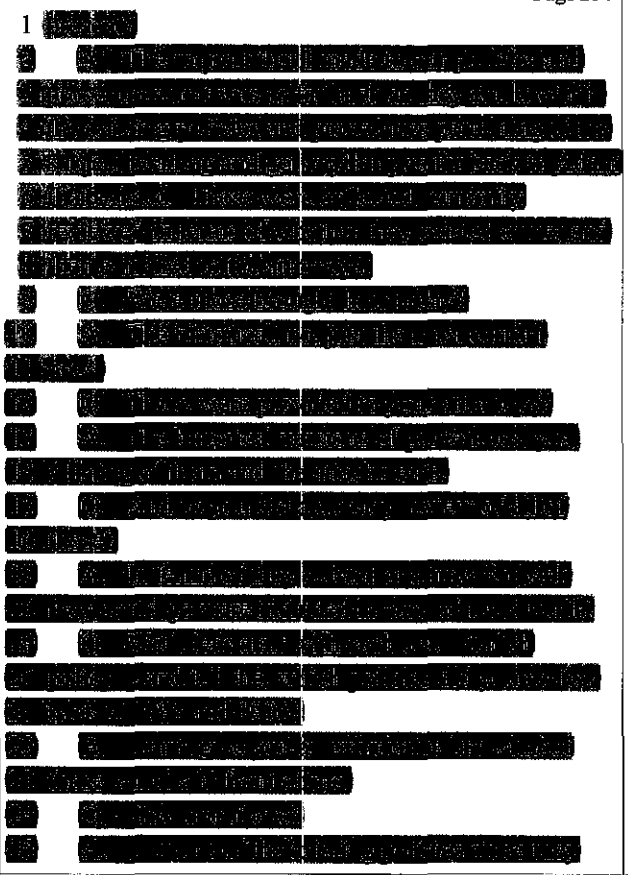
Q. And you would take action if you thought that there was some prescription that was written for

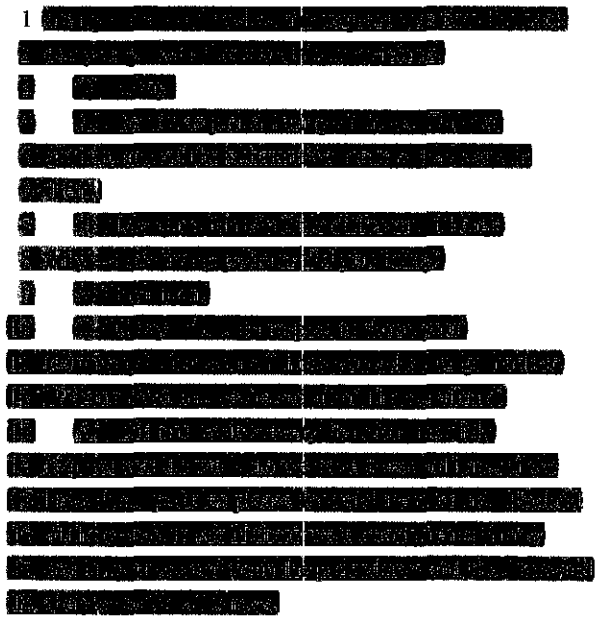
not a medically necessary purpose solely because of information that a third party gave a doctor. Right?
MR. LEONOUDAKIS: Objection.
THE WITNESS: As a just point of process, the only way I would likely know that is once the chief medical officer or the pharmacist knew it and brought it to one or the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

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

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

from our procedures unit that were the historical versions back to the point that they had those available.
Q. [redacted]
Q. To the substance of those documents?
A. Yes. Of course, more familiar with whatever their current form is.
Q. Okay.
MR. LEONOUDAKIS: No further questions. Thank you.
THE WITNESS: Okay.
REDIRECT EXAMINATION
BY MR. CHEFFO:
Q. So you said now that you are -- you thought the relevant timeframe was 1995 to -- or 1996 to the present?
MR. LEONOUDAKIS: Objection.
THE WITNESS: Yes.
Q[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

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. LEONOUDAKIS: 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. LEONOUDAKIS: 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. LEONOUDAKIS: 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

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

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

their clinical judgment are allowed to provide treatment to the inmate population.

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

(Deposition concluded at 3:40 p.m.)
(Signature required; witness excused.)

CERTIFICATE OF DEPONENT

I have read the foregoing transcript of my deposition and except for any corrections or changes noted on the errata sheet, I hereby subscribe to the transcript as an accurate record of the statements made by me.

_____
CLINT CASTLEBERRY

SUBSCRIBED AND SWORN before and to me this ____ day of _____, 20___.

_____
NOTARY PUBLIC

My Commission expires:

ERRATA SHEET
VERITEXT LEGAL SOLUTIONS
330 OLD COUNTRY ROAD
MINEOLA, NEW YORK 11501
516-608-2400
NAME OF CASE: STATE OF OKLAHOMA vs. PURDUE PHARMA
DATE OF DEPOSITION: SEPTEMBER 5, 2018
NAME OF DEPONENT: CLINT CASTLEBERRY

PAGE	LINE(S)	CHANGE	REASON

_____
CLINT CASTLEBERRY

SUBSCRIBED AND SWORN TO BEFORE ME
THIS__DAY OF _____, 20__.

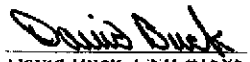
_____ _____
(NOTARY PUBLIC) MY COMMISSION EXPIRES:

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.

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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

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September 17, 2018

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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.

EXHIBIT E

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 knowledgably (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,

Ross Leonoudakis

Cc: Counsel of record for Defendants