EXHIBIT G

CONFIDENTIAL - SUBJECT TO PROTECTIVE ORDER

ROGERS vs. SHERIFF OF COOK COUNTY

DEPOSITION OF: STAMATIA Z. RICHARDSON, M.D.

MAY 10, 2018

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

KEITH ROGERS,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	No. 15 CV 11632
	)	
SHERIFF OF COOK COUNTY and	)	
COOK COUNTY, ILLINOIS,	)	
	)	
Defendants.	)	

The deposition of STAMATIA Z. RICHARDSON, M.D., called for examination pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before Kathleen M. Duffee, a Notary Public within and for the County of Cook and State of Illinois, at 200 South Michigan Avenue, Suite 200 Chicago, Illinois, on the 10th day of May, 2018 at the hour of 11:12 a.m.

Reported by: Kathleen M. Duffee, CSR
License No: 084-003497

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occupation?

A. I'm a physician.

Q. And where are you presently employed?

A. I'm employed by Cermak Health Services of the Cook County Health and Hospitals System.

Q. How long have you worked for Cook County?

A. Since August of 1993.

Q. When did you first become a physician?

A. June of 1990.

Q. When did you -- well, before working for Cook County, were you employed as a physician?

A. I was a resident physician.

Q. Where were you a resident physician?

A. I was at the Northwestern University/ St. Joseph Hospital family practice residency program from 1990 to 1993.

Q. And why did you leave there to go to work for Cook County?

A. I completed my residency program.

Q. What are your present responsibilities at Cermak Health Services?

A. I presently am a Division Chair of

Correctional Health. My title includes administrative operations and quality. I am also the Medical Director of the Opioid Treatment Program.

Q. For how long have you been the Medical Director of the Opioid Treatment Program?

A. Since September of 2009.

MS. SCHELLER: Counsel, just for the record, the witness does have her CV in front of her, and she did just reference it. So you are aware.

MR. FLAXMAN: Okay.

BY MR. FLAXMAN:

Q. Do you know who was the Medical Director of the Opioid Treatment Program before you?

A. No.

Q. Do you do any research in opioid treatment?

A. No.

Q. Have you published anything about opioid treatment?

A. Only about Narcan overdose treatment.

Q. And how many publications about --

BY MR. FLAXMAN:

Q. And which accrediting body is that?

A. There are several of them. There's the DEA; there's DASA, which is the State agency that licenses OTPs; the SAMHSA organization, which also licenses OTPs; and the National -- the NCCHC, national correctional care health guidelines that actually accredits the program.

Q. You mentioned a State agency. What's the name of the State agency?

A. DASA, the Drug Administration -- I'm sorry. I don't have that in front of me, so I don't remember what the acronym stands for.

Q. Is there a particular regulation of the DEA that speaks to 72 hours for detainees entering the jail?

A. I'm not sure if it's specific to the correctional setting. It's when we are transferring from one program to another.

Q. The State agency whose name you don't quite know, does that speak to 72 hours in a correctional institution?

A. None of the agencies are specific to correctional institutions.

Q. Well, the National Commission on Correctional Health Care, is that specific to correctional institutions?

A. Yes, it is.

Q. And to jails?

A. Not particularly, no.

Q. Is there anything in the NCCHC standards that refers to 72 hours?

A. I'm not sure.

Q. The next sentence in Exhibit 1 states that you're going to further opine that the OTP is a cutting-edge treatment program. Are you going to opine that the OTP is a cutting-edge treatment program?

A. Yes.

Q. And why do you believe that the OTP at Cermak Health Services is a cutting-edge treatment program?

A. Only about 1 percent of correctional facilities have an OTP. Most correctional facilities don't give any detoxification to patients that are on methadone.

Q. And what's the basis for your understanding that 1 percent of -- well, strike

those pregnant, who enter the Cook County Jail while taking methadone in a recognized program?

A. No, it is not.

Q. Has it ever been?

A. Yes.

Q. When was it?

A. In 2014 for instance. I can't tell you the exact date. Our policies keep changing based on community standards, based on community resources, based on the Affordable Care Act and who can get medication-assisted treatment medication for Opioid Use Disorder.

Q. Well, back in 2014 when Mr. Rogers entered the Cook County Jail, was the goal of Cermak Health Services to alleviate the symptoms of withdrawal from methadone for detainees whose methadone prescription was being tapered?

A. Yes.

Q. When did that change?

A. It changed in July of 2016. I'm sorry. 2017.

Q. And how did it change?

A. As we had more resources in the community and more public moneys actually, more

grant moneys, where the City, Public Health Department, and an Opioid Task Force that the City put together wanted to start more patients on medication-assisted treatment, we were able to start more patients, to keep -- maintain patients on methadone and to start patients on buprenorphine.

We also, since April of last year, have also had a VIVITROL program.

Q. I didn't hear that.

A. Since April of last year, we have also had a VIVITROL program, which is also medication-assisted treatment for Opioid Use Disorder.

We don't live in a vacuum in jail. Patients have to return to the community. It would be completely, utterly irresponsible to start patients on medication-assisted treatment if they don't have a provider to go to and can't pay for it.

Q. Am I correct that in July of 2017 Cermak Health Services changed its tapering program?

A. Yes.

that the OTP is in full compliance with the standards required for accreditation by the DEA, do you see that?

A. Yes.

Q. Is there anything in the DEA standards about tapering?

A. No.

Q. You also say that the program is in full compliance with the SAMHSA?

A. Yes.

Q. Is there anything in the SAMHSA standards about tapering?

A. Yes.

Q. And what is there in the SAMHSA standards about tapering?

A. So the -- I would need to see the document. I don't have it memorized.

Q. Let me show you what's been marked as Plaintiff's Deposition Exhibit No. 11 or 10. It looks like 10.

(Whereupon, Deposition Exhibit No. 10 was tendered.)

MS. SCHELLER: Thank you.

BY THE WITNESS:

A. Detox, page 71. You know what? It's not numbered according to the --

BY MR. FLAXMAN:

Q. Oh, okay. Is it 71?

A. Of the actual publication, and we took out pages. So I don't know what page it is.

Q. Is there a deposition exhibit page? Oh, you're looking at the Index?

A. Yes.

Q. All right.

A. So the Index, it starts on page 71. So, let's see, under Appendix C, I'll have to find what exhibit page it is. The document pages were taken out. Oh, 73.

Q. Detoxification Program?

A. Yes.

Q. Can you point me where?

A. The whole page is about detoxing, the Detoxification Program.

Q. And how does the program, the OTP program at Cermak comply with page 73 of Deposition Exhibit No. 10?

A. Well, the previous, all the previous

pages have all these standards, and we have to fulfill all of them. So we have to have a human resources manager, and we have to do risk management. We have to do program sponsor and Medical Director. We have to have a QA program.

There's all these guidelines as to how to run the program, and just because it's a detoxification program does not mean we can skip any of the points.

So we have to have a treatment plan. We have to have individualized. We have to have mental health programming for our patients. We have to have, uhm, we have to do urine toxicology screens. There's a whole -- the whole program is described.

Q. Was there a treatment plan for Mr. Rogers?

A. Yes, there was.

Q. Was that in his medical record?

A. Yes, it was.

Q. Mr. Rogers was tapered on methadone?

A. Yes, he was.

MR. FLAXMAN: We'll miss you.

MR. HENRETTY: Sorry. I've got to run.

BY MR. FLAXMAN:

Q. When you use the word certain, what did you mean?

A. I meant methadone.

Q. Okay. And then the next, after that it says: will not necessarily result. What did you mean by necessarily result?

A. So if a patient has withdrawal symptoms, it depends on the substance they took last and the half-life of that substance.

So some of the symptoms of withdrawal that our patients have while they are waiting to get their methadone dose is not related to methadone. So it's illicit substances, benzodiazepines, alcohol, heroin.

So the amount of time it takes from the last dose you took of your medication to the time you start having withdrawal systems is directly correlated with how long the meth -- how long the half-life is.

Q. How long does it take from when you stop taking methadone to when you experience withdrawal symptoms?

MS. SCHELLER: Objection, incomplete

is 24 hours, sometimes longer.

Q. And how did you learn that?

A. It's just anecdotal experience from having done receiving work for years.

Q. And do you have any data about how long it took in January of 2014, on average, from when you came into the jail to when you started to receive methadone if you were enrolled in a properly licensed methadone program?

MS. SCHELLER: May I have the question read back, please?

(Record read as requested.)

MS. SCHELLER: You may answer.

BY THE WITNESS:

A. So from the time? This is why I put together that spreadsheet with my lawyers. The spreadsheet went through 200 patients and how long from the time they were seen in medical intake to the time they started their first dose. So I think the average was less than three days.

BY MR. FLAXMAN:

Q. So if the average was two days and someone is in police custody for one day, then

we're at that 72 hours of withdrawal symptoms, aren't we?

MS. SCHELLER: Object to form of the question, incomplete hypothetical. You may answer.

BY THE WITNESS:

A. The reason we have the three-day rule is to be able to get information as fast as we can from the clinics they come from. I have no control how long police custody holds them or when they last got their last dose from the time before medical intake.

The reason we have the three days is to give us time to get the proper dose. If a patient gets the wrong dose, it could kill them. It's dangerous.

BY MR. FLAXMAN:

Q. Now, do you personally verify that someone is enrolled in a methadone program?

A. No, I do not.

Q. Who does?

A. We have had various clerical personnel that have done that over the years. Currently, and I believe in 2014, it was our urgent care

clerk.

Q. What about now?

A. I believe it's our urgent care clerks that do that.

Q. Is there more than one?

A. Yes.

Q. How many?

A. I don't know how many we have. We have a 24/7 run of urgent care. As soon as we get our methadone forms from the night before, they're faxed first thing in the morning when the clinics open so they can give us a response.

Q. When you say the night before, what do you mean by that?

A. Medical intake is always in the evening. None of their clinics are open. We cannot verify any doses even if we called them. They're not open.

Q. Is there any reason why it would not be practical to determine -- to get information from the detainee before the evening about whether he or she is enrolled in a methadone program?

A. They are physically not there.

enrolled in methadone programs, would they be continued on methadone or given methadone?

A. Once it was established that they had a dose and when their last dose was, yes.

MS. SCHELLER: Counsel, may I ask if you would try hitting Control +, because that would make these documents slightly larger.

MR. FLAXMAN: I'm giving up.

MS. SCHELLER: Oh, okay.

MR. FLAXMAN: This is not productive.

MS. SCHELLER: Okay. All the better for my eyes.

MR. FLAXMAN: You know, it's better for my eyes too. I thought it would be a good idea, but it's not.

THE WITNESS: I want to assure you that we took this very seriously. That's why I went through every single chart of 200 patients related to around this time to see if maybe there's something I had missed in our QA study.

It's my responsibility as the Medical Director of the program to realize if we had a substantial delay in many of our patients. Yes, Mr. Rogers and maybe a couple other people of

the 200, it was unexplained and an atypical delay, but most of our patients were within.

I looked at every single chart and every page of our OTP notes. I was concerned. I was, like, did I miss something? Were we having people delayed that much that this came up, and I didn't find that it was very many patients that were delayed.

BY MR. FLAXMAN:

Q. Do you know if there's ever been any study conducted to see if the delay from coming into the jail and getting restarted on methadone has decreased from 2010?

A. Yes. We have the same QA study that's provided by the pharmacy every year, and there's no change in the amount of delay we have. We don't have much of a delay.

I will insist, will always insist that we do the safest thing for our patients. We don't want to endanger anybody, starting too soon without getting that information. That's what takes sometimes a day or two to get that information. I need that information. I can't endanger any of the patients.

Q. When you did your tabulation, did you consider the pharmacy records would show when methadone was actually dispensed or did you consider the medical records would show when the enrollment in the program was verified?

A. So the prescription is signed by the provider. The actual record that I looked at was when the pharmacist put it in the system and literally gave the first dose.

In Mr. Rogers' case we were -- I noticed his first visit. He, uhm, we didn't catch, uhm, our own staff did not catch the delay. It was so atypical, so rare if there's a delay. Is it because the scrip was written and then the patient didn't start?

It was very atypical, and I was very glad to see that we weren't endangering other patients or purposely delaying other patients. I didn't see a big change. I really do think he was a big outlier.

Q. Did you ever look at the data for delay from entering the jail to when methadone was dispensed for 2011?

MS. SCHELLER: Objection.

BY THE WITNESS:

A. Yes.

MS. SCHELLER: Objection to the question. 2011 is far outside the temporal scope of any discovery order issued in this case. More to the point, the Court has already ruled that 2011 data is of questionable relevance here. We're not going to get into 2011, counsel.

MR. FLAXMAN: Are you instructing her not to answer?

MS. SCHELLER: I'll let her answer once, and beyond that I'm going to instruct her not to go into 2011 data since your client entered the jail in 2014.

BY MR. FLAXMAN:

Q. Can you answer the question?

A. So yes, the same QA study that the pharmacy has been having ever since I've been a Medical Director includes when, from the time from receiving to the time of first dose in tabulated form. It's, like, it comes up in the Bates records over and over again in our QA. Counsel mentioned which pages to look at.

Pharmacy gives a quarterly report, and

they keep adding on to the year by three months at a time.

Q. All right.

A. And we never had an outlier of delay at any point for the whole, whole group of our patients.

MR. FLAXMAN: I would go longer, but I feel terrible.

MS. SCHELLER: I'm sorry, counsel.

THE WITNESS: And that being said --

MS. SCHELLER: Stop talking. There's no question. Do you have any questions?

MS. WHITE: I don't have any questions.

MS. SCHELLER: I have a few questions.

EXAMINATION

BY MS. SCHELLER:

Q. Dr. Richardson, you've spoken a bit today about danger and safety. Could you please describe for us what dangers, if any, you believe are presented by methadone as a substance?

A. So methadone is a long-acting opiate. It has a very long half-life; and like any opioid, you can overdose on it. It causes