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Gastroenterology
General Surgery
Internal Medicine
Midwifery
Neurology
Obstetrics & Gynecology
Plastic Surgery
Urology

November 12, 2019

Rocky Anderson
Judge Building
Eight East Broadway, Ste 450
Salt Lake City, UT 84111

To Whom It May Concern:

WITNESS QUALIFICATIONS

My name is Tae Kim. I am a board-certified colon & rectal surgeon practicing with Intermountain Healthcare in Salt Lake City, UT. I received my medical degree from the University of Nevada School of Medicine. My general surgery residency was at the University of Utah. I completed my colon & rectal surgery residency at Western Pennsylvania/Allegheny General Hospital in Pittsburgh, PA. I have been practicing at LDS Hospital within the Intermountain Healthcare System for the past 11 years. I serve as the Chair of Surgery at LDS Hospital. I am the medical director for the GI Oncology program for the Intermountain Healthcare System. I have had vast experience in understanding, diagnosing, and treating peritonitis in my medical education, surgical training, extensive reading, and my treatment of hundreds of patients with peritonitis. I am the Chair of Western USA Committee for the International Society of University Colon & Rectal Surgeons. I am a clinical instructor with the St. Mark's Health Care Foundation Colon & Rectal Surgery Residency. I am an editorial reviewer for Diseases of Colon & Rectal Surgery and World Journal of Colorectal Surgery. Enclosed please find my CV.

I have published the following articles:

- Swords DS, Brooke BS, Skarda DE, Stoddard GJ, **Tae Kim H,** Sause WT, Scaife CL. Facility Variation in Local Staging of Rectal Adenocarcinoma and its Contribution to Underutilization of Neoadjuvant Therapy. *Journal of Gastrointestinal Surgery.* 2019 Jun; 23(6):1206-1217.
- Swords DS, Skard DE, Sause WT, Gawlick UT, Cannon GM, Lewis MA, Scaife CL, Gygi JA, **Tae Kim H**. Surgeon-level Variation in Utilization of Local Staging and Neoadjuvant Therapy for Stage II-III Rectal Adenocarcinoma. *Journal of Gastrointestinal Surgery*. 2019 Apr; 23(4):659-669.
- Bagshaw H, Sause W, Gawlick U, **Kim H**, Whisenant J, Cannon G. Vulvar Recurrences After Intensity-modulated Radiation Therapy for Squamous Cell Carcinoma of the Anus. *Am J Clin Oncol.* 2018 May;41(5): 492-496.
- **Kim H**, Bruen K, Vargo D. Human Acellular Dermis in the Management of Complex Abdominal Wall Defects. *Am J Surg* 2006; 192(6): 705-9.

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OTHER CASES IN WHICH I HAVE TESTIFIED

I have testified or provided consultation as an expert or a fact witness in the following cases:

a. *Ghekiere vs. Mortensen*, Montana Eighth Judicial District Court, Cascade County; No. CDV-17-0632
b. *Young vs. Grace,* Montana Medical Legal Panel; Helena, Montana; Claim No. 1802
c. Barbara Jensen, deposition on 10/26/12, (Lawyer contact: Anne Armstrong) (Utah)
d. *Blanke v Trowbridge*, Case No. 150900827, 3rd District Court, State of Utah
e. *Jensen v. Intermountain Health Care, Inc.,* Case No. 150900735, 3rd District Court, State of Utah
f. *Dicenzo v. Stewart*, Case No. 160900823, 3rd District Court, State of Utah

COMPENSATION

My compensation for review of documents, consultations, preparation of this report, and providing expert testimony in the matter of *Ostler v. Harris, et al.* is $500 per hour.

FACTS AND DATA CONSIDERED IN FORMING MY OPINIONS

I have received and reviewed medical and other records from the Law Offices of Rocky Anderson in regard to Lisa Marie Ostler. These records include the following:

A. Event timeline, summary narrative, (proposed) second amended complaint totaling 162 pages.
B. Salt Lake County Metro Jail Shift Logs 3/29 – 4/2. Incident Log 3/30-4/2. Control Room Shift Log 4/1-4/2.
C. Medical records from Office of Medical Examiner, Salt Lake County Metro Jail/Pearl Clinic, and Intermountain Medical Center.
D. Defendants' answers to Plaintiffs' interrogatories
E. Defendants' answers to Plaintiffs' requests for admissions and reformulated requests for admission.
F. Letter from Bridget Romano, dated October 4, 2019.
G. Inner Facility Movement History.
H. Three depositions of Richard Bell.
I. Deposition of Kristine N. Pugh.
J. Deposition of William J. Harris.
K. Deposition of Colby Grey James.
L. Deposition of Nicole Danielle Bates.
M. Deposition of Holly Patrice Harris.
N. Deposition of Todd Allan Booth.
O. Deposition of Brent Lee Tucker.
P. Deposition of Zachary Frederickson.
Q. Deposition of Todd R. Wilcox, MD.

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R. Deposition of Heather Beasley.
S. Deposition of Bradley K. Lewis, MD.
T. Deposition of Ronald Seewer, Jr.
U. Deposition of Scott Sparkuhl.
V. Deposition of Alisha C. Woodruff.
W. Deposition of Kellie Marie Sheppard.
X. Deposition of Jason Power.
Y. Deposition of Nathan Dean, MD.
Z. Deposition of Samuel Brown, MD.
AA. Deposition of Todd Riser, RN.
BB. Deposition of Matthew Dumont.
CC. Deposition of Kathy Berrett.
DD. Deposition of Pamela Ulmer, DO.
EE. Videos of Lisa Ostler in unit 5C on March 31 and April 1 and in unit 8C on evening of April 1.
FF. "Managing Opiate Withdrawal: The WOWS Method," by Todd Wilcox, MD, MBA, CCHP-P, CCHP-A.
GG. Salt Lake County Jail Medical records of Timothy Kukuchka, Duwayne Cotter, Loralie Querbach, Dustin Bliss, Casie Christensen, Angie Turner, and Melissa Montoya.

In addition to my review and consideration of the facts and data contained in the documents described above, I considered the following facts and data, which were provided to me by Plaintiff's counsel and conform with my review of the documents, in forming my opinions in this matter:

1. Lisa Ostler was booked into the Salt Lake County Metro Jail ("Jail") in the early morning of 3/30/2016. (SLCo Ostler 000017.)

2. Lisa Ostler underwent a "Pre-screen Examination" and "Comprehensive Nurse Examination" dated 3/30/2016. (SLCo Ostler 000128 – 000130.) Those examinations included the reporting of, among other findings, the following:
    a. "Level 3" medical acuity rating for "multiple medical issues,"
    b. Positive risk factors for withdrawal from Xanax, heroin, and prescription opiates,
    c. Temperature of 98.3 degrees Fahrenheit,
    d. Blood pressure of 115/75,
    e. Respiratory rate of 15 per minute,
    f. Oxygen saturation of 99%,
    g. Height of 69 inches,
    h. Weight of 124 pounds,
    i. Body mass index of 18.3,
    j. Tobacco use,
    k. Heroin use,
    l. Methamphetamine use,
    m. Dental findings of "broken/missing,"

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n. Rectal neuropathy,
o. Spondyloarthritis,
p. History of gastric bypass surgery in 2006,
q. Abscesses on right breast and right anterior chest,
r. Victimization through "violent abuse/assault," domestic violence, and "sexual abuse/assault/rape,"
s. Post-traumatic stress disorder.

3. Lisa Ostler was placed on the Wellcon Opiate Withdrawal Scale ("WOWS") protocol due to her history of heroin use and prescription opioids. (SLCo Ostler 000129, 000155, 000214.)

4. Lisa Ostler was placed on the Clinical Institute Withdrawal Assessment ("CIWA") protocol due to her use of prescription Xanax. (SLCo Ostler 000129.)

5. Both the WOWS and CIWA protocols required assessments twice daily for a minimum of five days. ("Managing Opiate Withdrawal: The WOWS Method," by Todd Wilcox, Medical Director, Salt Lake County Jail.) On 4/1/2016, Lisa Ostler was provided those assessments only once (if, in fact, the assessments, including monitoring of vital signs, were done at all on 4/1/2016), in the morning. (SLCo Ostler 000155–000156.) Defendants admit that the Jail was required to provide Lisa Ostler each of those assessments twice on April 1, 2016. (Defendants' Answers to Plaintiffs' Reformulated Requests for Admissions Nos. 6 and 7.)

6. As reflected in emails sent on 3/30/2016 between Brad Stoney, Dr. Brad Lewis, and Paula Braun (SLCo Ostler 000142 – 000145), medical staff at the Salt Lake County Metro Jail verified that Lisa Ostler had active prescriptions for Prilosec, Lexapro, Gabapentin, Adderall, Xanax, Oxycodone, Norco, and Ambien.

7. Paula Braun ordered a "librium taper for bzd w/d" on 3/30/2016. (SLCo Ostler 000144.)

8. Dr. Brad Lewis noted on 3/31/2016 as follows: "The patient was on a verified dose of Prilosec. We will go ahead and order 40 mg p.o. daily for this medication." (SLCo Ostler 000214.)

9. The medical record indicates that Lisa Ostler was not provided Prilosec while she was incarcerated. While Prilosec is included on her medication administration chart, that document indicates that Prilosec was never administered to Lisa Ostler. (SLCo Ostler 000151 – 000152.)

10. Dr. Brad Lewis also noted on 3/31/2016 as follows: "The patient was also on oxycodone and Norco. Due to the nature of these medications and we are not a chronic pain or withdrawal facility and neither one of them have been filled since December 2015, request for both have been denied. The patient will be placed on WOWS as a precaution." (SLCo Ostler 000214.)

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11. Dr. Brad Lewis also noted on 3/31/2016 as follows: "Apparently the patient is on Lexapro, gabapentin, Adderall, Xanax, and Ambien. All of these are referred to Mental Health as the patient is on them for posttraumatic stress disorder, depression, or attention deficit disorder, insomnia." (SLCo Ostler 000214.) Nothing in the medical record reflects that any member of the mental health staff followed up regarding these medications for Lisa Ostler. Her medication administration chart reflects that those medications were not ordered and that she was not provided any of these medications. (SLCo Ostler 000151 – 000152.) The medical record reflects that no follow-up was provided regarding those medications and none of them were ever administered to Lisa Ostler.

12. Lisa Ostler's vital signs on the morning of 3/31/2016 were recorded as follows: blood pressure of 106/76, heart rate of 119 beats per minute, temperature of 98.1 degrees Fahrenheit, respiratory rate of 16 breaths per minute, and oxygen saturation of 97%. (SLCo Ostler 000155, 000156.)

13. The "Intoxication and Withdrawal" policy of the Salt Lake County Jail states that "signs of withdrawal" include "[h]eart rate greater than 110" and that a registered nurse "will" "[n]otify the physician immediately for signs of withdrawal." (SLCo Ostler 001717 – 001718.)

14. In violation of the "Intoxication and Withdrawal" policy, the medical record does not reflect that any physician was informed that Lisa Ostler's heart rate significantly exceeded 110 on the morning of 3/31/2016.

15. Todd Riser, RN, testified, as the designated witness for Salt Lake County, as follows (Deposition of Todd Riser, 122:7–12):

    Q. And at least according to written policy, with a heart rate over 110, the physician should be notified immediately; correct?
    A. Correct.
    Q. But that wasn't the practice?
    A. That's correct.

16. Richard Bell testified, as the designated witness for Salt Lake County, as follows (Deposition of Richard Bell, May 20, 2019, 109:13 – 21.)

    Q. Right. But if there's a sign of withdrawal, which would include a heart rate greater than 110, a physician is to be immediately contacted?
    A. That's what it says, yes.
    Q. All right. And that's the one thing that's in this written policy that you don't actually do at the Salt Lake County Jail; correct? You don't strictly comply with that?
    A. Yes.

17. Lisa Ostler's vital signs on the afternoon of 4/1/2016 were recorded as follows: blood pressure of 89/68, heart rate of 133 beats per minute, temperature of 98 degrees Fahrenheit, respiratory rate of 16 breaths per minute, and oxygen saturation of 97%. (SLCo Ostler 000155, 000156.)

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18. Nothing in the medical record reflects that a physician was notified about Lisa Ostler's heart rate of 133, in violation of the "Intoxication and Withdrawal" policy.

19. The medical record reflects that no follow-up whatsoever was performed regarding Lisa Ostler's troubling vital signs on 4/1/2016.

20. At approximately 6:26 p.m. on 3/31/2016, Officer Grant noted as follows:

> Prisoner Ostler, Lisa SO# 236212 (5C04B [Lisa's cell number]) came over to the officer station and asked me if I knew were [sic] Claudia was and that she is supposed to be going to a wedding with her. I told prisoner Ostler that I didn't know a Claudi [sic]. Prisoner Ostler returned to her cell. I contacted MH worker Esther and informed her about prisoner Ostler. She said that she would come down and talk with her.

(SLCo Ostler 000098.)

21. At 6:33 p.m. on 3/31/2016, mental health professional Esther Israel noted as follows:

> Met with Lisa for a crisis call. Officer reported he had a strange interaction with her when she got up from sleeping and asked where Claudia was because they need to go to a wedding.

(SLCo Ostler 000153.)

22. The medical record reflects that no follow-up was performed regarding the change in Lisa Ostler's mental status evidenced by the incident of Lisa Ostler speaking about Claudia and a wedding.

23. Lisa Ostler's purported vital signs were recorded on the morning of 4/1/2016 as follows: blood pressure of 105/75, heart rate of 95 beats per minute, temperature of 97.6 degrees Fahrenheit, respiratory rate of 18 breaths per minute, and oxygen saturation of 95%. (SLCo Ostler 000155, 000156.)

24. Video records reflect a woman (who is seen entering and leaving Lisa Ostler's cell in Unit 5C) displaying the following characteristics and behaviors at the following approximate times:

3/31/2016 8:55 a.m.	She walks slowly, bent forward, holding her abdomen.
3/31/2016 8:56 a.m.	She bends over at the waist while waiting to see a nurse.

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3/31/2016	9:10 a.m.	She walks to a nursing cart while bent forward and holding her abdomen. She continues to hold her abdomen and remains bent forward while waiting in line and speaking to a nurse.
3/31/2016	2:33 p.m.	She speaks to a nurse and bends forward at the waist.
3/31/2016	2:42 p.m.	She is walking slowly while bent forward, holding her abdomen. She sits down while waiting to be seen by a nurse. She then stands in line waiting to be seen, during which time she bends forward several times and holds her abdomen. While speaking with the nurse, she appears to use her hands to direct the nurse's attention to her abdomen.
4/1/2016	8:29 a.m.	She bends forward several times while sitting down and waiting to be seen by a nurse. She is hunched forward while walking back to her cell.
4/1/2016	8:56 a.m.	She walks slowly to the nurse while holding her abdomen with a hunched forward posture. She returns to her cell, appears to pick up a piece of paper, which she then appears to give to the nurse.
4/1/2016	9:04 a.m.	She leaves her cell with a bundle of white clothing or linen, hunched forward, with her head down. She lays on the floor and moves very little for nearly forty-five minutes.
4/1/2016	9:49 a.m.	She stands up along with other detainees to leave the unit and holds her abdomen.

25. Video records reflect a woman, identified by Kellie Sheppard as Lisa Ostler, in Unit 8C displaying the following characteristics and behaviors at the following approximate time:

4/1/2016	11:10 p.m.	She leaves her cell for clothing exchange, walking slowly, holding her abdomen. She appears confused as she wanders in the wrong direction, away from her cell.

26. There are no records reflecting that Lisa Ostler consumed any food or liquids from March 31, 2016, until she was found unresponsive and not breathing on the morning of April 1, 2016.

27. The medical records reflect that nothing was done to assess whether Lisa Ostler was adequately hydrated.

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28. Jail logs reflect that Lisa Ostler did not receive a breakfast tray on 3/31/2016. (SLCo Ostler 000096.)

29. Jail logs reflect that Lisa Ostler did not receive a lunch tray on 3/31/2016. (Officer Shift Log, SLCo Ostler 000097.)

30. Jail logs reflect that Lisa Ostler refused her lunch tray on 4/1/2016 because she was "sick." (Officer Shift Log, SLCo Ostler 000111.)

31. Jail logs reflect that Lisa Ostler refused her breakfast tray on 4/2/2016. (SLCo Ostler 000116.)

32. Officer Zachary Frederickson recorded in his log, at approximately 6:38 a.m. on 4/2/2016, that it was reported to him by detainees that "Prisoner Ostler (236212) has not eaten since she arrived in the unit yesterday." (SLCo Ostler 000117.) Lisa Ostler was transferred to that unit, Unit 8C, at approximately 10:00 a.m. on 4/1/2016. (SLCo Ostler 002510.)

33. Lieutenant Kathy Berrett, designated to testify on behalf of Salt Lake County, testified that a Housing Officer was to send an e-mail each time a detainee did not take a meal tray; that Salt Lake County failed to preserve at least four e-mails reflecting that Lisa Ostler did not take her meal tray; and that those emails were expected to contain the communications from Lisa Ostler to the Housing Officers about why she was refusing the meal trays. (Deposition of Kathy Berrett, 50:1–51:23.) Ms. Berrett also testified it was the custom at the Jail to deliberately not preserve "transitory e-mails," which included the e-mails about detainees' missed meals, even when instructed by the District Attorney's Office to preserve all e-mails relating to a particular detainee. (Deposition of Kathy Berrett, 91:3–25.)

34. The WOWS and CIWA assessment forms for Lisa Ostler reflect that Lisa was given one bottle of Gatorade each on the morning and afternoon of March 31, 2016. All other dates and times for Lisa Ostler's WOWS and CIWA assessments reflect either a blank or zero in the space for "# of Gatorade given." (SLCo Ostler 000155–000156.)

35. Nurse Esther Israel noted on March 31, 2016, at 6:33 p.m. that there "were three bottles of Gatorade in [Lisa Ostler's] cell, one of them was spilled on the floor." (SLCo Ostler 000153.)

36. Nurse Todd Riser testified on behalf of Salt Lake County as follows:

    Q. And both CIWA and WOWS protocols require vitals to be taken twice a day for five days?

    A. Yes.

    (Todd Riser Deposition, 41:15–17)

37. Todd Wilcox, Medical Director of the Salt Lake County Jail, stated in his article, "Managing Opiate Withdrawal: The WOWS Method," as follows: "In my facility, any patient undergoing

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opiate withdrawal is assessed twice per day for a minimum of five days by nurses who have been trained in the WOWS protocol."

38. Lisa Ostler's purported vital signs were recorded on 4/1/2016 only once, around 8:00 a.m. (SLCo Ostler 000155 – 000156.) The medical record reflects that Lisa Ostler's vital signs were not recorded from that time until after she was found unresponsive and not breathing in her cell on the morning of April 2, 2016.

39. The medical record reflects that Lisa Ostler was not given WOWS or CIWA assessments on the afternoon or evening of April 1, 2016, and, instead, a circled "3" is noted on the WOWS and CIWA forms, erroneously indicating that she was unavailable for the assessment even though she was available in her cell, having been moved from Unit 5C to Unit 8C on the morning of April 1, 2016. (SLCo Ostler 000155–000156, 002510.)

40. Officer Todd Both recorded on 4/1/2016 at approximately 3:25 p.m. in his shift log the following: "Nurse Ron is in the unit for medication pass and diabetic check, Prisoner Ostler, Lisa so#26212 complaining of pain. Nurse Ron examined prisoner Ostler and cleared her to stay in the unit." (SLCo Ostler 000112.)

41. Nothing was recorded in Lisa Ostler's medical record reflecting anything about any purported interaction between "Nurse Ron" and Lisa Ostler on the afternoon of 4/1/2016.

42. Nurse Ron Seewer testified that he does not "have any recollections about Lisa Ostler" and has "no recollection whatsoever of anything" that he did concerning Lisa Ostler. (Deposition of Ron Seewer, 42:24–25, 46:1–4, 93:14–24.) He further testified that if he measured her vital signs he would have entered them on the medical records; that he does not recall examining Lisa Ostler; that if he examined her, he would have charted the examination in the medical record; and that he did not chart any examination of Lisa Ostler or any conclusion he drew about her condition. (Deposition of Ron Seewer, 50:14–51:4; 78:4–14; 171:20–172:20; 174:24–175:4.) The officer shift log reflects that Nurse Ron Seewer was in Unit 8C to pass medications and to perform diabetic checks on 4/1/2016. (SLCo Ostler 000111–000112.)

43. Nurse Ron Seewer testified that it was not his responsibility to provide the second set of WOWS and CIWA assessments for Lisa Ostler on 4/1/2016. (Deposition of Ron Seewer 100:7–13.) Todd Riser testified that it was the responsibility of the "pod nurse" to provide those assessments. (Deposition of Todd Riser, 96:9–97:17) The Health Services Unit Daily Assignment Log indicates that "Disa" was the nurse assigned to C Pod on 4/1/2016. (SLCo Ostler 030924.) However, counsel for Defendants state that relevant records contain "no indication 'Disa' provided services in that pod on that day" and that the log is not treated "as a reliable or official log." (Letter from Bridget Romano, dated October 4, 2019.) Nurse Ron Seewer provided services in that pod on that day. (SLCo Ostler 000112.) Ron Seewer was not subject to any discipline or corrective action relating to his failure to perform the WOWS and CIWA assessments for Lisa

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Ostler on the afternoon of 4/1/2016, but he was "coached" "just to make sure his documentation is there." (Richard Bell Deposition, May 20, 2019, 53:11–18.)

44. Officer Todd Booth testified that he does not "recall anything on that day [April 1, 2016];" that to his knowledge he did not have any view as to whether Lisa Ostler was withdrawing from drugs; and that he knew Lisa Ostler had been sick, refused her lunch tray, and was complaining of pain. (Deposition of Todd Booth, 39:9–40:9, 68:3–24.) There is no description in the shift log of what examination took place and there is nothing in the medical records reflecting anything about such an examination or that such an examination took place. (SLCo Ostler 000112.)

45. Detainee Nicole Bates testified that she remembered "more than one inmate" trying to get a guard's attention, who she believed was Officer Todd Booth, to let him know that "something wasn't right" with Lisa Ostler and that "she needs medical attention." She further testified that the guard responded by saying "mind your own fucking business and leave her alone," telling them Lisa Ostler already "knew to put a sick call in to see triage in the morning," and threatening that the detainees would not continue to have time out of their cell if they did not mind their own business. (Nicole Bates Deposition, 51:15–54:13.) Todd Booth noted in his log, at 4:39 p.m. on April 1, 2016, that he "had to tell [the detainees] twice to quiet down" and that "[p]risoners will lose one hour of their recreation time out of their cells." (SLCo Ostler 000112.) Nicole Bates also testified that Summer Johnson spoke to Todd Booth about Lisa Ostler and he responded by saying he would take away Summer's job if she did not mind her own business. (Nicole Bates Deposition, 67:11–25.)

46. Detainee Nicole Bates testified that on other occasions she has heard Todd Booth say "what the fuck are you standing over there for," "you guys are just a bunch of fucking drug addicts," and "get the fuck away from my desk" and that he has taunted her about being away from her kids while she is incarcerated. (Nicole Bates Deposition, 66:2–67:10). Todd Booth admits saying things like "get away from my fucking desk." (Todd Booth Deposition, 48:23–25.)

47. In a separate incident, when Angie Turner sought help from a guard because she believed she was having a stroke, the log of Officer Ryan Giles reflects that he "told her not to act like an asshole towards" him and that it took 13 minutes from the time she began screaming until a nurse arrived in the unit. (SLCo Ostler 012785.) Angie Turner soon thereafter died from a stroke. (SLCo Ostler 026477.)

48. Nurse Ron Seewer testified that he uses the Jail's desktop computers to access the internet "probably every day;" that he watches television shows or YouTube videos while on the job, sometimes alone and sometimes with other nurses; that nurses watching television shows or YouTube videos at the Jail is fairly common and occurs on a daily or almost daily basis; that he has seen nurses watch videos or surf the internet for "an hour or two" on a day; that he has spent an hour or two watching videos at the Jail on a single day; and that he does not know of

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any policy applicable to nurses watching videos on the job. (Ron Seewer Deposition, 20:12–23:25.)

49. Former Sheriff James Winder testified that throughout his tenure as Sheriff he had received complaints of nurses sometimes spending hours outside of their break time engaging in entertainment; that he had conversations "on several occasions" to address that issue; that he received complaints from "inmates, visitors, and other staff members" about that issue; that the issue occurred for a fairly long period of time and continued even after he attempted to "put an end to it;" that he attempted to address the issue with "road officers and their MDTs," "office staff," and "Housing Officers, et cetera;" and that it was "an ongoing issue." (James Winder Deposition, 128:8–131:9.) Richard Bell testified that he "wouldn't encourage [nurses] watching movies" and does not know about television shows. (Richard Bell Deposition, March 25, 2019, 115:8–116:10.)

50. Detainee Nicole Bates testified that when Lisa Ostler was transferred into Unit 8C at approximately 10:00 a.m. on 4/1/2016 "she was really frail, sickly looking," "[t]here wasn't really an expression on her face," and "[s]he just looked down, had her stuff in her hand, her bedroll." (Nicole Bates Deposition, 45:20–46:2.)

51. Detainee Alisha Woodruff testified that when Lisa Ostler was transferred into Unit 8C at approximately 10:00 a.m. on 4/1/2016 she "looked dead," "it was kind of scary," "she looked just like a skeleton," her skin was "gray," she was "hunched over," "she didn't come out of her cell," she was "rocking" on her bed, and the other detainees in the unit were talking about the fact that "she needed help." (Alisha Woodruff Deposition, 7:16–8:22.)

52. Detainee Nicole Bates testified that on 4/1/2016, after dinner, Lisa Ostler "was sitting on her bed with her -- she was sitting with her legs up to her -- both legs up to her, holding her stomach going like this, like moaning, crying." (Deposition of Nicole Bates, 47:13–16.)

53. Detainee Nicole Bates also testified as follows about how Lisa Ostler appeared on 4/1/2016:

> And [s]he was holding herself, sitting on her bunk rocking back and forth moaning and crying, like she was in severe pain. And I tapped on her glass. I was like, hey, are you okay? I didn't get no response from her. She didn't even seem like she -- like she didn't acknowledge me at all. It didn't even seem like she heard me or anything. That was when we were told by the officer to mind our own fucking business and to leave her alone.

(Deposition of Nicole Bates, 52:21–53:6.)

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> She seemed more like she was suffering from pain, a severe pain than she was anything else. It didn't seem like she was withdrawing from anything. It seemed like she had more abdominal pain, like something abdominally was bothering her severely.

(Deposition of Nicole Bates, 55:19–23.)

54. Detainee Alisha Woodruff testified that on 4/1/2016 Lisa Ostler "didn't move around a lot," "was rocking back and forth," appeared to be in a lot of pain, "looked miserable," "didn't get up," "just sat on the edge of her bed," looked more sick than anyone Ms. Woodruff had seen in her life, looked "horrible," "didn't look coherent at all," looked "much worse" than someone withdrawing from heroin, was "gray" in color, "was always hunched over," "looked awful," "looked like death," and "looked dead." (Alisha Woodruff Deposition, 7:16–8:22, 10:21–11:19, 13:7–14:4, 15:23–16:14, 21:22–22:16, 23:3–8, 34:4–14, 38:18–39:1). Alisha Woodruff was worried when she saw Lisa Ostler that she looked like she might die. (Alisha Woodruff Deposition, 10:21–11:19.)

55. Detainee Kellie Sheppard testified that on 4/1/2016 Lisa Ostler had "yellowish" "really pale" skin, "looked very weak and sick," appeared desperate, appeared to be in agonizing pain, was rocking back and forth on her bed, and held up her hands and said to Sheppard "please help me." (Deposition of Kellie Sheppard, 7:5–13, 7:23–8:7, 8:10–23, 9:6–14.)

56. Scott Sparkuhl, who was employed to work in the jail's Central Control, testified as follows:

> When I came on shift [on the evening of 4/1/2016], we were given a briefing -- I was given a briefing from my panel that included information about Lisa Ostler as someone who had been repeatedly calling in for medical care, medical attention. I'd been told that she'd been doing this for several days and that she had seen nurses and doctors and medical staff, and they'd all checked her out and said that she was coming off of heroin, and that was the information I had on my account on shift.

(Deposition of Scott Sparkuhl, 41:16–25.)

> I contacted the Deputy the first time she [Lisa Ostler] called in to make sure that he was aware of the situation, and I asked him how he wanted to respond, and he said, "Go ahead and ignore the cell," . . . .

(Deposition of Scott Sparkuhl, 51:6–10.)

57. Scott Sparkuhl also testified "it didn't seem odd" to be instructed to ignore Lisa Ostler's communications and "that's the way" he "was trained to handle situations." (Deposition of Scott Sparkuhl, 101:22–102:7.) He testified that he had experienced "a dozen or so" prior instances

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where Housing Officers instructed him to ignore a detainee's calls when the detainee was reporting experiencing a serious medical problem and needing medical help. (Deposition of Scott Sparkuhl, 67:20–68:6.)

58. Scott Sparkuhl also testified that through the night of 4/1/2016 into the morning of 4/2/2016 he received communications from Lisa Ostler about her pain and her need for medical treatment "many times that night," "perhaps once or twice an hour," which amounted to approximately 16 separate occasions. In those communications, Lisa Ostler "said that she was in pain" and "was requesting medical." (Deposition of Scott Sparkuhl, 40:18–41:11, 45:12–18, 49:10–14.) Mr. Sparkuhl also testified that during the same night a detainee communicated with him about her concern for Lisa Ostler's medical problem and another detainee communicated with him to complain about the noise Lisa Ostler was making. (Deposition of Scott Sparkuhl, 69:22–70:6, 70:11–23, 72:25–73:19.)

59. Scott Sparkuhl testified that no record is maintained of the contents of shift briefings for Central Control operators or of the communications between detainees and operators. (Scott Sparkuhl Deposition, 42:24–44:2, 66:14–22.) He testified that after Lisa Ostler's death, the practice changed in that operators were then required to log when they were ordered to ignore communications from certain detainees if there were repeated calls. (Scott Sparkuhl Deposition, 66:22–67:5.)

60. Officer Holly Harris was the guard responsible for supervising the unit in which Lisa Ostler was housed on the "graveyard" shift the night of 4/1/2016. Ms. Harris stated in her answers to interrogatories that "[a] few of the female prisoners were concerned about her [Lisa Ostler], so I called the nursing staff and had asked about Lisa Ostler" and that the nurse informed Ms. Harris that Lisa Ostler's "vitals were taken a few hours prior and her vitals were good." (Holly Harris Answers to Interrogatories Nos. 2 and 22.) However, the medical record reflects that the last time Lisa Ostler's vital signs purportedly had been recorded was approximately 15 hours prior to the exchange described by Ms. Harris. (SLCo Ostler 000155–000156.) Nothing in the medical record or shift log corroborates Ms. Harris's account of communicating to a nurse. Ms. Harris did not log anything about Lisa Ostler or any purported call to a nurse. (SLCo Ostler 000114–000116.) She testified it is her normal practice to log when she communicates to a nurse about a detainee. (Deposition of Holly Harris, 83:6–85:1.)

61. In his answers to interrogatories, Officer Zachary Frederickson stated the following regarding the beginning of his shift, at approximately 6:00 a.m. on 4/2/2016:

> I recall that I was told there was an inmate in 8 Charlie that had been asking for medical help all night. I was informed she constantly pushed her intercom button asking for a nurse. I was also told that medical had been down several times over the course of the night and she had been evaluated and cleared to remain in her housing unit.

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* * *

> [Inmate workers] did tell me about Ms. Ostler refusing her meals. I also spoke with another inmate while walking along the top tier. I do not recall her name either, but she was concerned about Ms. Ostler and told me she had been yelling for help all night.
>
> * * *
>
> The Deputy from grave yard shift tells me I had 64 inmates and no issues other than a female in cell 16 who had been asking for medical all night. I was told then she had been assessed by medical and cleared.

62. Officer Zachary Frederickson testified that Officer Holly Harris briefed him on the morning of 4/2/2016 by saying "you've got a woman in [Lisa Ostler's cell] who's been crying and screaming all night." (Deposition of Zachary Frederickson, 100:21-101:6.)

63. Officer Zachary Frederickson testified he spoke with Summer Johnson, a detainee, on the morning of 4/2/2016 before Lisa Ostler was found unresponsive and not breathing and that Ms. Johnson told him that "[Lisa Ostler] had been yelling out of her cell for help all night long," that "nobody was doing anything," and that Ms. Johnson was "really worried" about Lisa Ostler.

64. During the night of 4/1/2016, Lisa Ostler left her cell during clothing exchange. Detainee Nicole Bates testified that Lisa Ostler "was incoherent," "stumbling," "having a hard time," and "struggling to even be moving;" that "her color wasn't right;" that "[s]he didn't really seem like she knew where she was;" that "she couldn't understand why she was being yelled at;" that "[s]he looked like she was in a lot of pain;" that "she was "crouched down" and "walking really slow, kind of stumbling over her feet" and "holding her clothes to her stomach;" that she looked like "[s]he was in pain somewhere in her abdomen;" that she looked "grayish" in color, similar to the nightgowns given to detainees. (Deposition of Nicole Bates, 49:1–7, 49:14–50:25.)

65. Detainee Nicole Bates testified that during the night of 4/1/2016 and early morning of 4/2/2016 she could hear Lisa Ostler "crying all night long," "crying for help, moaning," and saying "something is not right, something is wrong with me, I really need Medical, I'm in pain." (Deposition of Nicole Bates, 61:16 -62:25, 68:11–24). Ms. Bates also testified that during the same night Officer Holly Harris was "extremely rude to Lisa [Ostler]," kicked her window, yelled at her, threatened to "write her up for misusing Medical," and told her "you shouldn't do drugs" and "something along the lines of you shouldn't come to jail if you don't want to be sick." (Deposition of Nicole Bates, 61:16–62:25.)

66. Detainee Kellie Sheppard testified that during the night of 4/1/2016 and early morning of 4/2/2016 she could hear Lisa Ostler "screaming, saying 'help me' throughout the night," that her screams were loud and sounded "as if she was in agonizing pain," that Lisa Ostler was "shrieking," that Ms. Sheppard had never heard anyone scream like that before, that it was

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obvious to Ms. Sheppard that Lisa Ostler was in pain and needed emergency medical help, that Ms. Sheppard was worried Lisa Ostler "wasn't going to make it through the night," and that she never saw a nurse come down to help during the night. (Deposition of Kellie Sheppard, 21:7–16, 21:23–22:13, 22:18–24, 25:5–27:9, 73:6–74:1.) Ms. Sheppard also testified that a detainee told Officer Holly Harris that "[Lisa Ostler]'s going to die" and that Ms. Harris's response was, "Well, don't do drugs." (Deposition of Kellie Sheppard 17:3-14.)

67. Nothing in the medical record reflects that anything was communicated to any medical staff about Lisa Ostler's cries, screams, and numerous calls for help during the night of 4/1/2016 and the early morning of 4/2/2016.

68. According to the shift log written by Officer Zachary Frederickson, after Officer Zachary Frederickson started his shift on the morning of April 2, Nurse Brent Tucker came to Unit 8C for diabetic checks at approximately 6:34 a.m. on 4/2/2016. (SLCo Ostler 000116 -000117.) Officer Frederickson mentioned to him that Ms. Ostler had been hitting her emergency button intercom "all night." (Deposition of Zachary Frederickson, 190:22–25.) Yet Nurse Tucker did not even go to see and evaluate Ms. Ostler or, if he did go to her cell, he did no medical evaluation of her whatsoever. Nothing reflects that Nurse Tucker went to Lisa Ostler's cell.

69. Officer Zachary Frederickson stated in his answers to interrogatories that on the morning of 4/2/2016 he spoke with Lisa Ostler "about why she hadn't been eating and urged her to try to eat something at lunch time" and that he "told her that [eating] would help her feel better and that her body needed food to get her through her sickness." (Zachary Frederickson Answer to Interrogatory No. 2.)

70. Officer Zachary Frederickson also stated in his answers to interrogatories that Lisa Ostler told him "she had some vaginal bleeding," that he "placed a call to medical to inform them," and that he was told medical staff "were aware of Ms. Ostler and that unless she was having a medical emergency then she would need to fill out a Sick Call Request Form and turn it in when they made their rounds." (Zachary Frederickson Answer to Interrogatory No. 2.) During the call by Frederickson to Nurse Tucker, Frederickson only told Tucker that Ms. Ostler had missed some meals and had complained of vaginal bleeding. He did not say anything about his knowledge that Ms. Ostler screamed out in pain all night, repeatedly asked for medical help, rang her emergency button and spoke over the intercom to Central Control all night, and exhibited obvious signs of abdominal pain, or that other inmates had expressed their urgent concerns about Lisa's medical condition, their fear that she would die without medical assistance, and the fact that no medical assistance had been provided.

71. Dr. Samuel M. Brown, who provided care to Lisa Ostler at Intermountain Medical Center after she was transferred from the jail, noted as follows: "While it's not entirely clear what caused the arrest, her request for medical assistance was by report regarding vaginal bleeding. [W]e haven't seen any here." (Ostler 001264.)

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72. Dr. Pamela Ulmer, who performed the autopsy of Lisa Ostler, testified that Lisa Ostler "didn't have any vaginal bleeding." (Deposition of Pamela Ulmer, 158:14–15.)

73. Officer Zachary Frederickson stated in his interrogatory answers as follows: "I told Ms. Ostler about the sick call request form and placed one in her cell for her to use. She thanked me." (Zachary Frederickson Answer to Interrogatory No. 22.)

74. Officer Frederickson stated in his answers to interrogatories that he "also told [medical] that [Lisa Ostler] had not eaten for a few meals" and that he was told by Nurse Brent Tucker that it "would not be considered a serious concern until 72 hours had passed." Officer Frederickson further stated in his answers that he notified his supervisor about his interactions with Lisa Ostler and that his supervisor told him "just to keep an eye on her." (Zachary Frederickson Answer to Interrogatory No. 2.)

75. Matt Dumont, designated by Salt Lake County to testify on its behalf, testified that no training is provided to Housing Officers regarding what information they are to provide to medical staff relating to detainees' requests for medical assistance. (Deposition of Matt Dumont, 60:21–24.) He further testified that it was in conformity with policy for Officer Zachary Frederickson to only tell Brent Tucker that Lisa Ostler had missed some meals and was experiencing vaginal bleeding and to refrain from telling him that Lisa Ostler had been asking for medical help all night, that she had been pressing her emergency button all night, and that another detainee was worried that Lisa Ostler might die. (Deposition of Matt Dumont, 170:5–22.)

76. Nurse Brent Tucker described his interaction with Officer Zachary Frederickson as follows:

> I was working C-pod on 4/2/16 and received a radio call to call 8c, I called the unit and the officer stated that he has a female that is c/o vaginal bleeding and not eating her meals. I asked the officer if the bleeding was from her menstrual, he replied he did not know. I asked him to ask her and then looked up this individual and saw she was W/D from ETOH and Drugs which explains why this pt. may not want to eat. I then asked if there was any visible blood from her bleeding or any excessive blood on her. The officer said no, the current time was about 0715-0730 the triage nurse had not been through the unit yet and the Nurse instructed that the officer have the pt fill out a SCR as the unit would likely be triaged in the next 30 minutes and I would check on her during my medication pass. I then finished preparing for my medication pass and went to start passing Charlie meds, triage came through 8c and the pt refused to fill out SCR for and denied triage, around 0745 and 0755. Not shortly later I was in 2 c and an emergency response was called to 8c to this pt and she was unresponsive.

(SLCo Ostler 026515.)

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77. Zachary Frederickson stated in his interrogatory answers that Brent Tucker asked him "[i]s [Lisa Ostler] having a medical emergency?" and that his answer was "that it did not appear to be one." (Zachary Frederickson Answer to Interrogatory No. 22.)

78. Nurse Colby James noted that while he was in Unit 8C shortly before Lisa Ostler was found unresponsive and not breathing, that Zachary Frederickson stated Lisa Ostler "was told to place a [sick call request] form in for her medical concerns" and "she had told him that she did not want to." Colby James further noted that he told Zachary Frederickson if Lisa Ostler "had a medical emergency to contact medical and if she had a triage kite [he] would take it at that time." (SLCo Ostler 026514.)

79. Nurse Colby James did not walk the several yards from where he was on the morning of April 2, 2016, to see Lisa Ostler, speak with her, or evaluate or monitor her. (Deposition of Colby James, 93:15–94:25.)

80. Richard Bell testified that the customs of the Jail allowed Colby James to refrain from walking over to Lisa Ostler's cell to check on her, even if he was informed that she had been crying out in pain, was begging for medical treatment, and hitting the emergency button all night long and that an another detainee had expressed concerns that Lisa Ostler was going to die and had not been provided any medical treatment. (Deposition of Richard Bell, May 20, 2019, 220:2–222:1.)

81. Richard Bell testified that he would "not necessarily" expect that if a nurse is made aware of an inmate screaming out in pain and requesting medical treatment that that would be included in the medical record. (Deposition of Richard Bell, March 25, 2019, 179:15–20.)

82. Nothing in Lisa Ostler's medical record reflects that a physician ever saw, monitored, diagnosed, treated, or examined Lisa Ostler after she was brought to the jail on 3/29/2016 until after she was found unresponsive and not breathing on 4/2/2016.

83. Nothing in Lisa Ostler's medical record reflects that a nurse ever saw, monitored, or examined Lisa Ostler, or referred her for monitoring, examination, or treatment from the time she first entered Unit 8C on the morning of April 1, 2016, until she was found unresponsive and not breathing on the morning of April 2, 2016.

84. Richard Bell testified, as the designated witness for Salt Lake County, that determining whether abdominal pain is an emergency is "a collaborative effort between the inmate and the officer;" that if it appears to the officer that the detainee's medical complaint may be an emergency then the housing officer is to contact a nurse to immediately assess the detainee; that the officer is "going to have to make" the determination of whether the detainee is experiencing an emergency "based on their observations;" and that "[i]f the patient just appears to be really in distress, they could look at other objective criteria[,] [a]nd if the patient appears to be

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unresponsive, close to it, incoherent, you know, just various observations, they will—they're instructed to call medical." (Deposition of Richard Bell, May 20, 2019, 84:5–85:7.)

85. Richard Bell further testified on behalf of Salt Lake County that what information about a detainee's medical complaint is communicated to a nurse "would be the officer's decision to make," including that an officer could, in accordance with custom at the Jail, decide *not* to convey to a nurse that the officer learned the "inmate had been calling out in pain and begging for medical treatment all night long" and "hitting her emergency button several times."

86. Richard Bell testified that if an inmate is crying out in pain and asking for medical help, nurses are not always expected to check it out. (Deposition of Richard Bell, March 25, 2019, 180:6–19.)

87. Richard Bell testified that when Lisa Ostler was sick and in pain and calling out for help, she could have been triaged on April 2, 2016, and then seen a doctor, which would have occurred, if at all, after she was found unresponsive and not breathing in her cell. (Deposition of Richard Bell, March 25, 2019, 215:3–19.)

88. Richard Bell testified that Lisa Ostler was not medically assessed or examined because, based on his review, he "wouldn't see that it would raise to that level." (Deposition of Richard Bell, March 25, 2019, 209:23–210:7.)

89. Richard Bell testified that even now, knowing that Lisa Ostler died of peritonitis and that she was found unresponsive and not breathing in the Jail, she did not have a "serious medical need" when she was in Unit 8C of the Jail. (Deposition of Richard Bell, March 25, 2019, 122:3–19.)

90. Medical records from Intermountain Medical Center ("IMC") indicate that Lisa remained unconscious; unresponsive to voice, sternal rub, and pain; and had no corneal reflexes. (Ostler 001250–001264.)

91. The Medical examiner's report stated the immediate cause of Lisa Ostler's death was peritonitis due to a perforated gastrointestinal ulcer. It also reported peritoneal effusion of 1000 ml, described as a "cloudy red-brown fluid." (Ostler 001270, 001273.)

92. The Jail conducted a "Morbidity and Mortality" review relating to the death of Lisa Ostler, the purpose of which is "to determine the appropriateness of custody and medical's emergency response actions surrounding the death" and "to assess the appropriateness of medical care received prior to the death." (SLCo Ostler 001596.) Richard Bell testified that at the time of the review of Lisa Ostler's death, he did not know Lisa Ostler's cause of death and that he could not think of a reason why a further review was not conducted once her cause of death was learned. (Richard Bell Deposition, March 25, 2019, 71:10–16, 73:15–22.) Richard Bell testified that no one was interviewed in connection with the morbidity and mortality review of Lisa Ostler's death. (Richard Bell Deposition, March 25, 2019, 65:5–11, 77:10–25.) Richard Bell also testified it was

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"correct" that there is no report or document generated by the entire Morbidity and Mortality review process. (Deposition of Richard Bell, May 20, 2019, 111:25–112:5.)

93. Lisa Ostler's Jail medical record contained the following errors:

(a) On March 30, 2016, Lisa Ostler's respiration rate was recorded as being 98 breaths per minute. (SLCo Ostler 000155.)

(b) On March 30, 2016, Lisa Ostler's oxygen saturation rate was recorded as being zero. (SLCo Ostler 000155.)

(c) On the afternoon of March 31, 2016, Lisa Ostler's resting heart rate of 133 beats per minute was scored as a "2" on the WOWS worksheet, even though a resting heart rate at or above 110 beats per minute was required to be scored as a "4." (SLCo Ostler 000156.)

(d) The times recorded in the electronic medical record for her CIWA and WOWS assessments and the monitoring of her vital signs do not reflect the actual times those assessments and monitoring occurred. (SLCo Ostler 000124, 000127, 000155–156.)

(e) On April 2, 2016, Lisa Ostler's weight was recorded as 200 pounds. (SLCo Ostler 000123, 000126.)

(f) In violation of written policies requiring documentation in the medical record about "communication with outside resources that might have relevant information about the patient," nowhere in the medical records is there any mention of highly relevant information, including communications between Officer Zachary Frederickson and Nurse Brent Tucker regarding requests for medical help for Lisa Ostler, information provided by Frederickson to Nurse Colby James that Lisa Ostler had a "medical condition" to which there was no medical follow up, and any communication, if there were one, from Officer Holly Harris to any nurse about Lisa Ostler on the night of April 1, 2016.

(g) The CIWA assessment form contains blanks for the afternoon of March 31, 2016, where information was supposed to be noted regarding Lisa Ostler's (i) signs and symptoms of tremor; (ii) signs and symptoms of paroxysmal sweats; (iii) signs and symptoms of anxiety; (iv) signs and symptoms of agitation; (v) signs and symptoms of tactile disturbances; (vi) signs and symptoms of auditory hallucinations; (vii) signs and symptoms of visual disturbances; (viii) signs and symptoms of headache; (ix) orientation to time, place, and person; and (x) total CIWA score. (SLCo Ostler 000155.)

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(h) Lisa Ostler's electronic medical record does not include the majority of her substance withdrawal assessments and nearly all of the measurements of her vital signs were not entered in the electronic medical record as text or displayed within the graphical representation of her vital signs. (SLCo Ostler 00123–127)

(i) Lisa Ostler's electronic medical record does not include any information about why no one recorded her vital signs or recorded CIWA and WOWS assessments on the afternoon of April 1, 2016, or the morning of April 2, 2016.

94. Richard Bell testified that at the Morbidity and Mortality review of Lisa Ostler's death, no errors were noticed in the medical records (Richard Bell Deposition, March 25, 2019, 143:6–14), notwithstanding that the score on the CIWA assessment form for Lisa Ostler's resting pulse was marked as "2" rather than "4+" (144:191–145:21); notwithstanding a notation of a zero oxygen saturation (which would mean the patient is dead) (146:16–147:12); notwithstanding that, in violation of jail policy, no vital signs were taken after April 1, 2016, at approximately 8:00 a.m. (148:7–149:11); notwithstanding two erroneous entries for respiratory rate (149:17–151:4); and notwithstanding the omission of the total CIWA score at 2:50 p.m. on April 1, 2016 (151:6–10).

95. Salt Lake County provided nurses a training presentation titled "Nursing Documentation" which stated, in part, as follows:

Protect the organization and other disciplines . . .
Use appropriate terms – "altercation with officers" vs "beat up by officers"

* * *

[Documentation Should] Not implicate others for failures / mistakes

* * *

Steer clear of words associated with errors
Terms such as "by mistake," "accidentally," "somehow," "unintentionally," and "miscalculated" are bonus words to a plaintiff's attorney.
Don't use a term that suggests an error was made or that a patient's safety was in jeopardy.

* * *

A patient was given Norco 10/325 when he was ordered Norco 5/325

You could chart "Pt was given Norco 10/325 mg 1 tab PO for back pain. Dr. Wilcox was notified but gave no orders. Patient's vital signs remained stable.

This entry would let other healthcare professionals who looked into the chart know that the patient was overmedicated without calling undue attention to it.

* * *

Avoid reporting staffing problems.

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Don't refer to staffing shortages in a patient's chart

* * *

Don't chart that you informed a colleague of a situation if you only mentioned it.

(SLCo Ostler 025305–025306, 025309–0253111.)

96. Richard Bell, the Responsible Health Authority at the Jail, testified regarding the training of nurses to create medical records as follows:

Q. So if a pod nurse failed to provide medications, you teach your nurses at the jail not to include in the medical record a statement that the pod nurse failed to provide medications?

A. Correct.

(Deposition of Richard Bell, May 20, 2019, 100:6–10.)

Q. Is it the custom of the Salt Lake County Jail also to train nurses not to use words that are associated with errors?

A. Yes.

(Deposition of Richard Bell, May 20, 2019, 100:13–16.)

Q. . . . I'm asking about errors in the treatment of the patient. Nurses at the Salt Lake County Jail are trained to steer clear of words associated with errors?
A. Yes.
Q. And they're also trained not to use any terms that suggest that an error was made or that a patient's safety was in jeopardy?
A. Yes. That suggests, yes.

(Deposition of Richard Bell, May 20, 2019, 101:6–15.)

97. Housing officers are not trained to recognize abdominal pain or the signs or symptoms of serious abdominal medical conditions. (Deposition of Zachary Frederickson, 20:14–21:11; Deposition of Matthew Dumont, 57:16–18.)

98. The medical records of numerous other detainees at the Jail reflect that nurses did not perform WOWS and CIWA assessments twice per day for five days, in violation of physician orders and official policy. The Jail's failures to provide all required WOWS and CIWA assessments include the following:

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a. Timothy Kukuchka. WOWS assessment was ordered on 8/28/14 (SLCo Ostler 003328, 3347) but was only performed once on 8/29/14 and twice on 8/30/14. Only 3 of 10 assessments were completed.

b. Duwayne Cotter. CIWA assessment was ordered on 8/21/12 by Dr. Wilcox (SLCo Ostler 003722, 003917-21, 4072-76) but was only performed 7 times from 8/22/12 - 8/25/12. Only 7 of 10 assessments were completed. In a separate period of incarceration, WOWS assessment was ordered (SLCo Ostler 003699, 003779, 003993). He was booked on 5/21/15. WOWS was only performed once on 5/23/15 and once on 5/24/15.

c. Chris Bybee. CIWA assessment was ordered on 11/6/2012 (SLCo Ostler 29654-29656). On 11/9/2012, only one assessment was performed. No assessments were performed on 11/11/12. In total, only 7 of 10 assessments were completed.

d. Loralie Querbach. Loralie was incarcerated numerous times, with many documented failures by the Jail to perform all WOWS and CIWA assessments.

CIWA assessment was ordered on 6/5/17 for alcohol abuse (SLCo Ostler 004478,4911). She was booked on 6/5/17. CIWA was only performed twice on 6/9/17 (SLCo Ostler 4794–95).

WOWS assessment was ordered on 2/19/16 (SLCo Ostler 004533-34, 4935-36). The assessment was performed just 4 times of 10 on 2/19, 2/21, and 2/2. She refused one assessment on 2/23.

WOWS assessment was ordered on 2/5/16 (SLCo Ostler 004536, 4937). She was booked on 2/5/16. The assessment was performed 3 out of 7 times (she was discharged on 2/9/16, less than five days after the WOWS assessment was ordered).

WOWS assessment was ordered on 12/1/15 (SLCo Ostler 004550, 4945). The assessment was performed 4 times of 10.

WOWS assessment was ordered on 9/22/15 (SLCo Ostler 004581, 4962). The assessment was performed 5 times of 10.

WOWS assessment ordered on 8/15/15 (SLCo Ostler 004591-93). 5 out of 10 assessments were performed.

WOWS assessment ordered on 10/21/14 (SLCo Ostler 004621-23, 4986-88). 6 out of 10 assessments were performed.

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WOWS assessment ordered on 9/10/14 (SLCo Ostler 4638-40, 4991-93). 5 out of 10 assessments were performed.

WOWS assessment ordered on 8/6/14 (SLCo Ostler 4657-59). 6 out of 10 assessments were performed.

WOWS assessment ordered on 5/24/14 (SLCo Ostler 4672-74, 4700, 5007-09). 4 out of 10 assessments were performed.

WOWS assessment ordered on 4/9/14 (SLCo Ostler 4701, 5021). 7 out of 10 assessments were performed.

CIWA assessment ordered on 1/14/14 (SLCo Ostler 4719). 6 assessments out of 10 were performed.

CIWA assessment ordered on 10/15/13 (SLCo Ostler 4736). 3 out of 10 assessments were performed.

CIWA assessment ordered on 9/17/12 (SLCo Ostler 4787-89, 5069-71). A total of 4 assessments were performed. No assessments were performed on 9/17, one was performed on 9/18, no assessments were performed on 9/19, one was performed on 9/20, and 2 assessments were performed on 9/21, at which time she was released.

e. Dustin Bliss. WOWS assessment ordered on 7/20/14 (SLCo Ostler 006329-31). 4 of 6 assessments completed for 7/20, 7/21, 7/22. Released 7/23.

f. Casie Christensen. CIWA assessment ordered on 2/26/13 (SLCo Ostler 006420-22). 5 of 10 assessments performed. In a separate period of incarceration, CIWA assessment ordered on 10/28/12 (SLCo Ostler 006427). No assessment was performed on 10/30/12, and she was released 10/31/12.

g. Angie Turner. CIWA assessment ordered on 1/3/12 (SLCo Ostler 008041-42). 6 of 10 assessments performed. In a separate period of incarceration, CIWA assessment was ordered on 7/8/16 (SLCo Ostler 008028-32). 7 of 10 assessments were performed. Only 1 assessment performed on each 7/9, 7/10, and 7/12.

h. Melissa Montoya. WOWS assessment ordered on 5/19/14 (SLCo Ostler 004218-19). Only 1 assessment was performed on 5/20 and only 1 was performed on 5/21.

EXHIBITS

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Any of the documents to which I have referred in this report may be used to summarize or support my opinions in this matter.

STATEMENT OF ALL OPINIONS TO BE EXPRESSED AND THE BASIS AND REASONS FOR THEM

The following is a complete statement of all opinions I will express at trial, which are based on the facts described above, my review of the case documents described above, and my education and experience:

1. There can be no question that Lisa was suffering from a serious, potentially life-threatening medical condition, a perforated ulcer and peritonitis, from at least March 31, 2016, until she was found unresponsive and not breathing on the morning of April 2, 2016. My opinion is based, at the very least, on a reasonable degree of medical certainty.

2. With appropriate monitoring and evaluation, Lisa's life-threatening medical condition would have been timely and accurately diagnosed and successfully treated, most likely saving Lisa's life. From at least March 31, 2016, forward, Lisa's signs and symptoms indicated Lisa should have been immediately and urgently taken to a hospital for further diagnosis and treatment. The perforation caused by Lisa's gastrointestinal ulcer could be repaired through surgery. To a reasonable degree of medical certainty, even though Lisa required surgery to repair the perforation, if Lisa had not suffered a cardiac arrest and the anoxic encephalopathy sequelae, there is nothing in her history or status that would have prevented her from recovering had she been admitted for surgery and other appropriate treatment prior to her cardiac arrest.

3. Because Lisa's life-threatening condition was not timely and properly diagnosed, it continually became worse. Her symptoms became so severe, by at least the time Lisa was moved from unit 5C to unit 8C around 10 a.m. on April 1, 2016, it would have been obvious not only to any trained medical person, but also to lay persons, that Lisa was suffering from significant pain and a serious medical problem that required urgent diagnosis and treatment. In fact, as indicated by Holly Harris, Zachary Frederickson, Nicole Bates, Kelly Sheppard, and Alisha Woodruff, it was obvious to other detainees that Lisa was suffering from significant pain and a serious medical problem that required urgent diagnosis and treatment.

   It is not possible that Lisa, while suffering from a perforated gastrointestinal ulcer and peritonitis, would not be exhibiting signs and symptoms of extreme abdominal pain. Neither is it possible that Lisa, suffering from peritonitis, would not be perceived as being in extreme pain, having a serious medical condition, and needing urgent medical attention.

   The fact that Lisa was experiencing severe abdominal pain and a serious medical problem that required immediate diagnosis and treatment, or urgent referral for diagnosis and treatment, has to have been evident to anyone, including other inmates and, especially, nurses or others charged with observing inmates and reporting medical problems to nurses or physicians. Included among the

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signs and symptoms indicating that Lisa was suffering from a serious medical problem were Lisa's bending over from the waist and holding her abdomen, as Lisa did several times from at least the time just before and after she had her vital signs checked on the morning of April 1, 2016, in unit 5C; sitting on the floor in unit 5C while other inmates were walking around, while Lisa was waiting to be transferred to unit 8C; her slow and tentative walking when she can be seen on video during the morning of April 1, 2016, and at clothing exchange on the evening of April 1, 2016, in unit 8C; her pale and gray complexion as noted by other inmates; her demeanor, as described by other inmates; Lisa's lack of movement outside of her cell in unit 8C, except during mandatory clothing exchange, which was unusual compared to the other inmates in Lisa's housing unit who are seen moving about the unit freely for many hours of the day; and Lisa's frequent moaning, groaning, "growling," and screaming out in pain, her cries for help, her begging for medical help, and her hitting her emergency button up to 16 times during the evening of April 1 and early morning of April 2, 2016, communicating to a person in Central Control at the Jail that she was in pain and needed medical help.

4. I work with healthcare professionals, including registered nurses, almost every day and am aware of their training and what they are expected to know, observe, and do. Anyone who has received medical training to become a nurse or a physician (had a physician been notified, as should have occurred) would have known that Lisa was extremely ill, would have known that she needed to be evaluated, monitored, and referred for diagnosis and treatment, and would have known how to evaluate her, including the monitoring of her vital signs, speaking to her about the location and severity of pain, palpating her abdomen, or even just bumping into her bed or her body to ascertain her response. The Defendants' actions and failures to act fell far below any applicable standard of medical care for any medical professional, could not have been the result of medical judgment, and reflect a deliberate indifference toward the serious medical needs of Lisa Ostler, specifically, and the serious medical needs of inmates, generally, at the Salt Lake County Jail.

5. Lisa died of peritonitis secondary to a gastrointestinal ulcer perforation near the site of her remote gastric bypass surgery. To a reasonable degree of medical certainty, Lisa's cardiac arrest was secondary to her perforated ulcer and peritonitis. A gastrointestinal ulcer starts by inappropriate gastric acid creating injury to the lining of the bowel. If left untreated, the ulceration erodes through the wall of the bowel to create a full thickness perforation. This allows for leakage of food, bacteria, digestive products, and digestive enzymes to be released into the sterile body cavity of the peritoneum, which houses most of the internal organs. When the peritoneum suffers an insult of this kind, peritonitis develops. A patient suffers from increasingly severe pain, followed by a worsening clinical condition as the inflammation/infection spreads. The body will react to the noxious stimulus by developing systemic inflammatory response syndrome. This is associated with increased heart rate, decreased blood pressure (at first, the blood pressure may be increased because of the onset of pain), increased or lowered body temperature; and, if allowed to progress, sepsis will develop. This is associated with mental status changes (such as the altered mental state manifested by Lisa Ostler when she spoke about meeting someone to go to a wedding), continually

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increasing pain, significant hemodynamic instability, and ultimately, if the patient is left untreated as Lisa was, death.

6. Gastrointestinal ulcers, when diagnosed appropriately, can simply be treated with an acid blocking medication, usually a proton pump inhibitor (*e.g.*, Prilosec). This medicine is readily available over the counter. Lisa was prescribed Prilosec before she entered the Jail and a Jail physician ordered that it was to be provided to her while she was in Jail. However, Prilosec was never provided to Lisa. The Medication Verification Sheet confirms Prilosec, an acid blocking medication, was one of the medications ordered to be provided to Lisa. Per the Medication Sheet, Prilosec was listed as "APR" under the column "Hour" with a circled "3". The Medication Sheet explanation of code states a 3 as not given because inmate not in cell. There is no explanation for the code "APR," but it appears to be referencing the month of April. These records reflect that Lisa did not receive any of the Prilosec that was ordered for her. That is tragic as this medication could have prevented the progression of the gastrointestinal ulcer to perforation, which ultimately caused Lisa's suffering and death.

7. The most common symptom of gastrointestinal ulcers is abdominal pain. As the ulcer progresses, it will perforate the peritoneal wall, which is very painful. Then, as fluid travels into the peritoneal cavity, patients with a perforated ulcer like Lisa's uniformly experience increasingly excruciating pain if left untreated. On a pain scale of 1 – 10, my clinical experience is that such patients report pain between an "8" and a "10." There can be no mistaking that a person with peritonitis, particularly after it has progressed, is in tremendous pain, is suffering from a serious medical condition, and requires urgent medical attention. To fail to provide or obtain medical attention for a person suffering from peritonitis, particularly that that person is incarcerated or otherwise unable to obtain medical treatment on her own, would be cruel and, at the least, deliberately indifferent.

8. The prognosis for a perforated ulcer is inversely related to the time of diagnosis and intervention. Delay in diagnosis and treatment results in rapidly escalating hypotension, metabolic acidosis, acute renal failure, exponentially increased pain, and likelihood of death. Per Rhodes et al. Surviving Sepsis Campaign: International Guidelines for Management of Sepsis and Septic Shock: 2016. Intensive Care Med (2017) 43:304–377: "Infectious foci suspected to cause septic shock should be controlled as soon as possible following successful initial resuscitation. A target of no more than 6–12 h after diagnosis appears to be sufficient for most cases. Observational studies generally show reduced survival beyond that point... Therefore, any required source control intervention in sepsis and septic shock should ideally be implemented as soon as medically and logistically practical after the diagnosis is made." My clinical experience and numerous studies demonstrate that delay in diagnosis leads to worse outcomes.

9. As stated above, the prognosis for a perforated gastrointestinal ulcer is inversely related to the time of diagnosis and intervention. Accordingly, Lisa had the greatest chance of a full recovery had she been provided an appropriate medical assessment and intervention on March 31, 2016. The failure to provide Lisa appropriate diagnosis and treatment, or referral for diagnosis and treatment, on

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March 31, 2016, caused the worsening of Lisa's condition, a high degree of continuously increasing pain and suffering to Lisa, and a significant negative effect on her prognosis for survival. While written policy at the jail reflected that a physician was required to be called when a substance withdrawal patient had a heart rate greater than 110, the medical record reflects that no physician was called when Lisa had a heart rate of 119 on the morning of March 31, 2016, or when she had a heart rate of 133 on the afternoon of March 31, 2016. If a nurse failed to notify me about such alarming vital signs for one of my patients, I would ensure that nurse's employment was terminated. The failure to notify a physician of Lisa's alarming vital signs on March 31, 2016, falls far below any applicable standard of care, could not have been the exercise of medical judgment, and reflects a deliberate indifference toward Lisa and her serious medical condition. Any physician being notified of Lisa's vital signs on March 31, 2016, would have known that Lisa required immediate further assessment and failure by any nurse to ensure such an assessment occurred could not be the exercise of medical judgment.

10. Throughout April 1, 2016, Lisa's prognosis for survival was good, with a likelihood of survival, had she been properly assessed and referred for diagnosis and treatment. On the afternoon of April 1, 2016, the failure of Todd Booth to ensure that Lisa received a medical assessment for her complaints caused a worsening of Lisa's condition, a high degree of pain and suffering to Lisa, and a significant negative effect on her prognosis for survival. Similarly, on the same afternoon, Nurse Ron Seewer's failure to provide an appropriate medical assessment of Lisa Ostler or referral for diagnosis and treatment caused a worsening of Lisa's condition, a high degree of pain and suffering to Lisa, and a significant negative effect on her prognosis for survival.

11. During the night of April 1, 2016, and early morning of April 2, 2016, Lisa's clearly manifested abdominal pain and her repeated screaming, crying, moaning, and pleas for help reflect a severe worsening of her condition. However, through the night, Lisa's prognosis for survival remained good if she had been properly assessed or referred for diagnosis and treatment. Within a reasonable degree of medical certainty, Lisa stood a good chance of survival had she received medical attention during the evening of April 1 and early morning of April 2. The failure of Holly Harris during that night and early morning to ensure that Lisa received a medical assessment for her complaints caused a severe worsening of Lisa's condition, a high degree of severely increasing pain and suffering to Lisa, and a highly negative effect on her prognosis for survival. Similarly, the practice at the Jail of Central Control employees "ignoring" complaints from certain inmates and the fact that Scott Sparkuhl was instructed to, and did, "ignore" Lisa's complaints of pain and requests for medical attention caused a serious worsening of Lisa's condition, a high degree of severely continuous increasing pain and suffering to Lisa, and a significant negative effect on her prognosis for survival.

12. On the morning of April 2, 2016, after Zachary Frederickson and Nurse Brent Tucker began their shifts, Lisa had a fair chance of recovery had she been immediately referred to and transported to a hospital for diagnosis and treatment. However, once Lisa arrested at approximately 8:00 a.m. on April 2, 2016, as is apparent from her subsequent treatment and assessment at the hospital, she

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suffered irreparable brain damage from lack of oxygen because she was lying in her cell without breathing. If at any time during Zachary Frederickson's shift, prior to her cardiac arrest, Lisa had been placed in the care of a hospital, Lisa likely would not have experienced an extended period of time without oxygen. Accordingly, the failure of Zachary Frederickson to urgently obtain medical assistance for Lisa and the failure of Nurse Brent Tucker to ensure that Lisa was provided referral and transportation to a hospital for urgent diagnosis and treatment caused a severe worsening of Lisa's condition, a high degree of increasing pain and suffering to Lisa, and a reduction of her prognosis for survival from fair to assured death.

13. A trained medical provider can, and should be able to, diagnose peritonitis, particularly as it progresses. Nurses, at the least, would certainly be able to recognize that a person suffering from peritonitis is suffering from a serious medical condition that requires immediate evaluation, monitoring, and referral for diagnosis and treatment. At the very least, any trained medical professional, including all nurses and paramedics, should be able to recognize symptoms and signs that would alert them to the possibility of peritonitis or some other serious abdominal medical condition, regarding which they should notify a physician at once. A physical exam, which can be performed by any trained and licensed nurse, and certainly should be performed for any person exhibiting the signs and symptoms that accompany peritonitis, will reveal an ill-appearing patient, abnormal vital signs, and a concerning abdominal exam that requires urgent follow-up. Examining the abdomen would disclose tenderness and perhaps distension. As the peritonitis worsens with time between the onset of symptoms and diagnosis and treatment, the physical exam will reflect rebound tenderness and rigidity, which would be ascertained by any trained nurse engaging in the most minimal of evaluation and monitoring that must always be done for a person who is demonstrating the signs and symptoms that always accompany peritonitis. As a matter of professional standards and simple common sense, these concerning findings must prompt further emergent workup, which would include cross-sectional imaging and/or surgery, as well as the administration of antibiotics.

    Upon first suspecting that someone is suffering from peritonitis, antibiotics should be administered immediately, or the person should be urgently referred for diagnosis and treatment, including the administration of antibiotics. It was far below any applicable standard of care, and could not have been the exercise of medical judgment, for Nurse Ron Seewer to fail to provide and record an appropriate assessment for Lisa on the afternoon of April 1, 2016, or refer her to a physician for diagnosis and treatment. Similarly, it was far below any applicable standard of care, and could not have been the exercise of medical judgment, for Nurse Brent Tucker to rely on a guard with no medical training to determine whether Lisa was experiencing a medical emergency on the morning of April 2, 2016, rather than gather information by visiting and evaluating Lisa to make that determination himself.

14. Lisa's vital signs were very concerning on March 31, 2016, and must have alerted any nurse paying any attention to Lisa that she was likely suffering from a serious medical condition. She was both tachycardic (fast heart rate) and hypotensive (low blood pressure). There was a worsening trend to

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her vital signs at this time. These abnormal vital signs were associated with her witnessed altered mental status. She thought she was at a wedding. This reflects her progression to sepsis from the perforation of her gastrointestinal ulcer and peritonitis. To a reasonable degree of medical certainty, Lisa's mental status changes and abnormal vital signs reflect early signs of sepsis beginning, at the latest, on the morning or afternoon of March 31, 2016.

15. The last entry of Lisa's vital signs at the Jail, which occurred on the morning of April 1, 2016, is highly suspect. The numbers themselves reflect normal values, which would not be clinically possible with the now known untreated gastrointestinal ulcer perforation. The video shows the nurse interaction for the vital signs lasted 30 seconds (approximately 8:30:15 to 8:30:45), during which time the nurse is addressing both Lisa and another patient simultaneously. Standard automated blood pressure machines usually take at least 45 seconds to measure. This does not include the time to put on the blood pressure cuff.

16. Medically trained personnel, including physicians, nurses, paramedics and anyone charged with observing and reporting possible serious medical conditions, should always consider life threatening causes of abdominal pain, especially in patients with known chronic abdominal comorbidities such as Crohn's disease and post-gastric surgery, both of which are noted on Lisa's medical records created at the Jail, which should have been reviewed by anyone responsible for monitoring or observing Lisa. Screening with vital signs is an efficient tool to determine the potential for life threatening problems, such as peritonitis. From all appearances on the videos showing Lisa in units 5C and 8C of the Jail, as well as the statements of witnesses, Lisa was suffering from obvious abdominal pain, which should have been evaluated, or referred for evaluation, immediately by a nurse or physician. An abdominal exam is imperative to determine the etiology of the pain. The nursing pre-screen examination acknowledges Lisa's prior gastric bypass and her Crohn's disease (incorrectly spelled by the nurse as "Chron's"). It is a potentially fatal error to assume a benign pathology, such as minor drug withdrawal, is the cause of abdominal pain without screening for potentially life-threatening causes of abdominal pain.

17. I am very familiar with the signs and symptoms of drug withdrawal. My knowledge is based on my medical education, my extensive training, and my involvement in the treatment of, or consultation regarding, hundreds of patients experiencing drug withdrawal. The hospital at which I have worked, and where I am Chair of Surgery, is the detoxification unit for the entire Intermountain Healthcare system, where many hundreds, perhaps thousands, of patients withdrawing from drugs are treated every year. From my careful review of the records and video, Lisa did not act or appear like a person experiencing classic drug withdrawal. Classic heroin withdrawal patients are somnolent with outbursts of pain when aroused. Lisa was continuously complaining and showing obvious signs of abdominal pain. It is telling that several of her cellmates who have experienced/witnessed heroin withdrawal noted she did not appear to be withdrawing from heroin. They describe her skin as ashen and "gray." This is far more consistent with sepsis. Generally, heroin withdrawal patients have normal skin color or are flushed. Any medically trained people working at the Salt Lake County Jail, where many inmates go through drug withdrawal, must be familiar with the signs and symptoms of

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drug withdrawal, as compared with the signs and symptoms of a perforated gastrointestinal ulcer and peritonitis.

18. I have read "Managing Opiate Withdrawal: The WOWS Method," and I agree with the statements of its author, Dr. Todd Wilcox (who I understand is the Medical Director at the Salt Lake County Jail), that opiate withdrawal is "clinically severe and can frequently result in death if not managed appropriately" and is "a life-threatening medical condition." For any medical provider or anyone else to ignore a person exhibiting signs of abdominal pain, screaming out in pain, and asking repeatedly for medical attention is professionally outrageous and reflects deliberate indifference because, under those circumstances, the person is obviously at risk of a serious, perhaps life-threatening, medical condition that cannot be ignored. That is true regardless of whether the person failing to respond to those circumstances believes the person in pain and screaming out is withdrawing from drugs or not. As Dr. Wilcox notes, withdrawal from drugs is "clinically severe" and is "a life-threatening medical condition."

    I agree with Dr. Wilcox that it is appropriate and medically necessary to assess patients undergoing opiate withdrawal at least twice per day for a minimum of five days. I agree with Dr. Wilcox that patients with a low body mass index are particularly susceptible to "extreme distress." Patients with a low body mass index are more susceptible to morbidity and mortality from opiate withdrawal. A body mass index below 18.5 is considered underweight. Lisa's BMI was recorded as 18.3 soon after she was booked into the Jail, but would have declined throughout the time she was incarcerated because she was refusing all or almost all of her meals, was not leaving her cell to drink water, and was only given 3 bottles of Gatorade in an approximately 72-hour period (one of which was noted by Esther Israel to have been spilled on the floor). A decline in her body mass index is consistent with the description that Lisa was "very cachectic appearing" noted by Dr. A. Koy Lombardi. Lisa's weight was described as being 200 pounds in the Jail medical records, but that is clinically impossible.

    Because opiate withdrawal is a life-threatening medical condition, it was a complete abandonment of care, and could not have been the result of medical judgment, to ignore the signs of abdominal pain reflected on the limited video made available and witnessed by other inmates, and the crying, screaming, and repeated requests for help of Lisa Ostler throughout the night of 4/1/2016 and the early morning of 4/2/2016. Similarly, it was a complete abandonment of care and could not have been the result of medical judgment (a) for Nurse Ron Seewer to fail to perform and record an assessment of Lisa, including her vital signs, on the afternoon of April 1, 2016, or refer her for immediate diagnosis and treatment and (b) for Nurse Brent Tucker to rely on a medically untrained guard, Zachary Frederickson, to determine whether Lisa was experiencing a medical emergency rather than gathering information and making that determination himself.

19. The medical records reflect that Lisa was not assessed for dehydration, in contradiction of Dr. Wilcox's statements in the above article that it is important to "hydrate, hydrate, hydrate" and that the medical staff at the Jail "place[s] a significant emphasis on oral hydration." I agree with Dr.

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Wilcox that it is vitally important to ensure that patients experiencing heroin withdrawal are hydrated. Providing two or three bottles of Gatorade to Lisa (with or without any documentation that she consumed any of it), while she was refusing most or all of her meals and was not leaving her cell to drink any water, reflect that Lisa was likely severely dehydrated. The failure to ensure Lisa's hydration falls far below any applicable standard of care, cannot be the result of medical judgment, and reflects deliberate indifference toward Lisa's obviously serious medical condition, which was manifested by earlier concerning vital signs; Lisa's altered mental state; Lisa's refusal of food; Lisa's bearing demeanor, complexion, and overall appearance; and Lisa's screaming in pain and repeated requests for medical help for many hours.

20. Zachary Frederickson's description in his interrogatory answers of his interaction with Lisa is clinically impossible. It is impossible for someone dying of peritonitis to engage in anything close to a normal conversation. During the time of Lisa's interactions with Zachary Frederickson, Lisa must have been in extreme distress and likely had a highly altered mental status.

21. The records from Intermountain Medical Center reveal significant concerns. The intake history from the care providers in the Emergency Room reflects they were informed by EMS only of a history of drug abuse and a vague potential vaginal bleeding. There was no communication by EMS or anyone from the Jail of her abdominal pain that was going on for the previous days, or of Lisa's screaming and moaning in pain, her repeated requests for medical attention, the expressed concern of other detainees about Lisa's serious medical condition and the continuing failure to provide her with medical attention, her abnormal vital signs on April 1. The failure to provide relevant information about Lisa's signs and symptoms led to a workup by physicians at IMC involving drug-related problems and not anything remotely related to the cause of her death. If properly informed about signs of Lisa's abdominal pain and her abnormal vital signs, her screaming in pain, and pleading for medical attention prior to her arrest, the Emergency Department physician at IMC would have obtained an abdominal-pelvic CT scan which would have confirmed the findings of free air in association with free intrabdominal fluid. These are findings consistent with those from Lisa's autopsy. Because of the omissions of pertinent information, the workup of her arrest led to a wild goose chase. The lack of CT scan prevented diagnosis and surgical intervention. Surgery was the only intervention that could have saved her life. However, it is highly likely that because of Lisa's condition by the time she was finally taken to a hospital, she would have succumbed because of severely delayed diagnosis and treatment due to the indifference of medical and other personnel at the Jail. The failure to provide accurate and complete information to IMC about Lisa's serious medical problem reflects further deliberate indifference toward Lisa and her serious medical problem.

22. I am concerned with the Salt Lake County Jail's practice of determining medical emergency and find that it is not only obviously inadequate to protect the health and safety of inmates but is the product of practices evidencing a systemic and deliberate indifference toward the serious medical needs of inmates. The process that I reviewed shows the inmate contacts the guard. The medically untrained guard then determines if there is a medical emergency. In Lisa's case, a guard called a

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nurse and the nurse, completely inappropriately, left it for the guard to determine if Lisa's medical condition was an emergency requiring the attention of a nurse. The guard, who had not provided significant pertinent information to the nurse (including her altered mental state, her indications of abdominal pain, her screaming and moaning in pain for hours the prior evening, her pleas for medical attention, and the expression of other inmates that they were concerned that Lisa might die if she did not receive immediate medical attention) made the wholly unfounded determination there was not an emergency. Having a non-medically trained guard triaging potentially life-threatening conditions is a set up for disaster—a product of obvious deliberate indifference toward inmates' serious medical problems by people, including jail and health administrators and medical personnel at the Jail, who know the inappropriateness of leaving it for non-medically trained guards to make judgements about whether inmates are suffering from emergency medical problems.

23. The medical records of other detainees at the Jail reflect a widespread practice of failing to perform all required WOWS and CIWA assessments. That practice, in light of the knowledge of the policy requiring such assessments at least twice a day for five days, and in light of the obvious importance of monitoring and evaluating inmates and contacting a physician when there are signs or symptoms of drug withdrawal, seems the very definition of deliberate indifference, since jail personnel knew of the importance of performing the assessments, they must have known of the risks of not doing the assessments, yet they failed to do them anyway. Plaintiff's counsel has provided me medical records of Timothy Kukuchka, Duwayne Cotter, Chris Bybee, Loralie Querbach, Dustin Bliss, Casie Christensen, Angie Turner, and Melissa Montoya, all of which reflect on their face a failure to complete all ordered WOWS and CIWA assessments. I have been informed by Plaintiff's counsel that this sample of 7 detainees' records with failure to comply with WOWS and CIWA assessments comes from a set of less than thirty detainees' medical records who were ordered to be on a WOWS or CIWA protocol that were provided by Defendants. The noncompliance with the requirement that the assessments be done reflects a pattern of non-compliance that is shockingly high. Based on my clinical experience, education, and research, that many errors reflect a widespread practice and systemic failure to ensure that all WOWS and CIWA evaluations are performed as ordered, clearly constituting a pattern of deliberate indifference.

23. After reviewing the case, it is my opinion that Lisa developed a perforated gastrointestinal ulcer and life-threatening peritonitis while incarcerated. She did not receive any medication that was already prescribed to her that could have prevented the perforation. Her obvious signs and symptoms of a serious abdominal medical condition, as well as her screaming and moaning in pain and her multiple requests for help regarding her abdominal pain,as well as the expressions of deep concern about Lisa by other detainees, were ignored. She objectively, clinically deteriorated severely during her incarceration. Her condition was not evaluated, monitored, or referred for diagnosis and treatment by nurses who were responsible for her care. This led to her respiratory arrest and transfer to Intermountain Medical Center, where the breach in handoff led to an erroneous diagnostic workup. The actions and failures to act by the Defendants, reflecting their deliberate indifference toward Lisa's serious medical condition and reflecting the County's pattern and custom of deliberate indifference toward detainees' serious medical conditions generally, caused Lisa to suffer

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exponentially increasing excruciating pain, a drastic worsening of her condition, and a continual worsening of her prognosis for survival from near certain recovery to no chance of recovery.

All of the foregoing opinions are rendered within a reasonable degree of medical certainty.

Please feel free to contact me with any further questions.

Sincerely,

H. Tae Kim, MD, FACS, FASCRS
Colon & Rectal Surgery
Intermountain Healthcare

Chair of Surgery
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EDUCATION:

Bachelor of Science, in Radiologic Technology University of Nevada at Las Vegas Las Vegas, NV	Dec 1994
Doctorate of Medicine University of Nevada School of Medicine Reno, NV	May 2002

INTERNSHIP:

General Surgery University of Utah Affiliated Hospitals Salt Lake City, UT	Jun 2002- Jun 2003

RESIDENCY:

General Surgery University of Utah Affiliated Hospitals Salt Lake City, UT	Jun 2003- Jun 2006
Chief Residency in General Surgery University of Utah Affiliated Hospitals Salt Lake City, UT	Jun 2006 – Jun 2007

FELLOWSHIP TRAINING:

Colon and Rectal Surgery Western Pennsylvania-Allegheny General Hospitals Pittsburgh, PA	Jul 2007 - Jun 2008

LICENSURE: Utah Active

BOARD CERTIFICATIONS:

Board Certification in General Surgery	Jan 2008
Board Certification in Colon and Rectal Surgery	Sep 2009

FELLOWSHIP IN SPECIALTY COLLEGES

Fellow, American College of Surgeons	Oct 2011
Fellow, American College of Colon & Rectal Surgery	May 2013

HOSPITAL APPOINTMENTS:

Active appointment. LDS Hospital, Salt Lake City, UT. Sep 2008-present
Active appointment. Intermountain Medical Center, Murray, UT. Sep 2008-present

ACADEMIC APPOINTMENTS:

Clinical Instructor, Trauma Surgery. University of Utah General Surgery Residency. Salt Lake City, UT. Sep 2008 - Jun 2009

Clinical Instructor. St. Mark's Health Care Foundation Colon & Rectal Surgery Residency. Salt Lake City, UT. Nov 2016-present.

HONORS & AWARDS

General Surgery Chief Resident Outstanding Teaching Award Jun 2007
Presented by the medical students of University of Utah School of Medicine

Jack A. Barney Award Apr 2006
Presented by the Southwestern Surgical Congress for surgical resident presenting the outstanding manuscript at the SWSC 58th Annual Meeting

Surgical Intensive Care Unit Resident of the Year Jun 2005
Presented by the SICU

Clark County Medical Society Scholarship Jun 1998
Presented by the University of Nevada School of Medicine for academic excellence.

PROFESSIONAL SOCIETY MEMBERSHIPS:

Alpha Omega Alpha Honor Society
American College of Surgeons
・Utah Chapter
American Medical Association
American Society of Colon and Rectal Surgeons
International Society of University Colon & Rectal Surgeons
Southwest Surgical Congress
Utah Medical Association

PROFESSIONAL OFFICES:

Chair of Western USA Committee, International Society of University Colon & Rectal Surgeons 2017-present

Medical Director, General Surgery Development Team, Surgical Services Clinical Program, Intermountain Healthcare 2016-2017

Chief, Department of Surgery, LDS Hospital 2015-present

Medical Director, GI Cancer Team, Oncology Clinical Program, Intermountain Healthcare 2011-present

Chapter President, American Medical Association 1998- May 1999

PROFESSIONAL ACTIVITIES:

Sub-Investigator, Pilot study to determine the technical feasibility of circulating tumor DNA 2015-present

Sub-Investigator, MT4420 prospective colorectal cancer biomarker study 2015-present

Sub-Investigator, MT0265 Study of Frozen Tissue and Whole Blood in Crohn's Disease and Ulcerative Colitis Patients 2014-present

Reviewer for *World Journal of Colorectal Surgery* 2014-2018

Sub-Investigator, Randomized, Double Blind, Placebo Controlled Study to Study Intermountain Healthcare's Enhanced Recovery Protocol for Colon Surgery With and Without Alvimopan Use 2010-2012

Physician Member
Robot Committee, Intermountain Healthcare 2011-present

Physician Member
General Surgery Development, Intermountain Healthcare 2012-present

Physician Member
Physician Advisory Group, Intermountain NSL Region 2011-2014

Surgical Director 2010-2012
Huntsman-Intermountain Multidisciplinary Anal & Rectal Cancer Clinic

Board exam contributor Jul 2010-present
American Board of Colon & Rectal Surgery

Physician Member 2010-2012
Intermountain Healthcare Product Development Team

Course Director Mar 2010
GelPort HALS Workshop & GelPOINT GI Single Site Workshop
Salt Lake City, UT

Faculty Nov 2009
GelPORT HALS Workshop. San Francisco, CA

Reviewer for *Diseases of Colon and Rectum* Jul 2008-present

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Tom Herbert & **Tae Kim**. "Supplemental Evidence, Are They Performance Boosters or Snake Oils?" *Climbing* No. 208, Dec 15, 2001.

Presentations

Swords, DS, Sause, WT, Gawlick, U, Cannon, GM, Lewis, MA, Scaife, CL, Gygi, JA, **Kim, HT**, Skarda, DE. **Surgeon-level Variation in Utilization of Local Staging and Neoadjuvant Therapy for Stage II-III Rectal Adenocarcinoma.** Plenary Presentation at the 2018 meeting of The Society of Surgery for the Alimentary Tract (SSAT) & 33rd Annual SSAT Residents and Fellows Research Conference. Washington, DC. Jun 2018.

DS Swords, DE Skarda, **H Kim**, WT Sause, GJ Stoddard, CL Scaife. Facility Variation in Upstaging Adjuvant Chemoradiation in Clinical Stage I Rectal Cancer. 13th Annual Academic Surgical Congress Abstract. Jan 2018.

Douglas S. Swords, David E. Skarda, Gregory J. Stoddard**, H. Tae Kim**, William T. Sause, Courtney L. Scaife Facility variation in clinical staging of rectal adenocarcinoma and its contribution to underutilization of neoadjuvant therapy. 2018 ASCO Gastrointestinal Cancers Symposium. Jan 2018.

Kim HT. Speaker. Updates in Anorectal Disease in the Emergency Room. University of Utah School of Medicine Emergency Medicine Residency Education Conference. Salt Lake City, UT. Jul 2017.

Kim HT. Speaker. Updates in Colorectal Surgery. Rocky Mountain Regional WOCN Fall Conference. Sandy, UT. Oct 2016.

Kim HT. Speaker. Problem Solving: Surgical Site Infections. CRICO (Risk Management Division of Harvard Medical Institutions) Visit to Intermountain Healthcare. Apr 2016.

Kim HT. Speaker. Anorectal Disease in the Emergency Room. University of Utah School of Medicine Emergency Medicine Residency Education Conference. Salt Lake City, UT. Feb 2016.

Bagshaw HP, Sause WT, Gawlick U, **Kim HT**, Whisenant JR, Cannon GM. Vulvar Recurrences Following Intensity Modulated Radiation Therapy for Squamous Cell Carcinoma of the Anus. American Society for Therapeutic Radiology and Oncology 57th Annual Meeting. Oct 2015.

Kim HT. Speaker. Stoma Education. Ostomy Support Group. Intermountain Employee Service Center. Salt Lake City, UT. Jul 2015.

Kim HT. Participant. Deseret News/Intermountain Health Hotline. Colorectal Cancer. Salt Lake City, UT. Feb 2012

Kim HT. Speaker. Stomas: When and Why. Ostomy Support Group. Intermountain Doty Education Center. Salt Lake City, UT. Feb 2012.

Kim HT. Moderator. Anastomotic Leak: How can I prevent it? Lunch Symposium. American Society of Colon & Rectal Surgeons Annual Meeting. Vancouver, Canada. May 2011.

Kim HT. Speaker. Parastomal Hernias. Ostomy Support Group. Intermountain Doty Education Center. Salt Lake City, UT. Mar 2011.

Kim HT. Speaker. 21st Century Anorectal Disease. SelectHealth Care Management Clinical Education. Salt Lake City, UT. Aug 2010.

Kim HT, Christensen, BJ. Speaker. Transanal Endoscopic Microsurgery: An Alternative Method. American Society of Colon & Rectal Surgeons Annual Meeting. Minnesota MN. May 2010.

Kim HT. Speaker. Single Incision Laparoscopic Sigmoidectomy for Diverticulitis. 19th Annual Winter Meeting: Midwest Society of Colon & Rectal Surgeons. Breckenridge, CO. Mar 2010.

Kim HT. Surgical Cricothyroidotomy. Speaker. Difficult Airway Management Course. LDS Hospital Education Center, Salt Lake City, UT. May 2009.

Kim HT. Chasing the Truth. Podium Presentation. Surgery Grand Rounds. Allegheny General Hospital. Pittsburgh, PA. May 2008

Kim HT, Read TE. Diverticulitis in Immunocompromised Patients. Podium Presentation. 9th Annual Surgical Resident Research Day. Western Pennsylvania Hospital. Pittsburgh, PA. Apr 2008.

Wooten A, **Kim HT**, Read TE. Case Report: Iatrogenic Colonic Perforation Closed Using Endoclips. Podium Presentation. 9th Annual Surgical Resident Research Day. Western Pennsylvania Hospital. Pittsburgh, PA. Apr 2008.

Kim HT. 'Cause That's The Way We Do It. Podium Presentation. Surgery Grand Rounds. Western Pennsylvania Hospital. Pittsburgh, PA. Apr 2008.

Kim HT. To Drain or Not to Drain. Podium Presentation. General Surgery Grand Rounds. University of Utah Medical Center. Salt Lake City, UT. Apr 2007.

Kim HT, Glasgow RE. Laparoscopic Resection of a Gastric Glomus Tumor; a Case Report and Review of the Literature. Podium Presentation. Southwestern Surgical Congress 59th Annual Meeting. Rancho Mirage, CA. Mar 2007.

Kim HT, Sklow B. Laparoscopic Sigmoid Colectomy. Video presentation. American Society of Colon & Rectal Surgeons Annual Meeting. Seattle, WA. Jun 2006.

Kim H, Bruen K, Vargo D. Human Acellular Dermis in the Management of Complex Abdominal Wall Defects. Podium presentation. Southwestern Surgical Congress 58th Annual Meeting. Kauai, HI. Apr 2006

Kim H, Vargo D. Single Institution Series Utilizing Human Acellular Dermis. Poster presentation. American College of Surgeons, Utah Chapter Annual Meeting. Park City, UT. Feb 2006

Kim HT, Murray KD. Sternal Closure – Review, Analysis, and Recommendations. Podium presentation. University of Nevada School of Medicine George G. Bierkamper Student Research Convocation. Reno, NV. Jan 2002

VOLUNTEER ACTIVITIES:

Volunteers in Medical Missions. Honduras	1999
Outreach Clinic, Reno, NV	1998-1999