Pursuant to Fed. R. Civ. P. 26(a)2(B), Thomas D. Fowlkes, M.D. submits the following Expert Report on behalf of Defendants Salt Lake County and all named defendants.

(i) A complete statement of all opinions the witness will express and the basis and reasons for them.

Scope of report: (I.) The appropriateness of the medical care provided Ms. Lisa Ostler (Ms. Ostler) while she was incarcerated at the Salt Lake County Jail (SLCJ) in March and April 2016 (II.) How Ms. Ostler's past medical history and autopsy findings influence those opinions and (III.) Whether the Policies & Procedures in place regarding medical care at the SLCJ are reasonable and appropriate.

My opinions are limited to those that I can offer to a reasonable degree of medical probability or likelihood.

Factual Summary: 1. Ms. Ostler was a 37 year-old female with a past medical history significant for:

a. Roux-en-Y gastric bypass surgery in approximately 2006.

b. Cardiac ablation procedure secondary to supraventricular tachycardia (SVT) in approximately 2004.

c. HLA-B27 genotype, which is associated with ankylosing spondylitis and inflammatory bowel disease (Crohn's disease). Ms. Ostler had both of these chronic inflammatory conditions.

d. Chronic pain syndrome, specifically chronic abdominal and back pain, for which she had been prescribed long-term narcotic pain medications. Ms. Ostler had been receiving regular prescriptions of opiate pain medications and other controlled substances from Dr. Todd Furness. The last office visit with Dr. Furness in the records I have is from 9/11/2015. The eight page note from that office visit (SLCo Ostler 021458-021465) details her medical course for the prior couple of years. Dr. Furness documented his concerns about Ms. Ostler's escalating alcohol and illicit drug use. He prescribed her #90 oxycodone 30mg tablets and #90 hydrocodone 10mg tablets that day but planned to transition her to other providers for future prescriptions. Ms. Ostler did not fill prescriptions for opiates during the first three months of 2016.

e. Chronic polysubstance use disorder. Ms. Ostler had a long history of abusing multiple substances, including alcohol, opiates and stimulants. The record indicates a period of sobriety from alcohol prior to 2013 with a relapse after that. She also had received regular prescriptions for significant quantities of controlled substances in the months and years leading up to her death. Her Controlled

Substance Prescription Report indicates that Ms. Ostler filled prescriptions for the following controlled substances monthly during January-March 2016:

i. Xanax 2mg- benzodiazepine

ii. Ambien 10mg- sedative/hypnotic

iii. Amphetamine 20mg- stimulant

Ms. Ostler had a history of intravenous drug abuse (IVDA) of heroin and methamphetamine. During the first three months of 2016 she was not prescribed opiates but reported IVDA of heroin. In addition, Ms. Ostler reported sharing pain medications with a family member and receiving sedatives from another family member.

Ms. Ostler's Controlled Substance Prescription Report also shows that prescriptions for Ambien and Xanax were filled on 4/1/2016 while Ms. Ostler was incarcerated at SLCJ and that a prescription for Suboxone was filled on 4/13/2016 after Ms. Ostler's death. The records I reviewed from the SLCJ do not reflect that they filled these prescriptions or that Ms. Ostler filled them while incarcerated.

f. Rectal neuropathy, which was attributed to sexual abuse as a child.

g. Psychiatric conditions including anxiety, depression, post-traumatic stress disorder (PTSD), insomnia, and suicide attempts.

h. Psycho-social stressors including homelessness, strained family relationships and unemployment.

i. Skin abscesses and methicillin-resistant Staph aureus (MRSA).

j. Long-term disability since 2011 from the Social Security Administration for which she received Medicare coverage.

k. Kidney stones with lithotripsy in 2003.

l. Tobacco Use Disorder.

2. On Tuesday, 3/29/2016 at 10:23 p.m. Ms. Ostler was arrested by the Draper Police Department on charges related to possession of controlled substances and on outstanding warrants. Ms. Ostler admitted to injecting heroin and methamphetamine at approximately 1:00 p.m. that day.

3. Ms. Ostler was brought to the SLCJ at approximately 12:55 a.m. on Wednesday, 3/30/2016. A Nursing Pre-screen Examination by a Registered Nurse (RN) did not reveal any problems except drug use noted by the arresting officer plus the nurse noted her past medical history, medications, use of heroin, weight loss, lack of menses and two minor skin lesions. She was accepted for intake and was booked into the SLCJ at 2:21 a.m. on 3/30/2016.

4. Another RN reviewed the Pre-screen Examination and then conducted a Comprehensive Nurse Examination shortly after 5:00 a.m. on the morning of 3/30/2016. Findings included normal vital signs, a weight of 124 pounds, body mass index (BMI) of 18.3, and unremarkable physical exam including a soft, non-tender, non-distended abdomen with normal bowel sounds. Initial evaluations were

performed for signs of withdrawal from both benzodiazepines and opiates. Both scores were zero indicating no signs of withdrawal.

5. Many persons who are brought into a jail are physically dependent on one or more substances. Stopping these substances may lead to a withdrawal syndrome. The symptoms of those withdrawal syndromes differ depending on the specific substance used. Some withdrawal syndromes are more dangerous than others. The SLCJ has protocols for scoring and following the severity of withdrawal syndromes. There are different protocols for the assessment and treatment of withdrawal from alcohol/benzodiazepines and from opiates such as heroin.

The withdrawal syndromes from both alcohol and benzodiazepines are similar. Withdrawal from these substances can lead to a delirium and seizures and can be life-threatening. The severity of those withdrawal symptoms can be measured with a rating scale known as the Clinical Institute Withdrawal Assessment (CIWA).

Withdrawal from opiates such as oxycodone and heroin has different symptoms. The opiate withdrawal syndrome has prominent gastrointestinal symptoms (nausea, vomiting, diarrhea and abdominal cramping) and diffuse pain of bones, joints and muscles. Those withdrawal symptoms are monitored with the Clinical Opiate Withdrawal Scale (COWS). Opiate withdrawal is very uncomfortable but is usually not fatal unless severe dehydration develops. At the

SLCJ Dr. Wilcox has developed a protocol to prevent complications in his patients with opiate withdrawal by monitoring the COWS score along with monitoring other parameters not measured by the COWS score alone, such as measuring complete vital signs, inquiring about self-harm, ensuring access to adequate electrolyte replacement solution, using additional precautions with persons with low BMI, providing medications for the gastrointestinal distress and enhanced evaluation/treatment for patients not responding to the basic protocol. His protocol is named the Wellcon Opiate Withdrawal Scale (WOWS). (Reference 1)

6. The booking RN also instructed Ms. Ostler how to access medical care at the SLCJ, performed a mental health screening, referred her to a mental health professional (MHP), started the CIWA and WOWS protocols and placed a tuberculosis screening test.

Ms. Ostler was housed in a quarantine unit (5-C) and the two withdrawal protocols were begun. These protocols included orders for the measurement of vital signs, CIWA score and WOWS score twice a day for five days along with Phenergan for nausea/vomiting, Imodium for diarrhea, and a Librium taper for benzodiazepine withdrawal.

In the afternoon of 3/30/2016 Ms. Ostler's CIWA and WOWS scores were measured again and both indicated minimal withdrawal symptoms. Her vital signs

were unremarkable and she was provided symptomatic medication for the gastrointestinal symptoms of opiate withdrawal.

7. Upon intake Ms. Ostler verbalized medications that she was prescribed. The nurses at SLCJ verified her prescriptions at two pharmacies and referred the information on the prescriptions to Dr. Brad Lewis for orders.

Dr. Lewis documented this response along with his order for Prilosec. (SLCo Ostler 000214)

DOS: 03/31/2016 00:00

I received an e-mail regarding the patient's medications. 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. The patient was on a verified dose of Prilosec. We will go ahead and order 40 mg p.o. daily for this medication. 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. The patient also states that she was on Pentasa and prenatal vitamins, though there is no record of these medications. Subsequently, request for these has been denied. The patient may follow up in Doctor-Call as needed, sooner p.r.n. to triage.

Allergies: **NO KNOWN ALLERGIES.**

D: Brad Lewis, M.D.
T: Carole King II3

8. On Thursday, 3/31/2016 Ms. Ostler remained in housing unit 5-C.

a. Her CIWA and WOWS scores were measured twice and found to be indicative of only minimal/mild withdrawal symptoms. (N.B. Both times the WOWS score is recorded as five. The second score should have been calculated at seven. Either of these numbers indicates mild withdrawal symptoms.) She was not administered symptomatic medications for GI symptoms on this day. Her vital

signs were normal except for a heart rate of 119 on the morning check and a heart rate of 133 on the afternoon check. She was provided Gatorade for hydration at the afternoon assessment.

b. Ms. Ostler was administered Librium three times in accordance with the taper order.

c. A MHP assessed Ms. Ostler at 3:30 p.m. and documented this note: (SLCo Ostler 000154)

Mental Health Professional Progress Note

Patient Name: OSTLER, LISA M **SO #:** 236212

Date: Mar 31, 2016

Time: 1530

Notes:

Patient has reported past severe trauma with sexual assault. She reported she currently is not suicidal and does not have a plan.

While assessing she had visible marks all over her body. She would not look me in the eye while speaking with her. She had visible signs of anxiety and reported symptoms of depression.

She was referred to the doc as an acuity three. Her medications were out of date.

MH will continue to follow up with patient during triage and her mental health pod therapist was notified for follow up.

FACHOLAS, JAMIE

d. At approximately 6:30 p.m. a correctional officer (CO) summoned a MHP to re-assess Ms. Ostler. She documented this assessment: (SLCo Ostler 000153)

Mental Health Professional Progress Note

Patient Name: OSTLER, LISA M **SO #:** 236212

Date: Mar 31, 2016

Time: 6:33 PM

Notes: 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. When I arrived on the unit, Lisa was lying in bed. She responded when I approached and said she was sleeping and has "PTSD real bad." Lisa said was involved in a "murder-suicide" and is sometimes is living in the past. She was oriented to place. Lisa said she is comfortable. She said she is withdrawing from heroin. There were three bottles of Gatorade in her cell, one of them was spilled on the floor. I provided her with a mood chart and educated her about the triage process. Recommend follow up with pod therapist.

ISRAEL, ESTHER

9. On Friday, 4/1/2016:

a. At approximately 8:20 a.m. Ms. Ostler's vital signs and CIWA/WOWS scores were assessed. Her heart rate was now normal at 75 and the remainder of her vital signs were normal. Her WOWS and CIWA scores were both two indicating minimal withdrawal symptoms. She was administered symptomatic medications for gastrointestinal symptoms.

b. At approximately 10:00 a.m. Ms. Ostler was transferred to housing unit 8-C.

c. Ms. Ostler was noted on the log to refuse her lunch tray. There was a notation of "sick."

d. During the afternoon at approximately 3:30 p.m. a nurse was in the 8-C housing unit doing medication pass and interacted with Ms. Ostler.

i. The housing officer documented the interaction in the Shift Log as follows: (SLCo Ostler 000069)

Medication pass	Case number		1525
Nurse Ron is in the unit for medication pass and diabetic check, Prisoner Ostler, Lisa so#236212 complaining of pain.			
Nurse Ron examined prisoner Ostler and cleared her to stay in the unit			

ii. The nurse is seen to go off camera in the area of Ms. Ostler's cell for approximately four minutes.

iii. The nurse on duty in the area, Ron Seewer, RN, testified in his deposition that he does not have any independent recollection of the events of that day.

iv. There is no record on the handwritten CIWA and WOWS score sheets or in the electronic medical record (EMR) of an afternoon assessment of those two scores or vital signs. (N.B. I could not determine from the record where those two handwritten sheets would have been kept given Ms. Ostler's recent housing move. Nurse Seewer testified in his deposition that there would not have been a computer available to him while he was on that housing unit to chart contemporaneously in the EMR.)

e. Ms. Ostler was administered Librium pursuant to Dr. Lewis's order three times this day. (SLCo Ostler 000151) No problems were noted during the medication administration.

10. Overnight 4/1/2016 through 4/2/2016 there is some indication in the record that Ms. Ostler was activating the intercom which was re-routed to the control room during the overnight shift. The control room operators communicated with the CO's in the housing area and they indicated that the complaints which Ms. Ostler was reporting had already been assessed by a nurse and that she had been cleared to remain in the unit. The records I reviewed do not indicate that Ms. Ostler complained of abdominal pain or of a new or changed condition.

11. On the day shift of Saturday, 4/2/2016 according to the CO's shift log:

a. Several inmates including Ms. Ostler refused breakfast at 6:30 a.m. (SLCo Ostler 000073)

b. Nurse Brent was on the unit for diabetic checks at 6:35 a.m.

c. CO Frederickson documented at 6:38 a.m. (SLCo Ostler 000074)

Meal refusal/Medical	Case number		0638
Unit works report Prisoner Ostler (236212) has not eaten since she arrived in the unit yesterday. When I spoke with the prisoner she confirmed that she doesn't want to eat and also reports that she is bleeding vaginally. A call was placed to Sgt. Beasley and Nurse Brent. Brent said that a triage kite is the best way to handle her bleeding concern if she is not having a medical emergency, he also states that Prisoners not eating is not generally a concern until it has been 72 hours without a meal.			

12. CO Frederickson documented in an incident report that he completed a watch tour in 8-C at approximately 07:50 a.m. and saw her lying on her bunk, breathing and apparently asleep. Shortly thereafter he was alerted by other inmates to a medical emergency with Ms. Ostler. He responded to her cell, found her in a sitting position, unresponsive and not breathing. (SLCo Ostler 000237)

13. The audio tape of the interview with Summer Johnson revealed that Ms. Ostler appeared to her to be chronically ill. She reported that Ms. Ostler was transferred to 8-C on Thursday evening 3/31/2016 in contrast to the other portions of the record that indicate that she was transferred on 4/1/2016. Her primary interaction with Ms. Ostler was on the morning of her medical emergency on 4/2/2016.

14. At approximately 8:07 a.m. on 4/2/2016 a medical emergency was called. Security staff began cardiopulmonary resuscitation. Nursing personnel responded and took over resuscitation and applied the automated external defibrillator. Shortly thereafter EMS arrived, began advanced life support (ALS) and transported Ms. Ostler to Intermountain Medical Center (IMC).

15. Ms. Ostler had return of spontaneous circulation by the time she arrived at IMC. She was in cardiogenic shock and was admitted to the intensive care unit. Peritonitis was not suspected as a cause of her cardiac arrest. Infection was felt to be less likely than drug overdose because of her relatively normal white blood cell count, lack of a fever, cool/dry skin, negative blood cultures and positive urine drug screen.

Despite initially regaining a pulse, Ms. Ostler died in the ICU at 1:14 a.m. on Sunday, 4/3/2016.

16. An autopsy was performed on 4/4/2016. The medical examiner made the following findings: (SLCo Ostler 000160)

FINAL PATHOLOGIC DIAGNOSES

I. Peritonitis due to perforation at anastomosis site of stomach and small bowel.
   A. Peritoneal effusion (1000 ml).
II. Gastric bypass, remote.
III. Crohn's disease (clinical diagnosis).
IV. Bilateral pleural effusions (right 200 ml, left 90 ml).
V. Atherosclerotic cardiovascular heart disease with moderate coronary artery disease.
VI. Recent methamphetamine use.
VII. Cholecystectomy, remote.
VIII. Evidence of medical therapy including endotracheal tube, intravascular catheters, and Foley catheter.

Toxicology Results:

Methamphetamine:	0.09 µg/ml (hospital blood),	>2.0 µg/ml (urine)
Amphetamine:	Negative (hospital blood);	>2.0 µg/ml (urine)
Morphine:	Negative (hospital blood);	Positive (urine)
Chlordiazepoxide:	928 ng/ml (hospital blood)	
Nordiazepam:	40 ng/ml (hospital blood)	

OPINION: This 37 year-old Caucasian female, Lisa Marie Ostler, died as a result of peritonitis due to gastrointestinal perforation at the anastomosis site of a remote gastric bypass. The decedent's medical history is significant for Crohn's disease which may have been a contributing factor to the perforation.

Opinions: The following are my opinions to a reasonable degree of medical probability on each of these areas based upon my training, experience, and a review of the records in this case:

I. The actions taken by the employees of the SLCJ in their assessment and treatment of Ms. Ostler during March and April 2016 while she was incarcerated at the SLCJ were reasonable, appropriate and within the acceptable standard of care. Specifically:

1. The intake and screening process in place at the SLCJ is exemplary. The nurses did a very thorough job of identifying Ms. Ostler's past medical problems and medical complaints. They identified the two classes of substances which Ms. Ostler was likely dependent upon and they initiated protocols to address the expected withdrawal syndromes. They recorded and verified her prescription medications. The nurses then appropriately communicated with a physician to provide prescription orders.

2. A remote gastric bypass and a history of Crohn's disease would both be a risk factor for subsequent bowel perforation and peritonitis. Nevertheless, Ms. Ostler did not present with signs or symptoms which should have alerted the nurses that Ms. Ostler was developing a perforated ulcer or peritonitis.

Ms. Ostler had a history of chronic pain of both the abdomen and back for which she was receiving multiple pain medications. The records I reviewed do not reflect that Ms. Ostler complained of abdominal pain specifically or an acute change in her chronic pain. In addition, there is no recorded fever or other objective finding which was indicative of an acute abdomen.

3. Ms. Ostler was known to be using heroin and prescription opiates regularly. This would predictably lead to opiate dependence. When an opiate dependent person is incarcerated it is standard treatment that the detention facility does not continue the chronic pain medications or illicit opiates. Instead, we discontinue

those substances and prepare to treat the expected withdrawal. (N.B. A provider can also taper the substance to reduce the withdrawal syndrome as was done with the benzodiazepine in this case.)

The opiate withdrawal syndrome is characterized most prominently by gastrointestinal symptoms of nausea, vomiting, diarrhea and abdominal cramping along with muscle and bone pain. Thus, one would expect a person withdrawing from opiates to have those symptoms. The presence of those symptoms should not lead a reasonable nurse or provider to suspect any other condition besides opiate withdrawal in the absence of new or worsening symptoms.

4. The withdrawal protocols in place at the SLCJ were designed to identify and aggressively treat life-threatening withdrawal syndromes. They performed exactly as designed in this case. Five serial measurements did not indicate the development of significant withdrawal symptoms. After five scores with no significant withdrawal it was reasonable to move Ms. Ostler to less restrictive housing. Her WOWS and CIWA scores had been consistently mild. Her vital signs had been normal except the two elevated heart rate readings on 3/31/2016 which had normalized by the morning of 4/1/2016. The plan was to continue the taper for benzodiazepine withdrawal and to continue to monitor the CIWA/WOWS score twice a day through 4/3/2016.

5. On the afternoon of 4/1/2016 the CO in Ms. Ostler's new housing unit documented that the nurse doing medication pass evaluated Ms. Ostler for "pain." The video shows this nurse interacting with Ms. Ostler for an extended period of time. There is no documentation of the assessment he performed during this time or the results of the CIWA/WOWS scores or vital signs. His deposition testimony is that he would not have had a computer available to him on the housing unit to document contemporaneously and it is unclear to me where Ms. Ostler's withdrawal assessment sheets were at this time. What is clear is that as a result of this assessment, the nurse on duty did not find a reason to transfer Ms. Ostler to a hospital or the medical unit and did not find a reason to contact a provider.

6. It was certainly reasonable of the security staff to rely upon this assessment by the nursing staff on duty that Ms. Ostler did not require additional medical treatment or heightened medical observation at that time. The day shift housing officer appropriately relayed this information to the evening shift. In the absence of new or worsened symptoms it was likewise reasonable of the night shift officers to rely upon the assessment of the nurse that Ms. Ostler's course was progressing as expected.

7. The nursing staff administered medications three times on 4/1/2016 and did not note any new symptoms or a change in Ms. Ostler's condition requiring further treatment on any of those three encounters.

8. It cannot be known what the nursing assessment scheduled for Ms. Ostler on the morning of 4/2/2016 would have shown since she suffered a sudden medical emergency prior to the assessment.

9. The actions of the nurse on the morning of 4/2/2016 in response to the CO's communication were reasonable and appropriate. Refusing one or more meals and a complaint of vaginal bleeding were both new complaints which would appropriately be addressed through the sick call triage process or by the nurse who would assess Ms. Ostler on the morning of 4/2/2016.

10. The response to the medical emergency and the actions of the nursing and security personnel in resuscitating Ms. Ostler were reasonable and appropriate.

11. There is certainly no evidence in the record that indicates that any of the nursing, security staff or anyone else intentionally or deliberately denied Ms. Ostler access to medical care or disregarded a known serious medical condition. Furthermore, her presentation would not have alerted SLCJ medical, nursing, or security staff that she was suffering from a serious medical condition that was so obvious that even a lay person would easily recognize the necessity for medical attention.

II. Ms. Ostler's past medical history and autopsy findings influence my opinions as follows:

1. Ms. Ostler had several very serious chronic conditions which made it more likely that she would develop a life threatening perforation of her GI tract whether she was incarcerated or not. Gastric bypass surgery has, as one of its known complications, the very type of perforation that occurred to Ms. Ostler. (References 2-3)

2. HLA-B27 positivity and ankylosing spondylitis are associated with increased mortality, especially related to cardiovascular causes and infection. (References 4-6)

3. Ms. Ostler had poor compliance with her medical follow-up and treatment regimens. This made it more likely that complications would develop and would go undetected.

4. Ms. Ostler had a very severe substance use disorder. Her IVDA and the multiple controlled substances she was obtaining from various physicians increased her mortality and the likelihood of complications

5. It is unclear the extent to which Ms. Ostler was compliant with immunosuppressant agents, specifically Humira, which had been prescribed to treat her ankylosing spondylitis and/or Crohn's disease in the months leading up to her death. What is clear from the record, however, is that Ms. Ostler was in a relatively immunocompromised and malnourished state at the time of her incarceration. She had very little physiologic reserve. She was described as

cachectic at the hospital. Another inmate described Ms. Ostler this way: (Woodruff Dep page 23)

Q. Was it just her skin color alone alarming to you?
A. No. Her bones were sticking out like out of her face, and just the way she walked, and you could see how -- like her bones just through her clothes, like she was so skinny, like, she just looked horrible.

This made it more likely that if a complication occurred, such as a perforation at the site of her remote gastric bypass, the presentation would be atypical and would be more likely to be fatal before significant symptoms developed than in a person without those underlying risk factors. The likelihood of Ms. Ostler's atypical response is substantiated by the absence of any direct report by her to any SLCJ staff of abdominal pain or severe abdominal pain.

These were the very types of patients who Dr. Wilcox was concerned about having more complicated opiate withdrawal and why he developed the WOWS protocol. Despite the reasonable efforts of the nursing, medical and security staff of the SLCJ, Ms. Ostler developed an unforeseen condition which was rapidly fatal.

III. The Policies & Procedures in place regarding medical care at the SLCJ were reasonable and appropriate. Specifically:

1. The Policies and Procedures of the SLCJ are in conformance with the National Commission on Correctional Health Care (NCCHC) and reflect best practices in the industry. (Reference 7)

2. The protocols implemented by the medical providers of SLCJ in their treatment of patients suffering from drug withdrawal and other medical conditions, such as Ms. Ostler, are exemplary and are well above the standard of care.

3. The practices of the medical, nursing and security staff relating to delivery of medical care at the SLCJ that I have reviewed are all designed to deliver quality care and are well within the standard of care.

Summary of My Opinions

The medical protocols in place at the SLCJ to treat patients with severe substance use and co-morbidities go well beyond the required standard of care and reflect best practices in the field. One hundred percent compliance with each of these protocols and best practices is aspirational and is not realistic. Just because each of these protocols is not complied with 100% of the time does not indicate that there is a breach of the standard of care or demonstrate deliberate indifference. The standard of care was exceeded in this case. Ms. Ostler's death was neither reasonably foreseeable nor preventable and was not a result of a breach of the standard of care. These nurses and correctional officers had no awareness that Ms. Ostler was suffering from a life-threatening condition, let alone severe abdominal

pain. They were attempting to deliver the highest level of care and there is certainly no indication that they intentionally or deliberately failed to provide care for a known serious medical need.

These opinions are expressed as requested to a reasonable degree of medical probability or likelihood. I reserve the right to review additional materials as noted or as they become available and to amend or modify these opinions based on the review of additional materials.

(ii) The facts or data considered by the witness in forming these opinions.

To assist me in forming these medical opinions I have reviewed records in this case, including:

1. Amended Complaint (& Proposed Second Amended Complaint)

2. SLCJ Administrative and Medical File

3. Medical Examiner Report

4. Investigative Reports, Incident Reports and Misc. Records

a. Notes from Nurses Colby James and Brent Tucker

b. Shift Logs and Watch Command Logs

c. Handwritten letter from inmate Candice Walker

d. Audio from DA and SSL investigators' interview with inmate Summer Johnson

e. Video footage

f. Radio transmissions

5. Various Pleadings in this case, including but not limited to:

a. Answer to Complaint

b. Response to Plaintiff's Request for Interrogatories of Colby James, Holly Harris, Jum Winder, Pam lofgreen, Salt Lake County, Todd Booth, Todd Wilcox, Brent Tucker

c. Responses to Plaintiff's Request for Production of Documents and Supplement

6. IMC Hospital Record

7. United Fire EMS Response

8. Prior Medical Records

a. Millennium ODT RADAR Reports, drug screens ordered by Dr. Todd Furness

b. DOPL Controlled Substance Report

c. Granite Peaks Gastroenterology

d. Dr. Murday

e. Dr. Todd Furness

f. Granite Peaks Medical

g. Jordan Valley Medical Center

h. University of Utah

i. Riverton Hospital

j. Taylorsville Instacare

k. St. Mark's Hospital

l. IHC American Fork lab records

m. Social Security Administration

9. SLCJ Policies & Procedures and Agreements

a. SLCJ Policy Manual 2016

b. SLCJ Health Services Unit Policies & Procedures

c. SLCJ Mental Health Services Agreement

d. Wellcon Agreement

e. SLCJ Procedural Orders

f. SLCJ Post Orders

g. SLCJ Emergency Orders

h. Prisoner Rules and Regulations Handbooks for years 2011-2016

i. Jail Red Book

10. Depositions

a. CO Todd Booth

b. CO Zach Fredrickson

c. CO Holly Harris

d. Nurse Colby James

e. Nurse Brent Tucker

f. Nurse Ron Seewer

g. Mr. Richard Bell

h. Ms. Pamela Lofgreen

i. Sheriff Jim Winder

j. Mr. Brad Lewis

k. Mr. Richard Bell 30(b)6

l. Todd Riser 30(b)6

m. Nathan Dean

n. Samuel Brown

o. Kellie Sheppard

p. Ms. Alicia Woodruff

q. Ms. Nicole Bates

r. Chief Deputy Matt Dumont 30(b)(6)

s. CO Michael Denning

t. CO Scott Sparkuhl

u. CO Donald Pace

Additional records requested:

I have also requested the following records which I have not received at this time:

1. Medical records from Dr. Robert Duncan Wallace (psychiatrist)

2. Medical records from Dr. Christopher Burgon Valentine

3. Medical records from Ann Elizabeth Lapolla, APRN

(iii) Any exhibits that will be used to summarize or support these opinions.

1. Wilcox, T. (2016). Managing Opiate Withdrawal: The WOWS Method. *Correct Care*, *30*(3), 12-13.
2. Coblijn, U. K., Lagarde, S. M., de Castro, S. M., Kuiken, S. D., & van Wagensveld, B. A. (2015). Symptomatic marginal ulcer disease after Roux-en-Y gastric bypass: incidence, risk factors and management. *Obesity surgery*, *25*(5), 805-811.
3. Azagury, D. E., Dayyeh, B. A., Greenwalt, I. T., & Thompson, C. C. (2011). Marginal ulceration after Roux-en-Y gastric bypass surgery: characteristics, risk factors, treatment, and outcomes. *Endoscopy*, *43*(11), 950-954.
4. Walsh, J. A., Zhou, X., Clegg, D. O., Teng, C., Cannon, G. W., & Sauer, B. (2015). Mortality in American Veterans with the HLA-B27 gene. *The Journal of rheumatology*, *42*(4), 638-644.
5. Braun, J., & Pincus, T. (2002). Mortality, course of disease and prognosis of patients with ankylosing spondylitis. *Clinical and experimental rheumatology*, *20*(6; SUPP/28), S-16.
6. Zochling, J., & Braun, J. (2008). Mortality in ankylosing spondylitis. *Clinical & Experimental Rheumatology*, *26*(5), S80.
7. National Commission on Correctional Health Care. (2014). *Standards for Health Services in Jails.*

(iv) The witness's qualifications, including a list of all publications authored in the previous 10 years.

See Appendix A for my current CV.

(v) A list of all other cases in which, during the previous four years, the witness testified as an expert at trial or by deposition.

See Appendix B for my case list from the last four years.

(vi) A statement of the compensation to be paid for the study and testimony in the case.

See Appendix C for my fee schedule.

X Thomas D. Fowlkes, M.D.

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SUMMARY OF QUALIFICATIONS

Seasoned Physician Board Certified in both Emergency Medicine and Addiction Medicine and with more than 20 years of practice in Correctional Medicine.

Accomplished expert witness with more than 10 years of experience at both deposition and trial in state and federal courts and before state regulatory bodies on behalf of plaintiffs/prosecutors/state boards as well as defendants in these matters.

Areas of expertise include:
- Correctional Healthcare
- Deaths in Custody
- Drug Abuse and Effects of Addiction
- Drug testing interpretation and effects of substances
- Urgent Care & Emergency Medicine

CERTIFICATIONS

Board certified emergency physician (American Board of Emergency Medicine)- July 1993 - Dec. 2023

Board certified in Addiction Medicine (American Board of Addiction Medicine)- Dec. 2010 - Dec. 2020

Certified Correctional Healthcare Professional - Physician (CCHP-P) - July 2017 - June 2020

Certified Medical Review Officer for Drug/Alcohol Testing (MROCC) - Dec. 2012 - Dec. 2022

Unrestricted license to practice medicine in Mississippi since 1993

PROFESSIONAL EXPERIENCE

1998-Present	Medical Director at Lafayette County (MS) Detention Center, a 140-bed jail facility holding local and federal (US Marshal) detainees. From 1998-2015, as an independent contractor responsible for provision of all medical, nursing, medication and lab services at the facility. Responsible for all these health services as an employee of Lafayette County, MS since 2015
2011- Present	Medical consultant for Third Circuit Judicial District Drug Court, a felony drug court in Oxford, MS under the direction of Administrator Brandon Vance and Judge Andrew Howorth
2007- Present	Prisoner Advocate Member, Institutional Review Board, Division of Research Integrity & Compliance, University of Mississippi
2018- Present	Co-owner and Physician at Right Track Medical Group, an outpatient provider of mental health services in North Mississippi

PROFESSIONAL EXPERIENCE (cont.)

1992-Present	Sole shareholder of Thomas D. Fowlkes, M.D., P.A. Contractor of emergency physician services to acute care facilities and emergency medicine/EMS consultant. Operated correctional medical facility at Lafayette County, MS Detention Center and conducted court ordered mental health, substance abuse & competency evaluations for Chancery Court in Lafayette County. Expert witness & litigation support practice
1999-Present	Served as Deputy Medical Examiner Investigator for Lafayette County MS from 1999-2008 after completing 40-hour Death Investigation Certification Class. Since 2008 I have served as the medical consultant to the Lafayette County Coroner.
2011-Present	Medical Director for A&D Services for Region IV Comm. Mental Health Center. 2011-2014 Detox Services at Tupelo CSU. 2017-Present at Corinth (Part-time)
2019-Present	Medical Director and co-owner of Express Care of Mississippi, LLC, an urgent care center in Cleveland, MS.
2015- 2018	Director of Professional & Medical Relations/Addiction Physician for American Addiction Centers, a nationwide provider of addiction services, at Oxford Treatment Center (formerly The Oxford Centre)
2009- 2017	Owner of a primary care clinic in Oxford, MS. Provider of primary and urgent care and an office-based addiction medicine practice. Until 2015, I practiced as a solo-practitioner then in partnership with a nurse practitioner as Oxford Family Clinic, LLC
2011- 2015	Co-owner and Chief Medical Officer of The Oxford Centre, Inc. a 76-bed CARF accredited detox, residential and outpatient substance abuse treatment facility. Sold to American Addiction Centers, a publicly traded company, in August 2015
2008-2011	Addiction physician for detox and residential unit at Haven House, substance abuse treatment facility in Oxford, MS operated by Region II CMHC (Part-time)
2005-2009	Urgent care physician at Robinsonville (MS) Urgent Care Clinic and part-time physician at the Harrah's Employee Health & Wellness Center
1998-2001	Private practice of Emergency Medicine with Oxford Emergency Group, P.A. Provided emergency physician services to Baptist Memorial Hospital-North Miss. and Tri-Lakes Medical Center
1997-1998	Chief Medical Officer for Rural-Metro Corporation's Mid-South region. Rural-Metro provides ambulance services and fire protection throughout the United States and internationally.
1995-1997	Chief Medical Officer, secretary/treasurer and co-owner of Priority EMS, an ambulance provider in north Mississippi and metropolitan Memphis. Corporation merged with Rural-Metro Corp., a publicly traded company
1992-1994	Private practice of Emergency Medicine as shareholder and officer in Mid-South Emergency Physicians, P.C. Provided emergency department services for St. Joseph Hospital in Memphis, TN

EDUCATION

University of Pittsburgh Residency in Emergency Medicine
Pittsburgh, PA
1989-1992
Selected Chief Resident-1992
Served as medical command & on-scene physician for City of Pittsburgh, Dept. of Public Safety
Served as flight physician for STAT Med-evac helicopter program

University of Tennessee Medical School
Memphis, TN
M.D. 1989
Faculty Medal for Highest GPA
Alpha Omega Alpha Medical Honor Society

Rhodes College
Memphis, TN
B.S. in Psychobiology 1985
EMT with Shelby County Sheriff's Department, Division of Emergency Services
Psychiatric Technician at Memphis Mental Health Institute, an acute care psychiatric hospital

University of the South
Sewanee, TN
1980-1982
Community Volunteer Firefighter
Emergency Medical Technician (EMT-A)

CURRENT MEMBERSHIPS/RECOGNITIONS

American College of Correctional Physicians
Fellow of the American Society of Addiction Medicine
Mississippi Society of Addiction Medicine
North Mississippi Medical Society/Mississippi State Medical Association/American Medical Association

PUBLICATIONS

Fowlkes T. "Shortness of Breath." *Prehospital Systems and Medical Oversight.* 3rd ed. Ed. Kuehl A. Dubuque: Kendall/Hunt, 2002. 665-671. Print.

Fowlkes T. "Shortness of Breath." *Prehospital Medicine: The Art of On-Line Medical Command*. 1st ed. Eds. Paris, Roth, Verdile. Maryland Heights: Elsevier, 1996. 101-112. Print.

Fowlkes T, Verdile V. "Managing Gunshot Wounds." *The Journal of Emergency Services.* Vol. 23 (1990): 20-27. Print.

PRESENTATIONS/TEACHING

Instructor for modules on “Health Care Issues,” “Responding to Medical Emergencies,” and “Responding to Special Needs Inmates” for the *Mississippi State Standards & Training- Corrections Officer Training Course,* September 18 & 19, 2019, at the DeSoto County Sheriff’s Department in Hernando, MS

Videotape Presentation on “Reasonable Suspicion for Drug Testing” as part of *DOT Training for Supervisors,* Asmark Institute, Owensboro, KY, September 9, 2019

"Safe Prescribing of Sedative-Hypnotics" at *MPHP Prescribers' Summit: Controlled Substance Update* June 22, 2018, Pearl, MS

"Safe Prescribing of Sedative-Hypnotics" at *MPHP Prescribers' Summit: Controlled Substance Update* April 13, 2018, Gulfport, MS

"Safe Prescribing of Sedative-Hypnotics" at *MPHP Prescribers' Summit: Controlled Substance Update* March 9, 2018, Oxford, MS

"Case Studies in Controlled Substance Prescribing" at *MPHP Prescribers' Summit: Controlled Substance Update* October 13, 2017, Jackson, MS

"Case Studies in Controlled Substance Prescribing" at *Mississippi State Medical Association Foundation Prescribers' Summit* March 31, 2017, Oxford, MS
"Update on the Prescription Drug Epidemic, Disturbing New Trends & Drug Testing Basics" at *Lafayette County Bar Association's Continuing Legal Education Conference* October 20, 2016, Oxford, MS

"Benzodiazepines: An Update" at *North Mississippi Medical Center's 13th Annual Outcomes Conference* August 25, 2016, Pickwick, TN

"Sedative Hypnotics: Avoiding Prescribing Pitfalls" at *Mississippi Professionals Health Program Prescribers' Summit* June 24, 2016, Gulfport, MS

"Benzodiazepines: Update on Prescribing Trends" at *Mississippi State Medical Association Foundation Prescribers' Summit* April 1, 2016, Oxford, MS

"An Introduction to the Prescription Drug Epidemic", Guest lecturer, *Addiction Counseling Course in the Graduate School of Counselor Education, University of MS*, February 22, 2016, Oxford, MS

"Benzodiazepines: An Update" at *37th Annual Caduceus Retreat & Conference of MS State Medical Association Foundation*, July 11, 2015, Louisville, MS

"An Introduction to the Prescription Drug Epidemic", Guest lecturer, *Addiction Counseling Course in the Graduate School of Counselor Education, University of MS*, February 10, 2015, Oxford, MS

"Prescription Drug Epidemic: Trouble at Home" at *Annual FACT Conference*, November 7, 2014, Tupelo, MS

"Mental Health in the Primary Care Setting" Keynote Address at *North MS Medical Center Outcomes Conference*, August 22, 2014, Pickwick, TN

"Managing Opiate Addicts with Painful Conditions" at *North MS Medical Center Outcomes Conference*, August 21, 2014, Pickwick, TN

PRESENTATIONS/TEACHING (cont.)

"Buprenorphine: The Rest of the Story" at *24th Annual MS Association of Addiction Professionals Conference*, July 22, 2014, Oxford, MS

"Prescription Drug Epidemic: Trouble at Home" at *24th Annual MS Association of Addiction Professionals Conference*, July 22, 2014, Oxford, MS

"Controlled Substance Update" at *MS State Medical Association Foundation Prescribers' Summit*, March 28, 2014, Oxford, MS

"Benzodiazepines: The Good News & Bad News" at *Northwest MS Regional Medical Center Staff Conference*, Dec. 10, 2013, Clarksdale, MS

"Benzodiazepine Update" at *Southern Medical Association Rules, Regulations, & Risks of Prescribing Controlled Substances,* November 15, 2013, Hattiesburg, MS

"Controlled Substances Update: Benzodiazepines" at *Singing River Health System Prescribers' Summit*, November 1, 2013, Moss Point, MS

"Controlled Substances Update: Benzodiazepines" at *MS Professionals Health Program Prescribers Summit*, October 18, 2013, Jackson, MS

"Managing Controlled Substances in MS: Benzodiazepines" at *North MS Medical Center Best Outcomes Conference*, August 22, 2013, Pickwick, TN

Appendix B

Thomas D. Fowlkes, M.D.

CASE LIST/EXPERT TESTIMONY LAST 4 YEARS (AS OF 11/08/2019)

State of Mississippi v. Kimberly Dobbs
Third Judicial Circuit (MS) Court

State of Mississippi v. Mark Tutor
Cause # Rankin 24,819
Third Judicial Circuit (MS) Court

State of Mississippi v. Cileste Donald
Cause # LK12-196
Third Judicial Circuit (MS) Court

State of MS v. Joshua Blunt
Cause # 2016-060-CR
Grenada County (MS) Circuit Court

MS Board of Medical Licensure v. Ikechukwe Okorie, MD
Hinds County, MS

MS Board of Nursing v. Justin Robbins
MS Board of Nursing v. Jennifer Robbins
Hinds County, MS

Lee v. Jackson County MS et al.
Case # 1:13-cv-441
US District Court, Southern District MS

Paylan v. Teitelbaum et al.
Case # 1:15-cv-159
US District Court, Northern District FL

Bost v. Wexford et al.
Case # 1:15-cv-3278
US District Court, Maryland

Singleton v. Southern Health Partners et al.
Case # 15-EV-000626
State Court of Fulton County, State of Georgia

CASE LIST/EXPERT TESTIMONY LAST 4 YEARS-CONTINUED

E/O Filichia v. Correct Care Solutions et al.
Case # 2:16-cv-296
US District Court, Southern District OH

Ajibade v. John Wilcher et al.
Case # 4:16-cv-82
US District Court, Southern District GA

Benoit v. Lincoln County et al.
Cause # 12L6-CC00060
Circuit Court of Lincoln County, State of Missouri

E/O Clark v. Hamilton County, NaphCare et al.
Case # 1:15-cv-512
US District Court, Southern District OH

E/O Hays v. Prison Healthcare et al.
Case # 2:16-cv-384
US District Court, Northern District AL

Sparks v. Tooke et al.
Civil Action # 099912-A
District Court, 7th Judicial District, State of Wyoming

Brooks (E/O Mixon) v. Wilkinson County et al.
Case # 5:17-cv-00033
US District Court, Middle District GA

E/O Gracia v. Orange County et al.
Case # 6:17-cv-01423
US District Court, Middle District FL

Parkes v. Jasper County et al.
Cause # 18AO-CC00016
Circuit Court of Jasper County, Missouri

E/O Leverett v. Correct Care Solutions et al
Cause # 2017RCSC00672
State Court of Richmond County, Georgia

CASE LIST/EXPERT TESTIMONY LAST 4 YEARS-CONTINUED

Ivey v. Audrain County et al.
Case # 2:17-cv-00082
US District Court, Eastern District MO

E/O Wesley v. Escambia County, et al
Cause # 3:18-cv-1368
US District Court, Northern District FL

Harris (E/O Wood) v. Entergy of Arkansas Inc., et al
Cause # cv-17-126-3
Circuit Court of Marion County, Arkansas Civil Division

Davis (E/O Stufflebean) et al v. Buchanan County, Missouri et al
Case # 17-cv-06058
US District Court, Western District of Missouri

E/O Legros v. Choctaw County, Oklahoma, et al
Case # 18-cv-261
US District Court, Eastern Division of Oklahoma

E/O Clifton v. Champaign County, Illinois, et al
Case # 1-2070
US District Court, Central District of Illinois

Marziale v. Correct Care Solutions, et al
Case # 5:18-cv-86
US District Court, Eastern District of Arkansas

E/O Warner v. Faulkner County, Arkansas, et al
Case # 4:18-cv-468
US District Court, Eastern District of Arkansas

E/O Angerbauer v. LaSalle Correctional, LLC, et al
Case # 4:16-cv-129
US District Court, Eastern District of Texas

Pickle v. Central Montana Medical Center, et al
Case # 6:18-cv-00029
US District Court, District of Montana

Appendix C

Thomas D. Fowlkes, M.D.

FEE SCHEDULE

I am being paid $500 per hour for review, study & testimony in this case plus travel expenses.

There is no charge for travel time.

Minimum charge for deposition testimony is 4 hours.

Minimum charge for trial testimony is 8 hours.