043133/19344/MHW/REN/SLB

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

JOHNNY JONES,

Plaintiff,

v.

WEXFORD HEALTH SOURCES, INC. and DR. MARSHALL JAMES,

Defendants.

Case Number 17 cv 8218

Honorable Mary M. Rowland

DEFENDANTS' LOCAL RULE 56.1 STATEMENT OF FACTS IN SUPPORT OF THEIR MOTION FOR SUMMARY JUDGMENT

Defendants, WEXFORD HEALTH SOURCES, INC. ("Wexford") and DR. MARSHALL JAMES ("Dr. James") (collectively, "Wexford Defendants"), by and through their attorneys, Matthew H. Weller, Ronald E. Neroda and Sandra L. Byrd of CASSIDAY SCHADE LLP, and for their Local Rule 56.1(a) Statement of Facts, state:

Jurisdiction and Venue

1. Plaintiff filed his Complaint on November 13, 2017 alleging deliberate indifference to Plaintiff's serious medical needs in violation of 42 U.S.C. § 1983 and healing arts malpractice. [Dkt. #1, ¶ 22]. Plaintiff's alleged injuries occurred while he was an inmate at Sheridan Correctional Center ("Sheridan") [Dkt. #1, ¶ 4] which is located in LaSalle County, Illinois, thus venue is proper in the Northern District of Illinois.

The Parties

2. Plaintiff, Johnny Jones, is a 47 year-old former inmate in the Illinois Department of Corrections ("IDOC") *See* Deposition Testimony of Johnny Jones, attached as ***Exhibit A***, 7:23-24; Dkt. #1, ¶ 4. Plaintiff was incarcerated in the IDOC between February 14, 2014 and

June 2016 serving a seven year sentence for the offense of Manufacture and Delivery of a Controlled Substance, (Ex. A, 11:1-3; 12:23-13:7; 14:11-14), and has been out of custody uninterrupted since his release. (Ex. A, 11:4-6). Plaintiff also has criminal convictions for attempt Armed Robbery, Possession of a Controlled Substance and Driving under the Influence. (Ex. A, 13:13—22). Plaintiff is not a licensed medical doctor and does not have any special education or work experience related to diagnosing or treating medical conditions. (Ex. A, 18:15-19:9; 20:3-4).

3. Defendant, Dr. Marshall James, is a physician currently employed at Marram Health Clinic in Gary, Indiana. *See* Deposition Testimony of Dr. Marshall James, attached as ***Exhibit B***. Between the dates of September 2014 and October 2015 Dr. James was employed by Wexford as the Medical Director at Sheridan. (Ex. B, 11:11-14).

4. Defendant, Wexford Health Sources, Inc. is a correctional healthcare company that provides specified medical services to inmates at IDOC prisons pursuant to a contract with the State of Illinois. [Dkt. # 1, ¶ 6].

Non-Party Witnesses

5. Neil Fisher, M.D. provided testimony as Wexford's 30(b)(6) witness. *See*, Deposition Testimony of Dr. Neil Fisher, attached as ***Exhibit C***.

6. Ankhur Behl, M.D. testified as Plaintiff's treating physician. *See* Deposition Testimony of Dr. Ankhur Behl, attached as ***Exhibit D***. Dr. Behl attended the University of Oklahoma for both undergraduate and medical school, (Ex. D, 5:7-10), trained in orthopedic surgery for five years at Fort Worth Affiliated Hospitals and did a one year fellowship in sports medicine at Indiana University in Indianapolis. (Ex. D, 5:10-20). Dr. Behl works at Midwest

Orthopedics in Sandwich, Illinois and has approximately 25 inmates as patients during the five years he has been employed by Midwest Orthopedics. (Ex. D, 6:11-20).

7. Nikhil Verma, M.D. testified as Plaintiff's treating physician. *See* Deposition Testimony of Dr. Nikhil Verma, attached as ***Exhibit E***. Dr. Verma attended medical school at the University of Pennsylvania, completed an orthopaedic residency at Rush University Medical Center in Chicago, Illinois, and completed a fellowship in sports medicine and shoulder at the Hospital for Special Surgery in New York. (Ex. E, 5:5-11).

8. Chadwick Prodromos, M.D. obtained his Bachelor of Arts degree from Princeton University in 1975 and his medical degree from Johns Hopkins University Medical School in 1979. He completed his surgical internship at the University of Chicago in 1980, his orthopaedic residency at Rush Presbyterian St. Luke's Medical Center in 1984 and his orthopaedic and sports medicine fellowship at Harvard Medical School/Massachusetts General Hospital in 1985. Dr. Prodromos has been board certified in orthopaedic surgery since 1987. Dr. Prodromos served as an assistant professor in Rush University's Department of Orthopaedic Surgery for more than 25 years and is currently the President of the Illinois Sportsmedicine and Orthopaedic Centers and Medical Director of the Illinois Orthopaedic Foundation. *See* Expert Witness Report of Dr. Chadwick Prodromos, attached as ***Exhibit F***.

9. Vincent Cannestra, M.D. testified on behalf of Plaintiff. Dr. Cannestra received his undergraduate and medical degrees from Northwestern University. He completed his internship in internal medicine at the State University of New York at Buffalo, his residency in orthopaedic surgery at Northwestern University in Chicago, Illinois and a joint replacement/reconstruction fellowship at Rush Presbyterian St. Luke's Medical Center and Central DuPage Hospital. Dr. Cannestra is employed by Orthopedic and Spine Surgery

Associates, Ltd. in Elgin , Illinois. *See* Deposition Testimony of Vincent Cannestra and attached Exhibits, attached as ***Exhibit G***.

Factual Background

10. Plaintiff entered the IDOC on February 14, 2014. After a short stay at Stateville Northern Reception Center, Plaintiff was transferred to Sheridan Correctional Center ("Sheridan") where he served the remainder of his sentence. (Ex. A, 14:15-15:6).

11. Upon his arrival at Sheridan, Plaintiff received an inmate handbook from which he learned the rules of the facility, including the rules related to sick call and grievances. (Ex. A, 15:7-16:15). In order to obtain healthcare while an inmate at Sheridan, Plaintiff would submit a request and he would be called to sick call the following day. (Ex. A, 16:13-18).

12. Plaintiff's left leg was injured prior to his admission to the IDOC—Plaintiff has a rod in his left leg as the result of a gunshot wound, (Ex. A, 24:9-25:2), and in 2007 he ruptured his left achilles tendon. (Ex. A, 28:7-16).

13. While an inmate at Sheridan, on Saturday, November 14, 2015, Plaintiff was playing basketball when he jumped up to rebound a basketball. While he was in the air Plaintiff felt and heard something snap. (Ex. A, 31:2-10; Dkt. #1, ¶9). Plaintiff was helped from the ground by a couple of prison guards who took Plaintiff to the health care unit where he was examined by a nurse. (Ex. A, 31:11-22). The nurse noted that Plaintiff's left knee did not have any swelling, any tenderness, any bruising, no cuts or open wounds, and Plaintiff's pain level was four on a scale of one to ten. (Ex. G, 42:22-43:17). The nurse contacted Dr. James via telephone and Plaintiff was returned to his cell with a pair of crutches and pain medication. (Ex. A, 32:3-33:5). Plaintiff was in the healthcare unit with the nurse for approximately one hour. (Ex. A, 32:19-21).

14. Two days later, Plaintiff returned to the healthcare unit to see Dr. James. (Ex. A, 33:21-34:11; Ex. B, 26:12-14). It was not unreasonable for Dr. James to wait two days to see Plaintiff based on the physical exam findings of the nurse on November 14, 2015. (Ex. G, 49:17-23). Dr. James conducted a 20 minute examination of Plaintiff during which Plaintiff told Dr. James that he injured his head and knee playing basketball and told Dr. James how he was feeling. (Ex. A, 34:17-20; 35:17-36:1; Ex. B 26:15-19). Dr. James noted that Plaintiff's left knee was slightly swollen, did not have any deformities, had a little laxity, or movement, in the patella, was similar in presentation to Plaintiff's right knee. (Ex. B, 15:14-16:1). Dr. James ordered x-rays, prescribed Plaintiff 600 milligrams of Motrin twice a day for pain for six weeks, crutches for six weeks, lay-in for four weeks, and no group classes for four weeks. (Ex. B, 26:22-27:10).

15. A week later, Dr. James personally told Plaintiff the results of his x-ray, (Ex. A, 36:13-20), which showed that Plaintiff had some osteoarthritis of his knee joint, mild swelling and a slightly high riding patella. (Ex. B, 34:16-22). Plaintiff's x-ray did not show any loose bodies and there was no evidence of an acute boney fracture. (Ex. B, 34:23-35:5).

16. Between the date Plaintiff first saw Dr. James after his knee injury and the date Plaintiff received his x-ray results, he received pain medication and all other requested healthcare from the prison healthcare staff, (Ex. A, 38:7-23), and Plaintiff was never refused healthcare treatment related to his knee injury. (Ex. A, 39:7-9). Plaintiff's only complaint related to Dr. James' medical care is that Dr. James did not order an MRI within the timeframe Plaintiff felt was appropriate. (Ex. A, 84:2-17).

17. Dr. James referred Plaintiff for an MRI on December 8, 2015 and his referral was approved by Wexford on December 15, 2015. (Ex. B, 38:21-41:8). When a Wexford-employed

physician, such as Dr. James refers a patient for an off-site medical procedure, that referral is forwarded to the Wexford corporate offices by an employee of the IDOC for a collegial review among physicians. (Ex. C, 7:14-11:8). These reviews take place on a weekly basis. (Ex. C, 10:8-10). Once an off-site procedure is approved, IDOC staff at the facility where the patient resides schedules the off-site medical procedures. (Ex. B, 44:9-18; Ex. C, 17:4-23). This procedure was followed for Plaintiff. (Ex. C, 18:19-22). Dr. James was not involved in scheduling off-site procedures for inmates. (Ex. B, 44:19-21).

18. Plaintiff had an MRI at Valley West Hospital on January 18, 2016. (Ex. B, 47:21-23). Between the date of his injury and the date Plaintiff had his MRI he saw Dr. James on multiple occasions. (Ex. A, 49:18-22).

19. Plaintiff's MRI showed a complete tear of his patellar tendon at its origin. (Ex. B, 51:2-10). Plaintiff first saw the surgeon, Dr. Behl, on February 8, 2016, (Ex. D, 15:10-13), and Dr. Behl successfully performed patellar reconstruction surgery on February 16, 2016. (*Id.*; Ex. D, 27:4-22).

20. The day after his surgery, Plaintiff saw Dr. James in the Sheridan infirmary. (Ex. A, 50:24-51:2). Between the date of his surgery in February 2016 and his release from the IDOC in June 2016, Plaintiff saw Dr. James three times a week. (Ex. A, 51:3-6). During this time, Plaintiff was housed in the prison infirmary where he had access to 24 hour a day medical care, (Ex. A, 51:7-24), and was never refused medical care. (Ex. A, 52:1-4; 62:13-18).

21. Following his surgery, and prior to his release from the IDOC, Plaintiff was taken to all his follow-up appointments with his surgeon, (Ex. A, 52:5-16), and his progress was as expected by Dr. Behl. (Ex. D, 28:9-11, 29:24-30:2, 31:2-4, 31:10-12). During at least two of these appointments, Plaintiff worked with a physical therapist. (Ex. A, 53:8-13; Ex. D, 29:1-7).

The physical therapist instructed Plaintiff on exercises to perform, (Ex. D, 29:4-10, 31:15-17), although Plaintiff denies this. (Ex. A, 53:17-20). Instead, every three days Plaintiff would do one exercise on his own that he learned about on television. (Ex. A, 53:21-54:9).

22. Plaintiff was released from custody on June 6, 2016, (*See*, Illinois Department of Corrections, Offender Count Adjustment, attached as ***Exhibit H***), with a knee brace, crutches and a cane. (Ex. A, 64:15-24). At that time, Plaintiff had a follow up appointment scheduled with his surgeon that he did not attend, (Ex. A, 62:19-63:22), instead, on July 5, 2016, a month after his release and nearly two months to the day after he last saw Dr. Behl, Plaintiff called Dr. Behl for a referral to a new physician. (Ex. D, 32:7-33:16). During this time, Plaintiff did not do any do any physical therapy, (Ex. A, 63:23-64:2; 67:17-21), or see any other doctors. (Ex. A, 64:3-5).

23. When Plaintiff left Dr. Behl's care, Dr. Behl considered Plaintiff's surgery a success and did not expect that Plaintiff would need further surgery. (Ex. D, 27:4-6, 34:1-4, 34:24-35:7). However, Plaintiff had a second surgery on October 11, 2016. At that time, Dr. Verma successfully performed elective arthroscopic surgery on Plaintiff's knee. (Ex. E, 19:2-21). According to Dr. Verma, the surgery he performed on Plaintiff is the most common problem doctors see following patellar tendon ruptures. (Ex. E, 9:3-8). Likewise, Plaintiff's prior medical history, including the history of Plaintiff's knee injury was irrelevant to Dr. Verma. (Ex. E, 16:18-19:1).

24. Following surgery, Dr. Verma ordered physical therapy for Plaintiff to try and maximize Plaintiff's motion recovery. (Ex. E, 21:16-22:2). If a patient does not follow through on the recommended physical therapy, they will have a suboptimal result, (Ex. E, 22:3-8), and it is Dr. Verma's expectation that his patients will follow through on his physical therapy orders. (Ex. E, 28:11-14). Between October 2016 and January 2017, Dr. Verma ordered a more than 60

physical therapy visits for Plaintiff. (Ex. E, 21:19-23, 26:8-11, 27:23-28:1, 30:21-31:1, 31:12-15, 33:5-6). On December 14, 2016, Dr. Verma admonished Plaintiff about the importance of his home exercise program, noting that the more compliant Plaintiff was with his exercises—whether they are done with a therapist or on his own—the better his surgical outcome would be. (Ex. E, 30:1-10). Plaintiff was discharged from physical therapy for non-compliance in February 2017 *See* Plaintiff's February 24, 2017 Physical Therapy note, filed under seal as ***Exhibit I***.

25. Dr. Verma order Plaintiff a hinged knee brace on December 14, 2016 to provide Plaintiff some additional stability. (Ex. E, 28:22-24, 29:1-5). Dr. Verma's expectation was that Plaintiff would wear the knee brace for standing and walking for six to 12 weeks, (Ex. E, 29:6-13). On January 13, 2017, Plaintiff reported to his physical therapist that he quit wearing his knee brace three weeks earlier, or December 23, 2016, nine days after Dr. Verma ordered it. *See* Plaintiff's January 13, 2017 Physical Therapy note, filed under seal as ***Exhibit J***.

26. In April 2017, Plaintiff complained to Dr. Verma that he was still experiencing pain. (Ex. E, 34:11-35:1). This was unexpected by Dr. Verma because there was no anatomic basis for this type of pain. (Ex. E, 35:2-6). At this time, Dr. Verma ordered another course of physical therapy for Plaintiff, (Ex. E, 35:19-21), and told Plaintiff there was no reason for him to be seen again by Dr. Verma. (Ex. E, 35:22-24). Regardless, Plaintiff again returned to see Dr. Verma in October 2017 at which time Dr. Verma again ordered a course of physical therapy for Plaintiff, (Ex. E, 41:16-18, 42:18-22), bringing the total number of physical therapy appointments ordered to approximately 100. (Ex. E, 43:8-12). Plaintiff only completed approximately 25 of those visits, resulting in a suboptimal outcome for his surgery. (Ex. E, 43:16-20).

27. It was incumbent upon Plaintiff following through on Dr. Verma's post-operative recommendations to have an optimal surgical outcome. (Ex. E, 44:16-45:3).

28. If a patient presented to Dr. Behl, a trained orthopaedic surgeon, with mild pain, no swelling, and an x-ray that showed a slightly high-riding patella, he would not expect that the person had a ruptured patellar tendon. (41:21-42:3). Instead, a physical exam of a person with a ruptured patellar tendon would show an inability to extend the knee, a palpable defect at the inferior aspect of the patella, a patella that is superiorly migrated which is confirmed by x-ray, immediate significant bloody swelling, and immediate and continued pain. (Ex. D, 40:14-41:20).

29. When Plaintiff presented to Dr. James he had little swelling, little pain, no bruising and an essentially normal x-ray. There was no reason for Dr. James or the nurse who initially triaged Plaintiff to suspect a complete patellar tendon rupture as the clinical and radiologic presentations were atypical. It would not be expected that a primary care physician would diagnose a complete patellar tendon rupture based on this presentation. (Ex. F, pg. 3).

30. Dr. James prescription of an MRI only after Plaintiff did not improve with rest and home exercise is exactly consistent with community norms and the standard of care. (Ex. F, pg. 4). Dr. James was astute in even considering an injury to Plaintiff's patellar tendon, *Id*., and Dr. James met the standard of care in the community for a primary care doctor evaluating an acute knee injury. (Ex. F, Op. 1).

31. Plaintiff's February 2016 surgery successfully restored function of Plaintiff's patellar tendon. (Ex. F., Op. 2). The success of Plaintiff's surgery was not affected by any perceived delay in surgery. (Ex. F., pg. 4). Any suboptimal result was the fault of Plaintiff for not following through on his ordered course of physical therapy. *Id*.

32. Between his first surgery and second surgery, Plaintiff had 90º of knee flexion which would allow him to perform all activities of daily living without pain. (Ex. F, pg. 4). Following his second surgery, Plaintiff maintain 120º of flexion which would not restrict activities of any kind. *Id.*

33. Plaintiff's expert, Dr. Cannestra, opined that Dr. James did not conduct a thorough examination of Plaintiff's knee based entirely on a review of Dr. James' examination notes. (Ex. G, 51:1-52:17).

Respectfully submitted,

WEXFORD HEALTH SOURCES, INC. and DR. MARSHALL JAMES

By: /s/ Sandra L. Byrd

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TABLE OF EXHIBITS

Exhibit A — Plaintiff's Deposition Testimony

Exhibit B — Defendant, Dr. Marshall James' Deposition Testimony

Exhibit C — Wexford Corporate Representative, Dr. Neil Fisher's Deposition Testimony

Exhibit D — Treating Physician, Dr. Ankhur Behl's Deposition Testimony

Exhibit E — Treating Physician, Dr. Nikhil Verma's Deposition Testimony

Exhibit F — Expert Witness, Dr. Chadwick Prodromos' Expert Report

Exhibit G — Expert Witness, Dr. Vincent Cannestra Deposition Testimony and Expert Report

Exhibit H — Illinois Department of Corrections, Offender Count Adjustment

Exhibit I — Plaintiff's February 24, 2017 Physical Therapy note, filed under seal

Exhibit J — Plaintiff's January 13, 2017 Physical Therapy note, filed under seal

CERTIFICATE OF SERVICE

I hereby certify that on July 6, 2020 I electronically filed the foregoing document with the clerk of the court for Northern District of Illinois, Eastern Division, using the electronic case filing system of the court. The electronic case filing system sent a "Notice of E-Filing" to the attorneys of record in this case.

/s/ Sandra L. Byrd

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EXHIBIT A

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

JOHNNY JONES,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	No. 17 CV 8218
	)	
WEXFORD HEALTH SOURCES, INC.,	)	
and MARSHALL JAMES, M.D.,	)	
	)	
Defendants.	)	

The Deposition of JOHNNY JONES, called by the Defendant for examination, pursuant to Notice and pursuant to the Federal Rules of Civil Procedure for the United States District Courts, taken before Victoria D. Rocks, CSR, and Notary Public in and for the County of Cook, State of Illinois, at 200 S. Michigan Avenue, Suite 201, commencing at 10:00 o'clock a.m., on the 16th day of October 2018, A.D.

APPEARANCES:

KENNETH N. FLAXMAN, PC
MR. JOEL FLAXMAN
200 S. Michigan Avenue
Suite 201
Chicago, Illinois 60604
(312) 427-3200
jap@kenlaw.com

appeared on behalf of the Plaintiff;

CASSIDAY SCHADE, LLP
MS. SANDRA L. BYRD
222 W. Adams Street
Suite 2900
Chicago, Illinois 60606
(312) 641-3100
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appeared on behalf of the Defendant.

I-N-D-E-X

WITNESS: JOHNNY JONES

Direct Examination by MS. BYRD: 6 - 119
Cross-Examination by MR. FLAXMAN: 119 - 12O
Redirect Examination by MS. BYRD: 12O - 122

EXHIBITS PAGE
Exhibit 1 Plaintiff's Complaint 28
Exhibit 2 grievance documents 28
Exhibit 3 Plaintiff's Interrogatories 116

(Witness sworn.)

MS. BYRD: Good morning, Mr. Jones. How are you. You're not feeling so well today, are you?

THE WITNESS: No

MS. BYRD: Are you okay to proceed with this?

THE WITNESS: Yes.

MS. BYRD: I know we introduced ourselves before, but we're on the record. So I will do that again.

I am Sandy Byrd. I represent Wexford Health Sources, and I represent Dr. James. You're here with your attorney, correct?

THE WITNESS: Yes.

MS. BYRD: This is the case of Johnny Jones versus Wexford Health Sources, Inc. and Dr. Marshall James, case number 17 CV 8218 pending in the U.S. District Court For the Northern District of Illinois, Eastern Division.

This is the deposition of the plaintiff in this matter, Mr. John Jones, and this deposition is being taken pursuant to notice and pursuant to Rule 30 of the Federal Rules of Civil Procedure and all applicable local rules.

Mr. Jones, have you ever given a deposition

before?

THE WITNESS: No.

MS. BYRD: So my guess is that your attorney explained some of the rules to you, but I will go over them to make sure we're on the same page.

You understand that I am going to be asking you questions, and you are going to give me answers?

THE WITNESS: Yes.

MS. BYRD: And when you give your answers, they need to be in words. If you shake your head or nod your head or say uh-huh or uh-uh, the court reporter can't take that down, okay.

She's writing down everything we're saying, so it's important that you answer in words. Is that fair?

THE WITNESS: Yes.

MS. BYRD: If I ask you a question and you don't understand it, I expect that you will tell me that. I could rephrase it. You could ask your attorney questions about it.

But if I ask a question and you answer it, I'm going to assume that you understood my question. Okay?

THE WITNESS: Yes.

Page 6

JOHNNY JONES,
called as a witness herein, having been first duly sworn, was examined upon oral interrogatories and testified as follows:
DIRECT EXAMINATION
BY MS. BYRD:
Q. And you understand you have taken an oath to tell the truth, right?
A. Yes.
Q. Is there anything affecting your ability to tell the truth?
A. No.
Q. So you're not on any medications that would affect your ability to understand what's going on here today?
A. No.
Q. You did not take any medication that would affect your ability to understand what's going on here today?
A. No.
Q. There are going to be times when you can figure out what the question I'm going to ask you is.
I'm going to ask that you allow me to

Page 7

finish the question before you answer it even if you think you know where I'm going. Is that fair?
A. Yes.
Q. I'm going to do my best not to interrupt you, and you do your best not to interrupt me because she can't write down what we're both saying at the same time.
A. Yes.
Q. If you need a break, let me know. We could take a break any time you need to.
My only request with that would be if a question is pending, that you answer the question before we take the break. Fair?
A. Yes.
Q. Any questions about any of those ground rules?
A. No.
Q. Can you state your full name for the record.
A. John Jones.
Q. Do you have a middle name or initial?
A. Johnny E. Jones.
Q. How old are you, Mr. Jones?
A. Forty-seven.

Page 8

Q. Where do you live?
A. 3041 West Cullerton.
Q. Is that Chicago?
A. Chicago, Illinois.
Q. Is there an apartment number with that?
A. Apartment 1R.
Q. And who do you live there with?
A. My sister.
Q. What is your sister's name?
A. My sister-in-law, Rhonda Washington.
Q. How long have you lived at that address?
A. Six months.
Q. Where did you live prior to this address?
A. Carol Stream.
Q. Do you remember the address?
A. 282 East St. Charles Road, Carol Stream, Illinois.
Q. Who did you live with there?
A. My daughter.
Q. What's her name?
A. Porsche Davis.
Q. Porsche, like the car?
A. Yes.
Q. Are those the only two addresses you have

Page 9

lived at since you were released from the Department of Corrections?
A. No. There was one other address. I forgot the address. I only lived there a short period of time.
Q. Was that in between?
A. Yes, in between.
Q. And was that in Chicago?
A. In Chicago.
Q. Are you married?
A. Separated.
Q. Do you have any kids?
A. Yes.
Q. How many kids do you have?
A. Six.
Q. How old are they?
A. 28, 25, 18, 17.
Q. That is only four. Are there twins in there?
A. No. 19 and 16.
Q. Do any of them live with you?
A. No.
Q. Where do they live, all in Chicago?
A. Yes, all in Chicago.

Q. Do you have a driver's license?
A. I have a restricted driver's permit.
Q. Explain to me what you mean by that.
A. A restricted driver's permit, I am permitted to drive certain places at certain times.
Q. So you have a driver's license. It has some restrictions placed on it?
A. Yes.
Q. Why did you have restrictions placed on it, you don't know why?
A. Can I confer with my lawyer?
Q. You're going to need to answer the question.
MR. FLAXMAN: You could explain why.
THE WITNESS: I caught a DUI in 2001.
MR. FLAXMAN: For the record, if you are concerned about something that might be privileged we could confer while a question is pending.
MS. BYRD: But he will probably object if there is something privileged.
MR. FLAXMAN: Probably.
BY MS. BYRD:
Q. Are you working?
A. No.

Q. I am going to back up. When were you released from the Department of Corrections?
A. In 2016, June.
Q. You've been out since. You haven't gone back for any reason, correct?
A. No.
Q. Since your release, have you worked?
A. No.
Q. You haven't worked at all since your release?
A. No.
Q. I am going to confirm that your IDOC number is B00208. Correct?
A. Yes.
Q. And you're currently still on parole?
A. Yes.
Q. Are there rules that you have to comply with being on parole?
A. Check in every week over the phone.
Q. And that is it?
A. Yes.
Q. There's no other restrictions on where you can go, who you can be with?
A. I can't go out of town. I can't leave the

State of Illinois.
Q. Within Illinois, are there any restrictions?
A. No.
Q. Does a parole officer come visit you?
A. Yes, once a month whenever I have one.
Q. Is it a scheduled visit or do they just show up?
A. Scheduled visits.
Q. It's usually monthly?
A. Yes.
Q. Is that pretty consistent, they show up?
A. No, it's not consistent.
Q. What's the name of your parole officer?
A. I haven't got one. Every three months, they switch over. I haven't got one yet.
Q. So every three months they switch?
A. They switch parole officers, and I haven't got a new one.
Q. What was the name of your last parole officer?
A. I can't remember.
Q. I know you were in the Department of Corrections for the manufacture and delivery of a

controlled substance, correct?
A. Yes.
Q. And that was out of Cook County?
A. Yes.
Q. You got seven years for that sentence, correct?
A. Yes.
Q. How much of that time did you have to serve?
A. In jail?
Q. Yes?
A. Three and a half years.
Q. And what are your other criminal convictions?
A. Attempted armed robbery and possession.
Q. Possession of a controlled substance?
A. Yes.
Q. And you said earlier that your license is restricted because of a DUI, correct?
A. Yes.
Q. Is it a DUI conviction?
A. Yes.
Q. Any other criminal convictions?
A. No.

Page 14

Q. I know we talked about medication a little bit earlier.
Are you currently taking any medications?
A. No.
Q. None at all?
A. None at all.
Q. Are there any that you have been prescribed and that you are not taking?
A. No.
Q. When did you, with your conviction that you are on parole for, when did you first arrive in the Department of Corrections?
A. February 14, 2014
Q. When you first arrived at the Department of Corrections, what facility did you go to?
A. Sheridan.
Q. You went straight from the Cook County jail?
A. Stateville.
Q. Did you go into NRC in Stateville?
A. NRC.
Q. Did you go from Stateville NRC to Sheridan?

Page 15

A. Yes.
Q. You served out the sentence at Sheridan?
A. Yes.
Q. You didn't get transferred back to a different facility back and forth?
A. No.
Q. When you got to Sheridan, did you receive an inmate handbook?
A. Yes.
Q. Did you read that handbook?
A. Yes.
Q. And was there any sort of orientation describing what was in the handbook?
A. Yes.
Q. Do you still have that handbook?
A. No.
Q. You didn't want to keep that?
A. No.
Q. Is it fair to say you were familiar with the contents of it?
A. Yes.
Q. So you knew how to follow the rules in the Department of Corrections?
A. Yes.

Page 16

Q. That handbook describes the grievance procedure, correct?
A. Yes.
Q. And it also describes the sick call procedure, correct?
A. Yes.
Q. And you were familiar with both of those procedures, correct?
A. Yes.
Q. And you knew what to do if you needed to file a grievance?
A. Yes.
Q. And you knew what to do if you needed to go to sick call?
A. Yes.
Q. Describe the sick call procedure for me.
A. I think you put in a request, and they will call you the next day.
Q. Where were the request slips located?
A. Front desk.
Q. And you had ready access to those, correct?
A. Yes.
Q. Was there ever a time that you wanted a

Page 17

sick call request slip, that you couldn't get a sick call request slip?
A. Yes.
Q. When was that?
A. I can't recall the date, but it has been a few times.
Q. And what did you do when that happened?
A. I used a blank sheet of paper and made me one.
Q. So you came up with a solution?
A. Yes.
Q. And you were still able to request sick call?
A. Yes.
Q. So the inability to get an official sick call slip didn't prohibit you from doing what you needed to do?
A. Exactly.
Q. Did you complete high school?
A. I have a GED.
Q. When did you get the GED?
A. In 1995.
Q. Have you done any college?
A. A little.

Page 18

Q. Tell me about your college classes.
A. I went to the College of Office Technology.
Q. The College of what?
A. Office Technology.
Q. What is that?
A. Medical office assistant.
Q. When did you do that?
A. In 2007.
Q. What did the education consist of, what did you learn?
A. Medical office.
Q. Tell me what that means.
A. File, look up insurance.
Q. Did you get any medical training in terms of being able to diagnose something?
A. No.
Q. Being able to take X-rays or MRIs?
A. No. Medical terminology, that's about it.
Q. It is fair to say that you -- would you consider yourself a medical professional?
A. No.
Q. Would you consider yourself someone who is able to diagnose medical conditions?

Page 19

A. No.
Q. Would you consider yourself someone who has above normal education regarding medical conditions?
A. No.
Q. It's fair to say -- this is going to sound like a stupid question, but you're not a licensed medical doctor, correct?
A. Correct.
Q. When you were in prison at Sheridan, did you ever receive any disciplinary tickets for anything?
A. I can't remember.
Q. Were you ever in segregation?
A. No.
Q. I know you said you're not working now. But prior to your incarceration, were you working?
A. I was doing labor work.
Q. What kind of labor work?
A. Cleaning up, yard work.
Q. Who were you working for?
A. I can't remember.
Q. Did you ever work at the education that you got at the medical office as a medical office assistant?

Page 20

A. No.
Q. So you never worked in a medical office?
A. No.
Q. How much were you making prior to your incarceration?
A. About $300 a week.
Q. When you were at Sheridan, did you have a job?
A. I was going to school, and I worked in the kitchen.
Q. What were you going to school for at Sheridan?
A. Forklift driver.
Q. Was that a certification program?
A. Yes.
Q. Did you complete that?
A. Yes.
Q. What did that job pay?
MR. FLAXMAN: Do you mean the kitchen?
MS. BYRD: Yes, because he didn't drive a forklift.
THE WITNESS: I can't remember. Twenty-five cents.

Page 21

MR. FLAXMAN: You need to speak up for the reporter.
BY MS. BYRD:
Q. An hour or a day? I know they pay really well in the Department of Corrections.
A. I think a day.
Q. And do you remember what career tech one is?
A. No.
Q. Would that potentially be the forklift?
A. It should be.
Q. Do you remember anything called career tech one in the Department of Corrections?
A. I can't remember.
Q. Any other jobs that you had while you were at Sheridan other than in the kitchen?
A. I can't remember.
Q. When you were in the kitchen, what were you doing? What were your duties?
A. On the line serving food.
Q. So did that require that you stand at any given time?
A. About two hours.
Q. How long did you do that job?

Page 22

A. About three months.
Q. How are you supporting yourself now if you are not working?
A. My children are.
Q. So they give you money or they pay your rent or tell me?
A. They pay my rent and give me money.
Q. I asked you before if you had ever given a deposition before, and you said no, correct?
A. Yes.
Q. I'm going to ask you some questions about your preparation for this deposition, but I don't want you to tell me anything that you discussed with your lawyer as part of those answers. Okay?
A. Yes.
Q. So did you review any documents in preparation for your deposition today?
A. No.
Q. What did you do to prepare for your deposition?
A. I just came to see him.
Q. And did you do that just today or was that on another day?
A. Yesterday.

Page 23

Q. So meeting with your lawyer yesterday was the extent of your preparation for your deposition?
A. Yes.
Q. You didn't take any other steps at all?
A. No.
Q. You didn't review any of your medical records?
A. No.
Q. Other than your attorneys, have you spoken with anyone else about this lawsuit?
A. No.
Q. So your kids don't know that it's pending?
A. No.
Q. Other than this lawsuit, have you filed any other lawsuits before?
A. No.
Q. Prior to your incarceration, did you have a primary care physician?
A. Excuse me?
Q. Did you have a primary care physician prior to your incarceration?
A. No.
Q. When you had to go to the doctor prior to your incarceration, what would you do?

Page 24

A. Go to Cook County Hospital.
Q. And that is the only medical provider you used prior to your incarceration?
A. Yes.
Q. Have you ever been hospitalized?
A. Yes.
Q. When?
A. In 1991 and 1993.
Q. What were you hospitalized for in 1991?
A. A gunshot wound.
Q. Where was that gunshot wound in your body?
A. On my left leg.
Q. And what happened as a result of that gunshot wound?
A. I got shot in a driveby.
Q. Physically to your body, what was the effect of that gunshot wound?
A. My leg was broken.
Q. When you were hospitalized, what kind of treatment did they give you for that?
A. Surgery.
Q. What was the surgery? Did they just remove the bullet or was there something else?
A. No, they had to give me a rod in my leg.

Page 25

Q. Is that rod still there?
A. Yes.
Q. Is that the extent of what they did when you were in the hospital in 1991?
A. Yes.
Q. And in 1993, what were you there for?
A. Gunshot wound.
Q. So you've been shot twice?
A. Yes.
Q. So we're lucky you're here.
A. Yes, thank God.
Q. Where did you suffer that gunshot wound?
A. In the chest.
Q. Where in your chest?
A. Left side.
Q. And you were hospitalized again for that. What did they do when you were in the hospital?
A. Just gave me a chest tube and got the blood off my lungs and that was it.
Q. Did they do surgery?
A. No.
Q. Is the bullet still inside you?
A. No, they removed it from the back.
Q. How did they remove it without doing

Page 26

surgery?
A. It was lodged in my back for a few months, and they pierced it and popped it out.
Q. So it was there or a couple of months and it kind of worked its way out, and they were able to remove it by cutting your skin?
A. Yes.
Q. And that's the extent of your hospitalizations?
A. Yes.
Q. Have you ever been to see any specialists instead of just a primary care doctor, someone who specializes in any kind of medicine?
MR. FLAXMAN: Before he was locked up?
MS. BYRD: Sure.
THE WITNESS: I can't remember.
BY MS. BYRD:
Q. You don't remember ever seeing a specialist before your incarceration?
A. No.
Q. Were you ever injured at work?
A. No.
Q. Were you ever injured in a car accident?
A. No.

Page 27

Q. And the two gunshot wounds that you just described, those are the only two gunshot wounds you had?
A. Yes.
Q. Do you currently have health insurance?
A. Yes.
Q. Who is your health insurance?
A. County Care.
Q. County Care?
A. Yes.
Q. What is County Care?
A. Medicaid. Obamacare.
Q. Does that cost anything or is that something that you get cost free?
A. Yes.
Q. It's cost free?
A. Yes.
Q. Prior to your incarceration, did you ever undergo any imaging studies, x-rays, MRIs, CT scans or anything?
A. No.
Q. Have you ever had any head injuries?
A. No.
(Recess.)

Page 28

MS. BYRD: We're back on the record.
BY MS. BYRD:
Q. Mr. Jones, it's my understanding that during the break you remembered another surgery that you had?
A. Yes.
Q. When was that surgery?
A. 2007.
Q. What was that for?
A. A ruptured Achilles.
Q. How did you rupture your Achilles?
A. Playing basketball.
Q. Where was that surgery done?
A. John Stroger Hospital.
Q. Which leg was that?
A. The left leg.
Q. Anything else you remember during the break?
A. No, that's it.
(Deposition Exhibits 1 and 2 were marked for identification.)
Q. I am going to show you what I have marked as Defendant's Exhibit 1. That is a copy of your complaint in this case, correct?

Page 29

A. Yes.
Q. And your allegations against the defendants are contained in that complaint. Correct?
A. Yes.
MR. FLAXMAN: I object to the foundation. Why don't you ask him if he ever saw this before.
BY MS. BYRD:
Q. Have you ever seen this complaint?
A. No.
Q. So you have never seen the allegations that you are making against the defendants in writing?
A. No.
Q. So you don't know what your lawyer has alleged in court?
A. No.
Q. So what is your reason for bringing this lawsuit? Tell me in your words what your reason for bringing this lawsuit is.
MR. FLAXMAN: You could tell without looking at the document.
THE WITNESS: Could you repeat the question.

Page 30

BY MS. BYRD:
Q. What is your reason for bringing this lawsuit?
A. Because if I had proper care, I wouldn't have this limp or still be in pain.
Q. If you had proper care, what?
A. I wouldn't have this limp or I wouldn't still have pain.
Q. Who do you understand that you are suing?
A. Wexford Health and Dr. James.
Q. Who is Dr. James?
A. The physician at Sheridan Correctional facility.
Q. And who is Wexford Health?
A. His employer.
Q. And when you said that if you had gotten proper care you wouldn't have a limp or be in pain, why do you have a limp and why are you in pain? What was your injury that caused that?
A. It was a torn patellar tendon.
Q. How did you tear your patellar tendon?
A. Playing basketball.
Q. And that is while you were in prison, correct?

Page 31

A. Yes.
Q. Tell me what happened, how that injury occurred?
A. I was playing basketball. When I went for a rebound, I felt something snap, and I heard something snap.
Q. When you went up in the air?
A. Yes.
Q. Not when you landed?
A. Not when I landed.
Q. What did you do in response to that?
A. Prison guard. The prison guard came and helped me off the ground. A couple of them loaded me up and took me to the health care unit.
Q. So you went straight from the basketball court to the health care unit?
A. Yes.
Q. When you were in the healthcare unit did you see Dr. James?
A. No.
Q. Who did you see?
A. I saw a nurse.
Q. Do you remember what day this happened?
A. November 16, 2015.

Page 32

Q. Do you remember the name of the nurse?
A. No, I don't.
Q. What did that nurse do?
A. She called Dr. James.
Q. So on November 16, 2015, you saw Dr. James?
A. No.
Q. When you say she called him, tell me what that means?
A. She called him over the telephone.
Q. And so what treatment did you receive that day?
A. I received a pair of crutches.
Q. Were you then sent back to your cell? Tell me what happened.
A. Yes, I was sent back to my cell.
Q. Any other testing done that day?
A. No.
Q. So you saw the nurse. How long were you in with the nurse?
A. About an hour.
Q. During that time she called Dr. James on the telephone?
A. Yes.

Page 33

Q. After she talked to Dr. James on the telephone, did she do anything?
A. She gave me pain medication.
Q. What kind of pain medication?
A. Ibuprofen.
Q. Did she diagnose you with anything?
A. No.
Q. Was it the nurse that sent you back to your cell?
A. Yes.
Q. What was next in the medical treatment you received related to your knee?
A. About a week later I got an x-ray.
Q. Who ordered that x-ray?
A. Dr. James.
Q. How do you know that Dr. James ordered it?
A. I was there when he ordered the x-ray.
Q. So was that the first time that you went back to the health care unit after November 16?
A. No.
Q. When did you go back to the health care unit next after November 16?
A. I think it was that next Monday. It was two days later.

Page 34

Q. Are you saying that it's your belief that you injured yourself on a Saturday?
A. I think it was Saturday.
Q. Then you went back to the healthcare unit on Monday?
A. Monday.
Q. Who did you see when you went back on Monday?
A. Dr. James.
Q. That would have been on the 18th?
A. Yes.
Q. What did Dr. James do on the 18th?
A. I can't remember. I can't remember if he gave me a brace to put on my leg. I can't remember.
Q. But he examined you, correct?
A. Yes.
Q. How much time do you think you spent with him that day?
A. About 20 minutes.
Q. Is that when he ordered the x-ray that you had?
A. Yes.
Q. What else do you remember him doing on that day?

Page 35

A. I don't remember nothing else.
Q. Is it fair to say that just because you don't remember him doing anything else on that day, it doesn't mean he didn't do anything else on that day?
A. He didn't do nothing else because he had a whole healthcare unit. A lot of people were waiting to be seen.
Q. But he spent 20 minutes with you?
A. Yes.
Q. He ordered an x-ray. He examined your body?
A. Yes.
Q. And then you said you can't remember if he did anything else?
A. He didn't do nothing else to me.
Q. So in that 20 minutes, he examined your body, ordered an x-ray?
A. Yes.
Q. When he was examining your body, did he have a conversation with you?
Were you able to tell him how you were able to tell me how you injured yourself?
A. I was able to tell him how I injured

Page 36

myself and what I felt.
Q. And then what approximately three or four days later that you had the x-ray?
A. It was probably a week later because the x-ray technician had to come to the facility.
Q. Between seeing Dr. James on the 18th and getting the x-ray, did you get any other health care?
A. No.
Q. And when you had the x-ray they took the x-ray of your knee, correct?
A. Yes.
Q. Then after the x-ray was taken, when did you get the results of the x-ray?
A. Probably a week later.
Q. Who gave you the results of the x-ray?
A. They called it into the health care.
Q. When you got to health care, who told you what the x-ray showed?
A. Dr. James.
Q. What did he tell you?
A. I can't remember.
Q. What did he do on that day?
A. Nothing.

Page 37

Q. So it's your memory that he called you into the health care unit, told you what the x-ray showed and then did nothing else?
A. Exactly.
Q. So between the date that you saw Dr. James on the 18th of November and the date that you got the results of your x-ray, how much time do you think passed? Was it a week? More than or less than a week?
A. I can't remember.
Q. During that time frame that you can't remember, between the date when you saw Dr. James on the 18th of November and the date you got the results of your x-ray, did you request any health care visits in that time?
You said you knew how to get to the health care unit, correct?
A. Yes.
Q. How many times did you request to go to the health care unit in that time?
A. I can't remember.
Q. Did you ask to go to the health care you unit during that time?
A. Yes. I can't remember how many times.

Q. And what was the results of you asking to go to the health care unit?
A. The pain mainly.
Q. You said to get to the health care unit you had to fill out a form?
A. Correct.
Q. When you filled out the form on those dates between November 18 and the day that you got the results of your x-ray, what happened?
Were you taken to the health care unit or were you not taken to the health care unit?
A. Could you repeat that.
Q. You said that you didn't receive any health care between November 18, 2015, and the day you got the results of your x-rays you said that you requested health care in between that time.
My question to you is what happened when you requested health care?
A. I think I went for pain, and they gave me pain medication.
Q. So when you requested health care, you received it?
A. Yes.
Q. Now, you said you can't remember what

Dr. James told you when he gave you the results of your x-ray?
A. I can't remember.
Q. After he gave you the results of your x-ray, when was the next time you got health care?
A. I can't remember.
Q. Were you ever refused health care in that period of time?
A. No.
Q. What is the next event that you remember from a health care standpoint after you got the results of your x-ray?
A. Putting in a request for pain medication, and a request to get an MRI. Yes, an MRI.
Q. So you put in a request for an MRI?
A. I put in a request to see Dr. James to ask him for an MRI.
Q. In relation to when you got the x-ray results back, when did you put that request in?
A. I can't remember.
Q. Was it the next day? Was it a week? A month?
A. I don't remember.
Q. After you put in that request, how long

was it before you saw Dr. James?
A. The next day.
Q. And did he order the MRI that you were asking for?
A. No.
Q. Eventually you got the MRI, correct?
A. Yes.
Q. When you say he didn't order the MRI, did he tell you why he wasn't going to order the MRI?
A. No, he didn't.
Q. Did you ask why?
A. No.
Q. How long after you requested the MRI did you get the MRI?
A. Three months later.
Q. Three months later?
A. Yes.
Q. That is three months from the time you put in a written request for an MRI, you finally got it three months later?
A. Yes.
Q. And who ordered the MRI when it was ordered three months later?
A. Dr. James.

Q. Was that at an appointment that you had with him?
A. Yes, I think. I can't remember.
Q. Were you present when the MRI was ordered?
A. No.
Q. Do you know the process that was involved in getting the MRI ordered?
A. No.
Q. Did you know you were going to have an MRI before you appeared in the imaging unit to have it done?
A. No.
Q. Was it done at Sheridan or did you have to go offsite to have it done?
A. Offsite.
Q. Where did you go to have the MRI done?
A. Midwest Orthopedics in Sandwich, Illinois.
Q. When did that occur?
A. I think February of 2016.
Q. Did they give you the results while you were there or did you get those later?
A. I don't remember.
Q. Do you remember if they gave you the

results or if someone at Sheridan gave you the results?
A. I can't remember.
MR. FLAXMAN: Do you need to stand up?
THE WITNESS: Yes.
BY MS. BYRD:
Q. Do you need a break?
A. No,just to stand.
Q. So what steps between the day you injured your knee and the day you got your MRI, tell me all the steps you took to get medical treatment for your knee?
A. Put in a medical request.
Q. How many?
A. I can't remember.
Q. Was it one?
A. It was more than one.
Q. Was it more than ten?
A. No.
Q. So was it more than five?
A. Yes, I think.
Q. So somewhere between five and ten requests?
A. Yes.

Q. And how many times were you seen in the medical unit based on those five to ten requests?
A. I can't remember.
Q. Did you ever refuse medical treatment in that time?
A. No.
Q. So every time you were offered sick call you went, correct?
A. Yes.
Q. And you were not present when your MRI was scheduled, correct?
A. Excuse me?
Q. You were not present when your MRI was scheduled, correct?
A. No, I don't think so.
Q. Did you ever fill out any form regarding scheduling the MRI?
A. I can't remember.
Q. And the first time you went to Midwest Orthopedics was in February of 2016?
A. I can't remember.
Q. That was your testimony, though, right that you had the MRI in February of 2016, correct?
A. To my knowledge, I had my surgery in

February of 2015. And I had the MRI I think earlier that month.
Q. When you just said 2015 you meant 2016? You said February of '15.
A. 2016.
Q. So the MRI and the surgery were done in the same month?
A. I think so.
Q. Between the date of your injury and the date of your surgery, describe what the limitations on your activities were.
A. I couldn't do nothing but stay in my cell. I ate in my cell. No activity, nothing.
Q. So between November when you injured yourself and February when you had your surgery, you never left your cell?
A. Never left my cell. Only to take a shower and use the phone and go to sick call.
Q. Prior to November of 2015, what was a typical day like in prison for you?
A. I would go to all of the activities.
Q. You have to tell me what that means because I have never gone to them.
A. I go to breakfast, lunch, dinner, group.

And gym, to the yard. And to church.
Q. So when you say group, what was group?
A. Group is AA meetings.
Q. And what would you do in the gym?
A. Jog. Lift a few weights and play ball.
Q. What would you do in the yard?
A. The same thing.
Q. The same thing as?
A. Playing ball, jogging and lifting weights.
Q. Would you do each of these things every day?
A. No, not every day.
Q. How often did you go to group?
A. I went to group every day.
Q. How often would you go to the gym?
A. Three times a week.
Q. And the yard?
A. Three times a week.
Q. Where were the group meetings located in relation to your cell?
A. Inside the unit where we were housed at.
Q. How big is that unit?
A. It's as big as two conference rooms.
Q. You're using this conference room as an

example?
A. Yes.
Q. So twice the size of this conference room?
A. Yes.
MS. BYRD: Mr. Flaxman, any chance you know the dimensions of this conference room off the top of your head?
MR. FLAXMAN: No, I would be guessing.
BY MS. BYRD:
Q. So from your cell, I'm going to guess. I am going to guess that it's 20 feet wide, 15 by 20. Does that sound reasonable?
MR. FLAXMAN: Sure. It's not a perfect rectangle.
BY MS. BYRD:
Q. Like a good guestimate. We could all agree on that?
A. Sure.
Q. So the size of your unit was roughly 40 by 30?
A. Yes.
Q. And your cell was located in that area?
A. Yes.
Q. And your group was located in that same

area?
A. Yes.
Q. And where in relation to your cell was where the telephone is located?
A. Where we hold our meetings, where the meeting was held at.
Q. So you were able to leave your cell to make it to the telephone, but you were not able to leave your cell to go to your group meeting?
A. I did go to group.
Q. You just testified you never left your cell between November of 2015 and February of 2016 except to take a shower and use the telephone and go to sick call.
A. Sorry.
Q. So the only things that you didn't do after your injury in November that you did do prior to your injury is go to the gym and go to the yard?
A. Exactly.
Q. And if you had to give me a scale of one to ten in November of 2015, what was the level of pain from the injury to your knee?
A. Like off the scale. Like a ten.
Q. Did it ever reduce from a ten prior to

your surgery?
A. No.
Q. So from the day of your injury until the day of your surgery, your pain level was a constant ten?
A. Yes.
Q. And if you had to use the same scale today, what is your pain level today?
A. About a five and a half every day.
Q. So in February of 2016, you had your surgery, correct, and your testimony is that it was about a week after you had your MRI, correct?
A. Yes.
Q. And it was Dr. James who ordered your surgery, correct?
MR. FLAXMAN: Object to foundation. You can answer if you know.
THE WITNESS: I don't know if he ordered it.
BY MS. BYRD:
Q. What is your knowledge of how you went from getting an MRI to getting surgery?
A. I don't know.
Q. No one told you that that is what was going to happen?

A. Yes. I think Dr. Behl told me.
Q. Who is Dr. Behl?
A. Dr. Behl is the surgeon who performed surgery on my leg.
Q. When did you first meet Dr. Behl?
A. When I got my MRI.
Q. So it's your testimony that no one at Sheridan in the medical staff had a conversation with you about getting surgery on your knee?
A. Yes, Dr. James. Dr. James told me that I'm going to have surgery.
Q. And he told you you were going to have surgery or did he talk to you about what the surgery meant?
A. I can't remember.
Q. Was that before or after your MRI?
A. That was after.
Q. How many times between the date that you injured your knee and the date of your surgery did you see Dr. James?
A. Quite a few. I can't remember the exact number.
Q. After your surgery did you still have physical limitations on what you could do?

Page 50

A. Yes.
Q. What were those? I'm going to rephrase that and put that between the time of your surgery and the time you were released from the department of corrections for now.
During that time frame, what could you not do?
A. I couldn't bend my knee. I couldn't walk without a cane, with crutches.
Q. Is that the extent?
A. I couldn't kneel.
Q. Anything else?
A. I couldn't run.
Q. Anything else?
A. That's it.
Q. Did any of those conditions improve in the time that you were in the Department of Corrections after your surgery before your release?
A. No.
Q. So they were the same from the day you came out of surgery until the day you were released from the Department of Corrections?
A. Yes.
Q. After your surgery, when is the first time

Page 51

you saw Dr. James?
A. The next day.
Q. Between the date of your surgery and the date of your release, how many times did you see Dr. James?
A. Three times a week.
Q. Following your surgery you were housed in the infirmary?
A. Correct.
Q. And that is a separate facility from where you were housed previously?
A. Yes.
Q. It's completely separate in a different part of the prison, is that fair?
A. Yes.
Q. You were housed there from the time you had the surgery until you were released?
A. Exactly.
Q. When you were in the infirmary, you had 24 hour access to medical care, correct?
A. Exactly.
Q. It was staffed by medical providers at all times, correct?
A. Yes.

Page 52

Q. During the time you were in the infirmary, was there ever a time that you requested medical care that you were denied medical care?
A. No.
Q. You had follow-up appointments with your surgeons at Midwest Orthopedics, correct?
A. Yes.
Q. You made all of those appointments, correct?
A. Yes.
Q. There was never a time that your surgeon at Midwest said we want to see you, and the Department of Corrections said or Wexford or Dr. James or anyone said we're not going to send you. Correct?
A. Correct.
Q. What did your surgeons at Midwest Orthopedics tell you about your injury?
A. That I would need physical therapy, which I didn't receive.
Q. Tell me what they told you about physical therapy.
A. A nurse is supposed to come and help me get motion back in my leg.

Page 53

Q. Did they give you exercises to do on your own?
A. They gave me exercises to do with that nurse.
Q. But they didn't give you any exercises to do on your own?
A. Not that I can remember.
Q. You said you had physical therapy at Midwest Orthopedics, right?
A. Yes.
Q. How many times did you see that physical therapist?
A. At least twice.
Q. When you saw that physical therapist, did you do exercises with that physical therapist?
A. Yes.
Q. And it's your testimony that that physical therapist did not give you exercises to do on your own?
A. I can't remember.
Q. What exercises did you do on your own when you were in the infirmary on Sheridan?
A. I took a towel, and I put it on the tip of my feet and put pressure on my feet and push my feet

Page 54

down.
Q. How often would you do that?
A. Probably once every three days.
Q. What other exercises did you do on your own?
A. That was it.
Q. And who told you to do that exercise?
A. I saw it on TV or something. I saw it on TV.
Q. So no one gave you instructions to do that exercise?
A. Not that I recall.
Q. And no one gave you instructions to do any exercises at all?
A. They gave nurses instructions to help me with the bending of my leg.
Q. Who gave the nurses instructions?
A. Midwest.
Q. How did Midwest doctors or physical therapists give that instruction to the nurses?
A. It was in writing.
Q. Did you ever see that writing?
A. Yes.
Q. Where did you see it?

Page 55

A. When I gave the nurses the paperwork.
Q. So Midwest would give you the paperwork and then you would give it to the nurses?
A. No. They gave me paperwork, and I gave it to the guard, and the guard gave it to the nurse.
Q. But you had the paperwork in your possession?
A. Yes.
Q. During the time you were being transported or when?
A. Not being transported.
Q. I didn't hear you.
A. Not at the time of being transported, at Midwest Orthopedics.
Q. While you were still at Midwest Orthopedics, they would give you paperwork and would you look at what it said and then you would give it to the guard?
A. Yes.
Q. When you were meeting with the surgeon or any of the health care professionals at Midwest were the guards in the room with you?
A. They were there.
Q. Do you remember any of those guards?

Page 56

A. No.
Q. But they would have been able to hear anything that you discussed with them, correct?
A. Yes.
Q. What do you remember seeing on the paperwork that the people at Midwest gave you that you gave to the guards that they gave to the nurses?
A. Assist patient with physical therapy.
Q. And did it give specific exercises?
A. Yes, the bending of the leg.
Q. And that is what it said?
A. Yes.
Q. And how did the nurse help you bend your leg?
A. They never did.
Q. How often did you ask the nurses to bend your leg?
A. About five times.
Q. Five times between the day of your surgery and the day you were released from the Department of Corrections?
A. Yes.
Q. Who did you ask?
A. I can't recall.

Page 57

Q. Do you recall the names of any of the nurses there?
A. No.
Q. I'm going to back up. When you went on your follow-up visits to Midwest, did you tell them that no one was helping you do your physical therapy?
A. No, because I didn't -- no, I didn't.
Q. And you weren't restricted in your communication with the doctors or physical therapists at Midwest, correct?
A. Yes.
Q. When you were there and visiting them -- maybe that was a bad question.
When you were in the exam room with whoever, physical therapy, medical treatment providers at Midwest, you were able to tell them anything you needed to tell them?
A. Yes.
Q. The guards that were in the room with you, no one threatened you and said you couldn't talk to the health care providers?
A. No.
Q. You were free to tell them anything you

Page 58

needed to tell them, correct?
A. Yes.
Q. And you didn't tell anyone at Midwest at any point that you weren't getting your physical therapy at Sheridan?
A. No.
Q. At some point did they give you a brace for your knee?
A. Yes.
Q. Do you know when you got the brace?
A. About two weeks after they took the cast off my leg.
Q. How long after your surgery did they take the cast off?
A. About two weeks.
Q. So roughly two weeks?
A. Roughly two weeks.
Q. So the brace was maybe about a month after your surgery, if you said you got that about two weeks after your cast?
A. I got the brace two weeks after the surgery.
Q. Two weeks after surgery you got the brace?
A. Yes.

Page 59

Q. Could you describe the brace for me? Did it have a hinge on it? Was it something that wrapped around your leg?
A. It wrapped around my leg with straps.
Q. Did you have any sort of hinge on it?
A. Yes, hinged on the side for my mobility to see how far I could stretch and bend.
Q. And it was the doctors at Midwest that gave you that brace?
A. Yes.
Q. And what did they tell you the purpose of that brace was?
A. I can't recall what they said the purpose was.
Q. What directions did they give you related to that brace?
A. Keep it on when I am out of the bed and moving around. Keep it on at all times.
Q. So keep it on at all times when you are not in bed or keep it on at all times, which one?
A. When I'm not in bed.
Q. Did anyone from the Department of Corrections prohibit you from having that brace when you were at Sheridan?

Page 60

A. No, they didn't prohibit me. No.
Q. Did anyone in the Department of Corrections tell you when you had to have it on and when you could take it off?
A. No.
Q. If you had it on or took it off, that was entirely your decision?
A. Yes. I couldn't go to general population because of the brace. I had to stay in the infirmary.
Q. So you had 24 hour access to your brace, correct?
A. Yes.
Q. And it was no one's decision whether you had it on or didn't have it on?
A. Yes.
Q. And what restrictions on activity did your doctors place on you, the doctors from Midwest?
A. I couldn't do no activities anyway. My leg was messed up.
Q. What would they tell you what you could or couldn't do?
A. I couldn't play ball.
Q. They specifically said Mr. Jones, don't

Page 61

play basketball? What did they tell you that you can't do?
A. They didn't tell me nothing.
Q. And did you ever refuse any treatment that they offered you?
A. At Midwest?
Q. Yes.
A. No.
Q. Did you ever refuse treatment that the Department of Corrections tried to give you?
A. Yes, once.
Q. What was that?
A. Tramadol.
Q. And that's a medication?
A. That's a medication.
Q. What does it do?
A. It was for pain, but it made me hallucinate.
Q. When did you refuse that?
A. I think it's two days out of surgery.
Q. You did that one time?
A. I did it one time. I couldn't handle it.
Q. That was a bad question. You refused it one time?

Page 62

A. Yes.
Q. That is the only treatment you refused from the time you had your surgery until the time you were released from the Department of Corrections?
A. No. I refused the Norco a few times because I wasn't feeling too well taking it.
Q. That was in the Department of Corrections as well?
A. Yes.
Q. How many times did you refuse Norco?
A. About five.
Q. Was there ever anytime in the Department of Corrections that you asked for treatment from the time you had your surgery until the time you were released, was there anytime that you asked for treatment that you didn't receive?
A. No.
Q. Prior to your release from the Department of Corrections, you had a follow-up appointment scheduled with Midwest Orthopedics, correct?
A. Yes.
Q. And that appointment fell after the time you were released from the Department of

Page 63

Corrections?
A. Yes.
Q. And you did not go to that appointment, correct?
A. Yes, I couldn't make it.
Q. So you did not go to that appointment, correct?
A. Correct.
Q. And why did you not go to that appointment?
A. I didn't have transportation at the time.
Q. And that appointment was scheduled in June of 2016, correct?
A. Correct.
Q. And then in July of 2016, you contacted Midwest Orthopedics to ask them for a referral in Chicago?
A. Yes.
Q. Between the date of your release in June of 2016 and you called Midwest Orthopedics in July, did you have any other contact with them?
A. No.
Q. Between the date of your release and July of 2016, what kind of physical therapy were you

Page 64

doing?
A. None.
Q. Did you see any other doctors in that period of time?
A. No.
Q. Midwest referred you to a doctor at Rush, is that correct?
A. Yes.
Q. So between the time you were released and the time you saw that doctor at Rush, did you see any other doctors?
A. No.
Q. Did you do any physical therapy?
A. No.
Q. When you were released from the Department of Corrections, were you released with your brace?
A. Yes.
Q. And were you released with crutches?
A. Yes.
Q. Were you released with your cane?
A. Yes.
Q. So you had all three of those when you were released?
A. Yes.

Page 65

Q. And you were able to take those home with you, correct?
A. Yes.
Q. And you were able to use those at home, correct?
A. Yes.
Q. How often were you wearing your brace in that period of time?
A. Every day.
Q. And who saw you wear your brace that period of time?
A. Excuse me?
Q. Who saw you wearing your brace?
A. Everyone.
Q. Tell me who that is.
A. My kids, my mom. My brothers.
Q. And what steps did you take after your release to get physical therapy?
A. I asked for the referral from Midwest.
Q. In that July phone call?
A. Yes.
Q. So between the date you were released in June and that July phone call to Midwest, what steps did you take to get physical therapy?

Page 66

A. I didn't take no steps to get physical therapy.
(Recess.)
Q. Mr. Jones, before we took the break you indicated that while you were in the Department of Corrections, you refused Norco approximately five times, is that correct?
A. Yes.
Q. Why did you refuse it?
A. Because it was too strong for me.
Q. What did you mean by that?
A. It had me real drowsy and nauseous.
Q. How often did you take it? If you refused it five times, were there times that you did take it?
A. Yes.
Q. How often would you take it?
A. At least three times a week.
Q. So after your release we established that in July you called Midwest Orthopedics, and they gave you a referral to a doctor at Rush, correct?
A. Yes.
Q. Do you remember who that doctor was?
A. I can't remember the doctor's name.

Page 67

Q. When did you first see that doctor?
A. I can't remember.
Q. Is it a male doctor or female doctor?
A. Male doctor.
Q. When you first saw that doctor, why did you go to the doctor? What was the reason you wanted to go see a doctor?
A. Because I was trying to see if there are any alternatives to getting my leg back to mobility.
Q. So the first time you saw that doctor is obviously after you were given the referral, correct?
A. Yes.
Q. Do you remember how long after the referral? Was it a month?
A. I can't remember.
Q. In the period of time between when you were given the referral and when you actually went to see the doctor, what steps did you take to do any physical therapy or exercises for your knee?
A. None.
Q. When you went to see that doctor, what did that doctor tell you?
A. That I had a significant amount of scar tissue on my knee.

Page 68

Q. Did he tell you what that scar tissue was from?
A. I can't recall.
Q. Did he tell you it was from the surgery?
A. He said it was from not moving my knee or having therapy.
Q. What did that doctor recommend?
A. Another surgery.
Q. And this is in your first meeting with that doctor?
A. Yes.
Q. How did he know you had scar tissue on your knee? Did he do an x-ray or MRI?
A. An x-ray.
Q. Did he do that on the same day as your first appointment?
A. I can't remember. No, not on the first date of my appointment. No.
Q. On the first day of your appointment he told you you had scar tissue on your knee and recommended surgery?
A. I can't remember if it was the first date or the second.

Page 69

Q. Ultimately he did surgery on you, correct?
A. Yes.
Q. How many appointments did you have with him between your first appointment and your surgery?
A. I can't remember.
Q. At what point during that time did he recommend surgery?
A. It was between one of those visits.
Q. And the only diagnostic test he did was an x-ray?
A. I am not quite sure. It could have been a a MRI or an x-ray.
Q. But was it only one diagnostic test, and you can't remember?
A. I can't remember.
Q. What did he tell you about the surgery that he wanted to do?
A. Go in and get rid of the scar tissue.
Q. How did he say he was going to do that?
A. Put holes in my leg. Incisions in my leg and cut the scar tissue out.
Q. What did he say he hoped to accomplish by doing that?
A. Mobility in my leg.

Page 70

Q. When did you do that surgery?
A. Sometime in October of 2016.
Q. Do you remember that doctor ever saying that your knee had been neglected?
A. The doctor at Midwest explained to me what happened.
Q. What do you mean by that?
A. With proper care, they could have repaired my patellar tendon instead of reconstructing it.
Q. And what do you mean by proper care?
A. Medical care.
Q. And what doctor told you that?
A. Dr. Behl.
Q. When did Dr. Behl tell you that?
A. When I went to Midwest Orthopedics.
Q. Which time?
A. The first time.
Q. But your doctor at Rush never told you that your knee had been neglected, correct?
A. Yes, from the scar tissue. I was supposed to have physical therapy.
Q. But did he ever tell you that your knee had been neglected?
A. I can't recall.

Page 71

Q. His only comments to you about it was that you should have had physical therapy?
A. Yes.
Q. And did he say that without physical therapy you wouldn't have had the scar tissue?
A. Yes.
Q. Do you know if the doctor at Rush obtained your medical records from Midwest Orthopedics?
A. Yes.
Q. They did?
A. Yes.
Q. Did they obtain your medical records from the Department of Corrections?
A. Yes.
Q. So your second surgery was arthroscopic surgery, correct?
A. Yes.
Q. And you were released home the same day that you had the surgery?
A. Yes.
Q. What were your instructions from your doctor?
What were your instructions from your doctor following your second surgery?

Page 72

A. To lay down and use this machine that he sent to me.
Q. What kind of machine?
A. To help my leg regain its mobility.
Q. So what did the machine do?
A. It is like electronic. It will go between my knee, the back of my knee, and it help, it raises up.
Q. So it would help to bend your knee?
A. It helped to try to bend my knee, yes.
Q. When did you get that machine?
A. I got that the next day after surgery.
Q. Do you remember that being called a CPM machine?
A. I guess. I don't know.
Q. Did you only receive one machine?
A. Yes.
Q. And how often were you supposed to use that?
A. Every day.
Q. And how often each day?
A. Three or four times a day.
Q. For how long?
A. I think like two weeks.

Page 73

Q. And how long each time? With each of the three to four times, was it for one minute or one hour?
A. Thirty minutes.
Q. I'm sorry?
A. Thirty minutes.
Q. I couldn't tell if you said 30 or three. Did you do that? Did you follow those instructions?
A. Yes.
Q. So you did it three to four times every day for two weeks?
A. Yes.
Q. Did that doctor eventually give you a knee brace as well?
A. Yes.
Q. When did that doctor give you a knee brace?
A. After my follow-up appointment.
Q. Which was how long after your surgery?
A. Two weeks.
Q. At your first follow-up appointment he gave you the knee brace?
A. Yes.
Q. What were your instructions from this

Page 74

doctor regarding the knee brace?
A. Keep it moving, walking.
Q. So you could weight bear on your leg after the surgery?
A. No, I had to have crutches.
Q. How long did you have crutches, a month after the surgery?
A. About a month after the surgery.
Q. The knee brace that this doctor gave you, was it a hinged brace like the one you got from the Department of Corrections?
A. No. It was half a brace.
Q. What do you mean by that?
A. It wasn't as long as the one I got from the Department of Corrections. It wasn't a full length knee brace.
Q. So the one you got at the Department of Corrections covered more of your leg?
A. Yes, from knee to thigh.
Q. The Department of Corrections one?
A. Yes.
Q. Then the one you got from the doctor at Rush covered what?
A. The knee.

Page 75

Q. Just the knee?
A. Just the knee.
Q. Was it hinged?
A. Could you explain to me?
Q. Did it have any device in it that folded?
A. Yes.
Q. So there was some sort of -- I never had to describe a hinge before, some sort of hardware in it?
A. Yes.
Q. That bent?
A. Yes.
Q. And how long were you supposed to wear that?
A. Forever.
Q. And have you worn it forever since then?
A. Yes.
Q. So every day since you had your surgery in October of 2O16, ever since it was given to you following your surgery you have worn it?
A. Yes.
Q. And it's your understanding you are going to have to do that for the rest of your life, and the Rush doctor also ordered you to do physical

Page 76

therapy?
A. Yes.
Q. Where did you do physical therapy?
A. At Rush and Schwab Rehabilitation.
Q. You did it at Rush first and then at Schwab?
A. Yes, and back at Rush.
Q. Then you went back to Rush after Schwab?
A. Yes.
Q. Do you remember how many visits you were ordered to have at Rush immediately after your surgery?
A. No, I don't remember.
Q. Do you remember if you attended all of them that you were supposed to attend?
A. Yes.
Q. You did attend all of them?
A. Yes, I did.
Q. And what directions did they give you regarding doing exercises at home?
A. She gave me a rubberband, a long rubberband. They put it on the ends of my toes and pushed down.
Q. Anything else?

Page 77

A. That's it. And to stand on my tippy toes.
Q. Anything else?
A. That's it.
Q. How often were you supposed to do those two exercises?
A. At least once a day.
Q. And you understood what you were supposed to do. You didn't have any problems understanding the instructions on that?
A. Yes.
Q. How often did you do that?
A. Once a day three times a week.
Q. There's a difference in those two things. Did you do them once day or do it three times a week?
A. I did them three times a week for 20 minutes.
Q. And you did that every single week? You did them three times a week for 20 minutes?
A. Yes, ma'am.
Q. What other recommendations did the physical therapist make -- and this is the physical therapist at Rush?
A. I can't remember.

Page 78

Q. You transferred from Rush physical therapy to Schwab physical therapy, correct?
A. Yes.
Q. When did you do that?
A. I can't remember.
Q. Why did you do that?
A. Because my insurance.
Q. Was there a gap in time between when you went from one to the other or did you transition?
A. Yes, there was a gap.
Q. How long?
A. About two months.
Q. In that two months where there was a gap, what were you doing for physical therapy?
A. What the physical therapist at Rush had me do.
Q. The exercises, rubberbands and standing on your toes?
A. Yes.
Q. No other exercises?
A. No.
Q. Is it fair to say the physical therapist at Rush did more exercises than the rubberbands therapy and standing on your toes when you were

Page 79

there?
A. Yes.
Q. You didn't do anything to try to replicate those exercises in that two month period between your two physical therapies?
A. No.
Q. How long did you go to physical therapy at Schwab?
A. I think I had at least seven sessions.
Q. Over what period of time?
A. Over a month.
Q. Is that the number of sessions that was recommended?
A. Yes.
Q. Did you attend all of the sessions that you were supposed to attend?
A. Yes.
Q. You didn't miss any?
A. No.
Q. Why did you leave physical therapy at Schwab?
A. Because I got my insurance transferred back to come back to Rush.
Q. So that is the only reason you left Schwab

Page 80

is because your insurance was now transferred back to Rush?
A. Yes.
Q. How much time elapsed between when you left physical therapy at Schwab and when you went back to Rush?
A. About three months.
Q. So you went three months without getting physical therapy?
A. Right.
Q. What exercises and physical therapy did you do in that three month period?
A. The same as the first physical therapy at Rush.
Q. The rubberbands and standing on your tippy toes?
A. Yes.
Q. No other exercises?
A. No.
Q. And when you went back to Rush the second time, how many physical therapy appointments did you do?
A. I think I did one.
Q. Was that the recommended number?

Page 81

A. Yes.
Q. You went in for one appointment, and they said you're good. You don't need to do anything else?
A. Just keep doing what I was doing.
Q. Is it fair to say then that the physical therapist at Rush said that your knee was back to normal?
A. No.
Q. What did the physical therapist tell you about your knee?
A. I can't recall.
Q. Did you see your doctor at Rush at the same time?
A. No.
Q. When is the last time you saw your doctor at Rush about your knee?
A. I can't recall.
Q. Has it been since the follow-up visit when he gave you the brace?
A. I can't recall. The last time I saw him was for pain, and he gave me a referral to the pain specialist at Rush.
Q. How many times after he did your surgery

Page 82

did you see that doctor?
A. At least seven times.
Q. And you don't remember when the last time was?
A. I can't recall.
Q. And that was seven times after your surgery?
A. Yes.
Q. Is it fair to say that you weren't very self motivated in doing your home exercises?
A. I was motivated.
Q. You were motivated?
A. Yes.
Q. So my statement is not a fair statement?
A. It's not.
Q. And if your physical therapist wrote in your notes that you were not self motivated, that would be an untrue statement?
A. Yes, that is an untrue statement.
Q. You claim that you're permanently disabled, correct?
A. Yes.
Q. Describe for me what your disability is.
A. I can't bend. I can't sit down too long.

Page 83

I can't stand too long.
Q. Have you been declared disabled by Social Security or anyone else?
A. No, not yet.
Q. Not yet?
A. I'm in the process of doing it.
Q. Of doing the Social Security?
A. Yes.
Q. What stage are you at with that?
A. I have been denied once for it. So I will apply again.
Q. When were you denied?
A. I can't recall.
Q. Was it after your second surgery?
A. Yes.
Q. So that was October of 2016, and we are now in October of 2018, so in that time frame?
A. 2017.
Q. Did they give you a reason that you were denied?
A. No.
Q. And it's your contention that it was Dr. James' medical care that led you to being disabled?

Page 84

A. Yes.
Q. What exactly did Dr. James do that resulted in you becoming disabled?
A. He didn't move swift enough to give me the medical care I needed.
Q. What was it that he didn't do swift enough?
A. Order the MRI.
Q. What else?
A. To get the care I really needed.
Q. Which is what?
A. Not order the MRI quick enough.
Q. So that is what Dr. James did that you believe resulted in you being permanently disabled?
A. Yes.
Q. Nothing else?
A. That's it.
Q. This is your chance to tell me. If there is something else he did, now is when you need to tell me.
A. If Dr. James had gotten me the MRI, my leg would have been repaired instead of being reconstructed.
Q. According to whom?

Page 85

A. According to Dr. Behl.
Q. When did Dr. Behl tell you that?
A. When I had an appointment down in Midwest Orthopedics.
Q. Before your surgery or after your surgery?
A. Before my surgery.
Q. Those were Dr. Behl's specific words?
A. Yes.
Q. And you have also alleged that your allegations are also against Wexford?
A. Yes.
Q. What did Wexford do that resulted in you becoming disabled?
A. Wexford employed Dr. James.
Q. There was never a time that you are aware of that Wexford denied you getting any treatment, correct?
MR. FLAXMAN: Objection, foundation.
MS. BYRD: I said if he's aware of.
MR. FLAXMAN: Tell her what you know about Wexford's actions.
THE WITNESS: Wexford should have had Dr. James go through the proper procedures to give me the MRI as soon as he could.

BY MS. BYRD:
Q. What are you aware of that Wexford did to prohibit that from happening?
A. Repeat that again.
Q. What are you aware of that Wexford did that prohibited Dr. James from taking the correct steps?
I think your words were go through the proper procedures.
A. They should have trained him properly to deal with situations like this.
Q. And what did Wexford do to not properly train Dr. James?
A. They didn't give him the right training to deal with injuries like mine in a timely manner.
Q. On what do you base that statement?
A. Because of the surgeon at Midwest Orthopedics.
Q. Because the surgeon at Midwest Orthopedics told you that Wexford improperly trained Dr. James?
A. No.
Q. On what do you base your statement that Wexford improperly trained Dr. James?
A. Because Dr. Behl and Midwest Orthopedics

informed me that the injury like mine should have been taken care of in between two to four weeks.
Q. So on what do you base your statement that Wexford did not properly train Dr. James?
A. I really don't understand the question.
Q. You said to me that Wexford did not properly train Dr. James, correct?
A. Yes.
Q. Those were your words, correct? I am asking you what it is that you know that allows you to have that opinion that Wexford did not properly train Dr. James.
What is it that you think Wexford should have done differently?
A. They should have moved more faster and swifter.
Q. Wexford should have?
A. Yes.
Q. What do you base that statement on?
A. That's my opinion.
Q. So in your opinion and your knowledge, what did Wexford do in relation to your injury that they should have done more quickly?
A. They should have gave Dr. James the

authority to go ahead with the ordering of the MRI.
Q. When did they not give Dr. James authority?
A. I don't know.
Q. Have you seen any documents that say that Wexford did not give Dr. James authority?
A. No.
Q. Have you had any conversations with anyone who told you that Wexford did not give Dr. James authority?
A. No.
Q. Has anyone specifically told you that Wexford did not give Dr. James authority?
A. No.
Q. So on what do you base your opinion that Wexford should have --
A. That is just my opinion.
Q. And you don't have anything to base that on?
A. No.
Q. Are you aware of Dr. James or any other doctor requesting approval from Wexford to provide you with medical treatment that was denied?
A. No.

Q. Tell me what you know about Wexford's policies and procedures.
A. I don't know anything about Wexford's policies and procedures.
Q. Tell me what training it is that you believe that Wexford gave to Dr. James?
A. I don't know what the training process is.
Q. Do you know anything about the training process that Wexford gave to Dr. James?
A. No, I don't.
Q. Have you ever seen any Wexford policies?
A. No.
Q. I know I asked this before. So why is it that you were suing Wexford in this case?
MR. FLAXMAN: Objection, asked and answered.
BY MS. BYRD:
Q. Are you suing Wexford simply because Dr. James is their employee?
MR. FLAXMAN: Objection, asking for a legal conclusion.
MS. BYRD: I'm asking. He's suing someone. I'm asking for his reasoning.
MR. FLAXMAN: You're asking him for a legal conclusion and asking him about attorney work

Page 90

product.
MS. BYRD: I am asking him why he is suing Wexford. Are you instructing him not to answer?
MR. FLAXMAN: No. He could give the best answer he can. I am putting my objections on the record.
MS. BYRD: Okay.
THE WITNESS: I can't answer that.
BY MS. BYRD:
Q. So your opinion, why are you suing Wexford?
MR. FLAXMAN: I want to restate the objections of asked and answered and asking for attorney-client work product. Go ahead.
THE WITNESS: Because Dr. James is their employee.
BY MS. BYRD:
Q. And that is the only reason you're suing Wexford?
MR. FLAXMAN: The same objection to attorney-client work product and asking him for a legal conclusion.
BY MS. BYRD:
Q. You could still answer the question.

Page 91

A. Because Dr. James is their employee.
Q. So my question after that was and that's the only reason you're suing Wexford, correct?
MR. FLAXMAN: The same objections. Answer the question.
THE WITNESS: Dr. James is their employee.
BY MS. BYRD:
Q. But my question is that is the only reason you are suing Wexford, correct? That's a yes or no.
A. Because --
Q. It calls for a yes or no answer.
MR. FLAXMAN: There are no other reasons that you know of?
THE WITNESS: No other reasons.
BY MS. BYRD:
Q. So that is the only reason?
A. Yes.
Q. And there are no other Wexford employees whose conduct you have an issue with, correct?
A. No.
Q. So you do not have an issue with any other Wexford employees' conduct?
I want to make sure that your answer to my question was what I understood it to be.

Page 92

MR. FLAXMAN: I object to it as being a vague question.
THE WITNESS: If the nurses work for Wexford, and they didn't give me my proper physical therapy at the time I was incarcerated.
BY MS. BYRD:
Q. And which nurses are those?
A. It was so many, I can't recall.
Q. Which nurses did you ask for physical therapy?
A. It's been so long I can't recall.
Q. But you asked nurses for physical therapy?
A. Yes.
Q. You specifically asked the nurses?
MR. FLAXMAN: Give a yes or no.
THE WITNESS: Yes.
BY MS. BYRD:
Q. How many times?
A. I can't recall.
Q. More than once?
A. Yes.
Q. More than 20 times?
A. I can't recall.
Q. Less than 20 times?

Page 93

A. From the time I had my surgery to the time I left, I asked.
Q. Every day?
A. I can't recall if it was every day.
Q. Well, if you did something every day you would recall that, correct?
A. Right.
Q. So it's fair to say you didn't do it every day?
A. Right.
Q. So did you do it once a week?
A. I can't recall that.
Q. Did you do it once every other day?
A. I can't recall.
Q. But you know for a fact that you asked nurses?
A. Yes.
Q. And if they didn't put that in your chart, then they didn't chart it properly?
A. Exactly.
MR. FLAXMAN: Objection, foundation.
BY MS. BYRD:
Q. From the date of your first surgery at Midwest Orthopedics through today, tell me all of

Page 94

the doctors that have prescribed you medication.
A. Dr. Behl and the doctor at Rush. I can't recall his name.
MR. FLAXMAN: For the record, B-e-h-l.
BY MS. BYRD:
Q. And no other doctors that prescribed you medication since February of 2016, correct?
A. Dr. Behl, Dr. James, and the doctor at Rush.
Q. And what did the doctor at Rush prescribe you?
A. Norcos.
Q. And that is the same drug that you were getting while you were in the Department of Corrections?
A. Yes.
Q. And did you refuse that drug from the doctor at Rush?
A. No.
Q. Why didn't you refuse it from that doctor?
A. Because I was moving around a lot, and it stopped my pain.
Q. Where did you get that prescription filled?

Page 95

A. Wal-Mart.
Q. Wal-Mart?
A. Yes.
Q. Where is that Wal-Mart located?
A. Cermak and Rockwell.
Q. Since February of 2016 when you had your first surgery through today, is there any doctor that has refused to prescribe you medication for anything?
A. Just the doctor at Rush.
Q. What did he refuse to prescribe you?
A. Norco.
Q. And why did he refuse to prescribe that?
A. Because I think it's their policy. You can't for so long prescribe a narcotic to patients.
Q. When did he refuse to prescribe that to you?
A. I can't recall that.
Q. In relation to your second surgery, when did he refuse to prescribe it?
A. About February of 2017.
Q. So four months after maybe?
A. Yes.
Q. Have you taken Norco since then?

Page 96

A. No.
Q. So what have you done for pain since then?
A. I was getting cortisone shots in my knee.
Q. Who was giving you cortisone shots?
A. The pain manager at Rush.
Q. Do you know that doctor's name?
A. No.
Q. Are you still seeing that doctor?
A. No.
Q. What date did you see that doctor, not a specific day, but kind of post surgery until today, when did it fall?
A. I can't recall. It's all in my medical records. I can't recall.
Q. When was the last time you were there?
A. Probably March of 2017.
Q. So what are you doing for pain now?
A. I am scheduled. I'm dealing with it until I go for my appointment in November to pain management at Stroger.
Q. How many times have you been to the pain management at Stroger?
A. This is going to be my first time.
Q. So what made you schedule an appointment

Page 97

at Stroger when the last visit at Rush was in March of 2017?
A. Because I've been trying to get to the pain manager at Rush, and they kept giving me the runaround.
Things weren't going right. So I switched it over to Stroger.
Q. So you have received no treatment for pain between March of 2017 and this upcoming appointment at Stroger in November?
A. Yes. I'm just dealing with it.
Q. And what steps have you taken to get pain medication in that period of time?
A. I am trying.
Q. But what have you done since March of 2017 to get treatment for your pain?
A. I am going to my primary doctor.
Q. Who is your primary doctor?
A. Dr. Orzinga.
Q. Can you spell that?
A. No.
Q. Can you say it again?
A. Orzinga. Daniel Orzinga.
Q. Where is he?

Page 98

A. Lawndale and Christianson.
Q. Is he prescribing you pain medication?
A. No.
Q. So what is he doing for your pain?
A. He gave me a referral. He told me to deal with it until we go to the pain manager.
Q. When did he tell you to just deal with it?
A. I can't recall, but he told me to.
Q. Was that in March of 2O17 or after?
A. After.
Q. How long after?
A. About three months after.
Q. So since June of 2017?
A. Yes.
Q. So in June, approximately June of 2017 Dr. Orzinga told you to deal with your pain until you could get to the pain management clinic.
And the first time you're getting to the pain management clinic is November of 2018, correct?
A. Yes.
Q. Is that the only plans you have to see a doctor in the future?
A. Yes.
Q. I'm sorry?

Page 99

A. Yes.
Q. So you don't have any other scheduled appointments with anyone?
A. Not for my leg, no.
Q. For anything else?
A. Yes, I got scheduled appointments.
Q. For what?
A. Colonoscopy and vasectomy.
Q. Anything else?
A. That's it.
Q. The last time you saw the surgeon at Rush, what were the recommendations that the surgeon made for you regarding your leg?
A. I can't remember.
Q. When Dr. James got the results of your MRI he made arrangements for you to see the surgeon right away, correct?
A. I guess.
Q. How much time passed between when you got the results of your MRI and when you saw the surgeon?
A. About a month. I don't know. I can't recall.
Q. And you said that you had the MRI. About a week later you had surgery, correct?

Page 100

A. Yes.
Q. And those were your words, correct?
A. Yes.
Q. And your surgeon that did the first surgery never told you that the period of time that elapsed between when you got your MRI and when you had surgery, that that was an unreasonable period of time, correct?
A. Can you repeat that.
Q. The surgeon, Dr. Behl, that did your first surgery, he never said that the period of time that elapsed between when you got the MRI and when you had the surgery was an unreasonable period of time, correct?
A. The reasonable time was from my injury to the MRI.
Q. But my question is the time between the MRI and the surgery, he never told you that was an unreasonable period of time, correct?
A. We didn't discuss that.
Q. But he never told you that that was an unreasonable period of time?
A. We didn't discuss it. He never said it.

Page 101

Q. So he never said it?
A. He never said it to me.
Q. He never recommended that you come for surgery following the MRI sooner than you did, correct?
A. No, he didn't. No.
Q. What is a normal day like for you right now? Let's say you weren't here today.
If you weren't here today what would you have done?
A. Sit in the house and watch TV.
Q. What time do you get up in the morning?
A. About 5:30.
Q. And then you just stay in the house all day?
A. Drink coffee until one of my kids come pick me up when he get off work.
Q. What time do they get off work?
A. About 4:30.
Q. P.M.?
A. Yes.
Q. And one of your kids comes every day about 4:30?
A. Not every day. Maybe a friend.

Page 102

Q. How often?
A. Maybe like twice a week.
Q. On the day that your kids don't come?
A. Yes.
Q. And then you leave every day roughly 4:3O?
A. Not every day.
Q. How often?
A. Probably four days out of the week.
Q. What do you do when you leave home at 4:30?
A. I probably get dropped off at an AA meeting.
Q. How often do you go to AA meetings?
A. Probably twice a week.
Q. Where do you go to AA meetings?
A. At Dear Rehabilitation.
Q. D-e-a-r?
A. Yes?
Q. Where is that located?
A. Roosevelt and Pulaski. I go to NA meetings too.
Q. How often do you go to NA meetings?
A. Probably once a week.
Q. Is that also Dear Rehabilitation?

Page 103

A. No, EU House on Madison and right off Ashland.
Q. And that's the same thing. Someone picks you up around 4:30 and takes you to one of those two places?
A. I use my sister's car sometimes.
Q. I am assuming the fact that you attend AA meetings and NA meetings is because you're an addict?
A. Yes.
Q. And are you currently clean?
A. Yes.
Q. How long have you been clean?
A. Since 2012.
Q. Congratulations. So since your release from prison you haven't used substances at all?
A. Except for the Norco.
Q. And did your doctor know that you're an addict?
A. Yes. That's why he stopped it.
Q. Other than the Norco, you have used no alcohol, no drugs since your release from prison?
A. No.
Q. That's a no?

Page 104

A. That's a no.
Q. And when you were just telling me that you get up at 5:3O and would drink coffee until 4:30 when someone picks you up, is that seven days a week or are the weekends different?
A. The weekend is different.
Q. What do you do on the weekends?
A. Sunday, I go to church.
Q. Where do you go to church?
A. The Upper Room on Washtenaw.
Q. That is where?
A. Roosevelt and Washtenaw.
Q. What time do you go to church?
A. 11:30 a.m.
Q. How long is church?
A. Until about 2:30 p.m.
Q. And then you go home after church?
A. I go watch the game.
Q. Where do you usually go watch the game?
A. A friend's house.
Q. What about on Saturdays, what do you do?
A. Laundry.
Q. You do that at home or go somewhere else?
A. Go to a laundry facility.

Page 105

Q. What laundry facility do you go to?
A. Roosevelt and Kedzie.
Q. Anything else that you do on the weekends?
A. No.
Q. When you were incarcerated at Sheridan, you said you knew the process for filling out grievances, correct?
And am I correct that you only filled out one grievance in relation to the injury that you suffered?
A. I can't recall. I think it was one, but I'm not sure.
Q. I am showing you what I marked as Defendant's Exhibit 2, and it's a three page document.
And if you look at the third page, is that your grievance?
A. Yes.
Q. And it's dated December 29, 2015, correct?
A. Where is it?
Q. If you look on the upper left hand corner of the grievance itself. I know they're printed the wrong way on the paper.
It says December 29, 2015?

Page 106

A. Yes.
Q. And that's your handwriting?
A. Yes.
Q. Where were you when you filled out this grievance?
A. In the general population.
Q. So in that cell block area that you described earlier?
A. Yes.
Q. That is correct?
A. Yes.
Q. And when you filled out this grievance, you were able to sit down and write out what you wanted to in the grievance, correct? No one told you what to write?
A. Correct.
Q. You got to use your own words?
A. Correct.
Q. You got to write down as much or as little as you wanted to, correct?
A. Yes.
Q. No one told you that you couldn't write something down that you wanted to write down, correct?

Page 107

A. Yes.
Q. You got to write down all of your concerns on this grievance, correct?
A. Correct.
Q. And if it didn't fit in the area that they gave you, you could write on the back, correct?
A. Correct.
Q. What is your understanding of how the grievance procedure works at Sheridan?
A. You write the grievance, and it gets looked over by the shift commander or committee. And then they find a decision and send it back to you.
Q. And if you didn't like what they wrote when they sent it back to you was there anything you could do about that?
A. I think you could appeal it, appeal the grievance.
Q. How do you appeal a grievance?
A. By rewriting a grievance. I can't recall what was the process of appealing a grievance.
Q. But you're the one that wrote this grievance that is in front of you as Defendant's Exhibit 2?

Page 108

A. Yes.
Q. One of the things you wrote in that grievance is that you said you know it takes time to get things done around here. Correct?
A. Yes.
Q. And what did you mean when you wrote that?
A. I meant that it takes time for a person to be seen by the medical staff because there's so many inmates in there.
Q. You also wrote twice in this grievance that you are going to be released in 156 days, right?
A. Uh-huh.
Q. Is that yes?
A. Yes, ma'am.
Q. And you wanted to make sure you got surgery before you got released, correct?
A. Yes.
Q. Why were you so concerned about getting surgery before you were released?
A. Because I wanted to be mobile so I could work when I got home.
Q. Did you have a job lined up?
A. Yes.

Page 109

Q. What were you going to be doing?
A. Labor.
Q. What kind of labor?
A. Physical labor.
Q. For whom?
A. For a few friends that's got properties.
Q. What are those friends' names?
A. Henry Shelton
Q. S-h-e-l-t-o-n?
A. Yes.
Q. Who else?
A. Darren McCule.
Q. Spell Darren's last name.
A. M-c-C-u-l-e.
Q. And do they own businesses?
A. No, they just subcontract.
Q. Subcontract doing what?
A. Buildings. Landscaping. Tuck pointing.
Q. And you would talk to them while you were in the Department of Corrections?
A. Yes, I talk to them. I talk to Darren, not Henry.
Q. How did you know you had work lined up with Henry?

Page 110

A. Because that was my wife's cousin, and she was relaying a message to me.
Q. Who else did you have work lined up with?
A. Cesar Brock.
Q. Cesar?
A. Brock.
Q. Who is Cesar Brock?
A. He's a friend of mine.
Q. Anybody else that you had work lined up with?
A. That was it.
Q. But once you got released you didn't work with any of them?
A. No, I couldn't.
Q. Why couldn't you?
A. Because of my leg. I couldn't do physical things they needed me to do.
Q. It takes four to six months to recover from surgery, correct?
A. Yes.
Q. And where did you come up with that number?
A. Off the top of my head.
Q. And you wrote that you needed to be at

Page 111

75 percent when you were released, correct?
A. Yes.
Q. Where did you come up with that number?
A. Off the top of my head.
Q. So you just kind of made those two things up?
A. Yes.
Q. And there's a place on the grievance for you to request relief, right?
A. Okay.
Q. And what you wrote in there is that you need for the process to speed up to get your leg fixed, correct?
A. Right.
Q. And again, no one told you what you had to write in that space either, correct?
A. Yes.
Q. And you could have written anything you needed in that space, correct?
A. Correct.
Q. What you chose to write is that you need the process to speed up, correct?
A. Correct.
Q. Where in your grievance did you write you

Page 112

were in pain, and you were suffering?
A. I did this when I put in my request for sick call.
Q. Where in your grievance did you write that?
A. I didn't put it in there.
Q. And where in your grievance did you say that your pain was a ten out of ten?
A. I told the nurse and the doctor that.
Q. But where in your grievance did you write that?
A. It's not on there.
Q. Where in your grievance did you write that you weren't getting medical care?
A. It's not on there.
Q. But you could have written all those things in there, correct?
A. Yes.
Q. No one stopped you from writing those things in there?
A. No.
Q. But in December of 2015, you chose not to write those things?
MR. FLAXMAN: Objection, asked and answered.

Page 113

BY MS. BYRD:
Q. You could answer unless he's directing you not to.
MR. FLAXMAN: Answer her question again.
BY MS. BYRD:
Q. You chose not to write those things in there in December of 2015?
A. Correct.
Q. And after you wrote this grievance on December 29, 2O15, what steps did you take to follow up on it?
A. There were no other steps to follow up on it.
Q. Did you get a response?
A. Yes, I got a response. The response was--
Q. The response was on January 6, 2016, right? And it says forwarded to HCU administrator for response?
A. That's when they received it.
Q. Right. You wrote it on December 29th, right?
A. Right.
Q. And on January 6, they wrote forwarded to HCU administrator for response. Correct?

Page 114

A. Right.
Q. And that is returned to you so that you could see that, correct?
A. It didn't return to me.
Q. They didn't return it to you?
A. No. I can't remember when. Right here -- I can't remember. I can't remember.
Q. Well, I guess there are two options, right? You either got it back from them or you didn't?
A. I can't remember. I got it back from them, but I don't remember when.
Q. So between the time you wrote it and the time you got it back, what steps did you take?
A. Steps to take?
Q. To follow up on your complaint in there?
A. I couldn't do nothing, but just wait until the grievance come back to me. That's the only steps I could take.
Q. You couldn't do anything else?
A. No.
Q. After you received it back, what steps did you take?
A. I was in the hospital by the time I got it

Page 115

back. I can't remember all this stuff.
Q. When you were in the hospital or when you were in the infirmary and no one was giving you physical therapy, how many grievances did you write then?
A. I didn't write none.
Q. Why not?
A. I can't recall why I didn't.
Q. And do you have any memory of writing any grievances other than the ones I just showed you?
A. No.
Q. What damages are you claiming as a result of your knee injury?
A. Pain and suffering.
Q. And tell me what you mean by that.
A. I am in pain constantly, and I suffered for four months until my leg got fixed.
Q. Four months between your injury and your first surgery?
A. Yes.
Q. Are you claiming any economic losses?
A. No.
Q. What are garden variety emotional damages?
A. Say that again.

Page 116

Q. What are garden variety emotional damages?
A. I don't know.
Q. Do you remember answering some questions in writing?
A. When?
Q. March, maybe.
A. With who?
Q. In relation to this lawsuit. They were questions that I or my law firm would have sent you to answer through your attorney.
A. I remember.
Q. Those are called interrogatories. Does that sound right?
A. Yes.
Q. And you answered those questions, correct?
A. Yes.
Q. And you answered them under oath, correct?
A. Yes.
(Deposition Exhibit 3 was marked for identification.)
Q. I am going to give you a copy of what I am marking as Defendant's Exhibit number 3.
Are those your answers to interrogatories?

Page 117

A. Yes.
Q. And in those interrogatories you answered those fully and correctly. Correct?
A. Yes.
Q. And you gave me all of the information that was asked for in those, correct?
A. Yes.
Q. There are none of those answers that you want to change, correct?
A. No. Everything is okay.
Q. So I'm going to direct you to question number 11, to which you answered, your entire answer is garden variety emotional damages only.
So when I just asked you what garden variety emotional damages are, you told me you do not know?
A. I know what it is.
Q. What is it?
A. It's an emotional injury.
Q. What are the emotional injuries that you have suffered?
A. That I can't do what I used to do. I can't run. I can't work out. I have to sit and stand a little.

Page 118

Q. I'm sorry?
A. I have to sit for a little while, stand for a little while, sit for a little while.
Q. Have you been to see a psychologist or psychiatrist about this?
A. No.
Q. Do you take any medication to help deal with them?
A. No.
Q. So what are you doing to deal with these emotional injuries that you have suffered or continue to suffer?
A. Nothing right now.
Q. Are there any other injuries that you are claiming that we have not discussed today?
A. No.
Q. Have you received any medical bills for any of the treatment that you received?
A. No.
Q. Everything has been paid for by your insurance?
A. Yes.
Q. Is there anything else that you think is relevant to your allegations that we haven't

Page 119

discussed today?
A. Not that I could think of right now.
MS. BYRD: That is all I have.
CROSS-EXAMINATION
BY MR. FLAXMAN:
Q. Mr. Jones, you mentioned your primary care doctor, Dr. Ozinga?
A. Yes.
Q. When was the last time you saw Dr. Ozinga?
A. Two weeks ago.
Q. And Dr. Ozinga is the one who gave you the referral to the Stroger pain clinic?
A. Yes.
Q. When did he first give you that referral?
A. I put the referral in, I can't recall. It was a while back, but I didn't get the referral. So I had to go again and ask him for it twice. I put in for it twice.
Q. Do you know what the problem was?
A. I don't.
Q. Can you recall when Dr. Ozinga first tried to get you a referral to Stroger?
A. About six months ago.
Q. And why was he giving the Stroger pain

Page 120

referral?
A. Because I told him I need something for pain.
Q. Where was the pain that you were talking about?
A. In my knee.
Q. The knee that we have been talking about today?
A. Right.
Q. You told us you go to church on Sundays?
A. Yes.
Q. Do you sit still through the church service?
A. No.
Q. Why not?
A. I can't.
Q. So what do you do during the service?
A. I stand up. Then I sit down, stand up, sit down.
MR. FLAXMAN: I don't have any other questions.
REDIRECT EXAMINATION
BY MS. BYRD:
Q. You said that Dr. Ozinga first referred you about six months ago for the pain clinic?

Page 121

A. Yes.
Q. Something happened, and the referral didn't go through?
A. Right. And then I had to ask him to do it again.
Q. So you had to ask him multiple times to get it done?
A. Yes.
Q. And that process started at least six months ago?
A. Yes.
Q. So are you suing Dr. Ozinga for taking too long to get you medical care?
A. No.
Q. Why not?
A. Why should I?
Q. You are suing Dr. James for taking too long, correct?
MR. FLAXMAN: Just say yes or no, did you file a lawsuit against Dr. Ozinga?
THE WITNESS: No, I didn't.
BY MS. BYRD:
Q. This just occurred to me when you asked your questions. I know it's not technically in

response.

We're talking about your left knee is what we've been talking about?

A. Yes.

MS. BYRD: That is all the questions I have.

MR. FLAXMAN: We'll reserve signature.

STATE OF ILLINOIS)
) ss:
COUNTY OF C O O K)

I, VICTORIA D. ROCKS, C.S.R., Notary Public, within and for the County of Cook, State of Illinois, a Certified Shorthand Reporter of said state, do hereby certify:

That previous the commencement of the examination of the witness, JOHNNY JONES, was first duly sworn to testify to the whole truth concerning the matters herein;

That the foregoing deposition transcript was reported stenographically by me and was thereafter reduced to typewriting via computer-aided transcription under my personal direction, and constitutes a true record of the testimony given and the proceedings had;

That the said deposition was taken before me at the time and place specified;

That the reading and signing by the witness of the deposition transcript was not waived;

That I am not a relative or employee of attorney or counsel, nor a relative or employee of

such attorney or counsel for any of the parties hereto, nor interested directly or indirectly in the outcome of this action.

IN WITNESS WHEREOF, I do hereunto set my hand and affix my seal of office at Chicago, Illinois this 30th day of October, 2018.

Victoria Rocks

VICTORIA D. ROCKS, C.S.R.
License No. 084-002692

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November 1, 2018

To: Joel A. Flaxman

Case Name: Jones, Johnny v. Wexford Health Sources, Inc., et al.

Veritext Reference Number: 3064600

Witness: Johnny Jones Deposition Date: 10/16/2018

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3064600
CASE NAME: Jones, Johnny v. Wexford Health Sources, et al.
DATE OF DEPOSITION: 10/16/2018
WITNESS' NAME: Johnny Jones

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Johnny Jones

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

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In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

_____ _____
Date Johnny Jones

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal

this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 10/16/2018

PAGE/LINE(S) / CHANGE /REASON

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_____ _____
Date Johnny Jones

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____
DAY OF _____, 20_____ .

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Notary Public

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Commission Expiration Date

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084-002692 124:9

1

1 3:8 28:20,23 125:4
10/16/2018 125:8 126:3 127:3 128:2
10:00 1:17
11 117:12
1100 125:1
116 3:9
119 3:4,5
11:30 104:14
122 3:5
12754 124:8
12o 3:5,5
14 14:14
15 44:4 46:11
156 108:11
16 9:20 31:24 32:5 33:19,22
16th 1:17
17 1:5 4:16 9:17
18 9:17 38:8,14
1820 125:2
18th 34:10,12 36:6 37:6,13
19 9:20
1991 24:8,9 25:4
1993 24:8 25:6
1995 17:22
1r 8:6

2

2 3:8 28:20 105:14 107:24
20 34:19 35:9,17 46:11,11 77:16,19 92:22,24 126:16 127:22 128:22
200 1:16 2:3
2001 10:15
2007 18:9 28:8
201 1:16 2:4
2012 103:14
2014 14:14
2015 31:24 32:5 38:14 44:1,3,19 47:12,21 105:19 105:24 112:22 113:7
2016 11:3 41:20 43:20,23 44:3,5 47:12 48:10 63:13 63:15,20,24 70:2 83:16 94:7 95:6 113:16
2017 83:18 95:21 96:16 97:2,9,15 98:13,15
2018 1:18 83:17 98:19 124:6 125:4
216-523-1313 125:3
222 2:9
24 51:19 60:11
25 9:17
28 3:8,8 9:17
282 8:16
29 105:19,24 113:10
2900 2:9
29th 113:20
2:30 104:16
2o15 113:10
2o16 75:19
2o17 98:9

3

3 3:9 116:19,22
30 4:22 46:20 73:7
300 20:7
3041 8:2
3064600 125:7 126:2 127:2
30th 124:6
312 2:5,10

4

40 46:19
427-3200 2:5
44114 125:2
4:3o 102:5

5

5:30 101:13
5:3o 104:3

6

6 3:4 113:16,23
60604 2:4
60606 2:10
641-3100 2:10

7

75 111:1

8

8218 1:5 4:16

a

a.d. 1:18
a.m. 1:17 104:14
aa 45:3 102:11,13 102:15 103:7
ability 6:10,14,18
able 17:12 18:16 18:18,24 26:5 35:22,23,24 47:7,8 56:2 57:17 65:1,4 106:13
access 16:21 51:20 60:11
accident 26:23
accomplish 69:22
achilles 28:10,11
acknowledge 126:11 127:16
act 126:14 127:20
action 124:3
actions 85:21
activities 44:11,21 60:19
activity 44:13 60:17
adams 2:9
addict 103:9,19
address 8:11,13,15 9:3,4 125:15
addresses 8:24
administrator 113:17,24
affect 6:14,18
affix 124:5
affixed 126:15 127:21
ago 119:10,23 120:24 121:10
agree 46:17
ahead 88:1 90:14
aided 123:16
air 31:7
al 125:6 126:3 127:3
alcohol 103:22
allegations 29:2 29:11 85:10 118:24
alleged 29:16 85:9
allow 6:24
allows 87:10
alternatives 67:9
amount 67:24
answer 5:14,21 7:1,12 10:12 48:17 90:3,5,8,24

91:4,11,23 113:2,4 116:10 117:12
answered 89:15 90:13 112:24 116:15,17 117:2 117:12
answering 116:3
answers 5:7,9 22:14 116:23 117:8
anybody 110:9
anytime 62:13,16
anyway 60:19
apartment 8:5,6
appeal 107:17,17 107:19
appealing 107:21
appear 126:11 127:15
appearances 2:1
appeared 2:6,12 41:10
appended 127:11 127:18
applicable 4:23
apply 83:11
appointment 41:1 62:20,23 63:3,6,10 63:12 68:17,19,20 69:4 73:18,21 81:2 85:3 96:19 96:24 97:9
appointments 52:5,8 69:3 80:21 99:3,6
approval 88:22
approximately 36:2 66:6 98:15
area 46:22 47:1 106:7 107:5
armed 13:15
arrangements 99:16
arrive 14:12
arrived 14:15
arthroscopic 71:15
ashland 103:2
asked 22:8 62:14 62:16 65:19 89:13 89:15 90:13 92:12 92:14 93:2,15 112:24 117:6,14 121:23
asking 5:6 38:1 40:4 87:10 89:19 89:21,22,23,24 90:2,13,21
assignment 126:2 127:2 128:2
assist 56:8
assistant 18:7 20:1
assume 5:22
assuming 103:7
ate 44:13
attached 127:7
attempted 13:15
attend 76:15,17 79:15,16 103:7
attended 76:14
attorney 4:12 5:3 5:20 89:24 90:13 90:21 116:10 123:24 124:1
attorneys 23:9
authority 88:1,3,6 88:10,13
authorize 127:11
ave 125:1
avenue 1:16 2:3
aware 85:15,19 86:2,5 88:21

b

b 94:4
b00208 11:13
back 11:1,5 15:4,5 25:23 26:2 28:1 32:14,16 33:8,19 33:21 34:4,7 39:19 52:24 57:4 67:9 72:7 76:7,8 79:23,23 80:1,6,20 81:7 107:6,12,15 114:9,11,14,18,22 115:1 119:16 125:15
bad 57:14 61:23
ball 45:5,9 60:23
base 86:16,22 87:3 87:19 88:15,18
based 43:2
basketball 28:12 30:22 31:4,15 61:1
bear 74:3
becoming 84:3 85:13
bed 59:17,20,21
behalf 2:6,12
behl 49:1,2,3,5 70:13,14 85:1,2 86:24 94:2,8 100:11
behl's 85:7
belief 34:1
believe 84:14 89:6
bend 50:8 56:13 56:16 59:7 72:9 72:10 82:24
bending 54:16 56:10
bent 75:11
best 7:4,5 90:4
big 45:22,23
bills 118:17
bit 14:2
blank 17:8
block 106:7
blood 25:19
body 24:11,16 35:12,18,20
brace 34:14 58:7 58:10,18,21,23 59:1,9,12,16,23 60:9,11 64:16 65:7,10,13 73:14 73:17,22 74:1,9,10 74:12,16 81:20
break 7:9,10,13 28:4,18 42:7 66:4
breakfast 44:24
bringing 29:18,20 30:2
brock 110:4,6,7
broken 24:18
brothers 65:16
buildings 109:18
bullet 24:23 25:22
businesses 109:15
byrd 2:8 3:4,5 4:2 4:5,7,10,14 5:3,9 5:17 6:6 10:19,22 20:21 21:3 26:15 26:17 28:1,2 29:8 30:1 42:6 46:5,9 46:15 48:19 85:19 86:1 89:16,21 90:2,7,9,17,23 91:7,15 92:6,17 93:22 94:5 113:1 113:5 119:3 120:22 121:22

122:5

c

c 109:14,14 123:3
c.s.r. 123:5 124:9
ca 125:24
call 16:4,14,16,18 17:1,2,13,16 43:7 44:18 47:14 65:20 65:23 112:3
called 1:11 6:2 21:12 32:4,8,10,22 36:17 37:1 63:20 66:20 72:13 116:12
calls 91:11
cane 50:9 64:20
car 8:22 26:23 103:6
care 23:18,20 26:12 27:8,9,11 30:4,6,17 31:14,16 33:19,21 36:8,17 36:18 37:2,15,17 37:20,22 38:2,4,10 38:11,14,16,18,21 39:5,7,11 51:20 52:3,3 55:21 57:22 70:8,10,11 83:23 84:5,10 87:2 112:14 119:6 121:13
career 21:7,12
carol 8:14,16
case 4:14,16 28:24 89:14 125:6 126:3 127:3
cassiday 2:8
cassiday.com 2:11
cast 58:11,14,20
caught 10:15
caused 30:19
cell 32:14,16 33:9 44:12,13,16,17 45:20 46:10,22 47:3,7,9,12 106:7
cents 20:24
cermak 95:5
certain 10:5,5
certificate 127:11
certification 20:15 126:1 127:1
certified 123:7
certify 123:8
cesar 110:4,5,7
chance 46:5 84:18
change 117:9 125:13,14 127:8 128:3
changes 125:12 126:7 127:7,9
charles 8:16
chart 93:18,19
check 11:19
chest 25:13,14,18
chicago 2:4,10 8:3 8:4 9:8,9,23,24 63:17 124:5
children 22:4
chose 111:21 112:22 113:6
christianson 98:1
church 45:1 104:8 104:9,13,15,17 120:10,12
civil 1:12 4:22 126:5 127:5
claim 82:20
claiming 115:12 115:21 118:15
classes 18:1
clean 103:11,13
cleaning 19:20
cleveland 125:2
client 90:13,21
clinic 98:17,19 119:12 120:24
coffee 101:16 104:3
college 17:23 18:1 18:2,4
colonoscopy 99:8
come 12:5 36:5 52:23 79:23 101:3 101:16 102:3 110:21 111:3 114:18
comes 101:22
commander 107:11
commencement 123:9
commencing 1:17
comments 71:1
commission 126:19 127:25 128:25
committee 107:11
communication 57:10
complaint 3:8 28:24 29:3,9 114:16
complete 17:19 20:17
completed 125:15
completely 51:13
comply 11:17
computer 123:16
concerned 10:17 108:19
concerning 123:11
concerns 107:2
conclusion 89:20 89:24 90:22
conditions 18:24 19:4 50:16
conduct 91:19,22
confer 10:11,18
conference 45:23 45:24 46:3,6
confirm 11:12
congratulations 103:15
consider 18:21,23 19:2
consist 18:10
consistent 12:12 12:13
constant 48:4
constantly 115:16
constitutes 123:17
contact 63:21
contacted 63:15
contained 29:3
contention 83:22
contents 15:20
continue 118:12
controlled 13:1,16
conversation 35:21 49:8
conversations 88:8
conviction 13:21 14:11
convictions 13:14 13:23
cook 1:15 13:3 14:18 24:1 123:6
copy 28:23 116:21
corner 105:21

correct 4:12 11:5 11:13 13:1,6,19 16:2,5,8,22 19:8,9 22:9 28:24 29:4 30:24 34:15 36:11 37:17 38:6 40:6 43:8,11,14,23 48:11,12,15 51:9 51:20,23 52:6,9,15 52:16 56:3 57:11 58:1 60:12 62:21 63:4,7,8,13,14 64:7 65:2,5 66:7 66:21 67:12 69:1 70:19 71:16 78:2 82:21 85:17 86:6 87:7,9 91:3,9,19 93:6 94:7 98:19 99:17 100:1,3,9,15 100:20 101:5 105:7,8,19 106:10 106:14,16,18,20 106:24 107:3,4,6,7 108:4,17 110:19 111:1,13,16,19,20 111:22,23 112:17 113:8,24 114:3 116:15,17 117:3,6 117:9 121:18
correctional 30:12
corrections 9:2 11:2 12:24 14:13 14:16 15:23 21:5 21:13 50:5,17,22 52:13 56:21 59:23 60:3 61:10 62:5,8 62:14,20 63:1 64:16 66:6 71:13 74:11,15,18,20 94:15 109:20 125:12 127:17
correctly 117:3
cortisone 96:3,4
cost 27:13,14,16
counsel 123:24 124:1
county 1:15 13:3 14:18 24:1 27:8,9 27:11 123:3,6 126:10 127:15
couple 26:4 31:13
court 1:1 4:17 5:11 29:16 31:16 126:7
courts 1:13
cousin 110:1
covered 74:18,23
cpm 72:13
criminal 13:13,23
cross 3:5 119:4
crutches 32:13 50:9 64:18 74:5,6
csr 1:14
ct 27:19
cullerton 8:2
currently 11:15 14:3 27:5 103:11
cut 69:21
cutting 26:6
cv 1:5 4:16

d

d 1:14 3:1 102:17 123:5 124:9
damages 115:12 115:23 116:1 117:13,15
daniel 97:23
darren 109:12,21
darren's 109:13
date 17:5 37:5,6 37:12,13 44:9,10 49:18,19 51:3,4 63:19,23 65:22 68:19,23 93:23 96:10 125:8 126:3 126:9,19 127:3,13 127:25 128:20,25
dated 105:19
dates 38:8
daughter 8:19
davis 8:21
day 1:17 16:18 21:4,6 22:23 31:23 32:12,17 34:18,24 35:3,5 36:23 38:8,14 39:21 40:2 42:9 42:10 44:20 45:11 45:12,14 48:3,4,9 50:20,21 51:2 56:19,20 65:9 68:16,20 71:18 72:12,20,21,22 73:11 75:18 77:6 77:12,14 93:3,4,5 93:9,13 96:11 101:7,15,22,24 102:3,5,6 124:6 126:16 127:22 128:22
days 33:24 36:3 54:3 61:20 102:8 104:4 108:11 125:18
deal 86:11,15 98:5 98:7,16 118:7,10
dealing 96:18 97:11
dear 102:16,24 125:10
december 105:19 105:24 112:22 113:7,10,20
decision 60:7,14 107:12
declared 83:2
deed 126:14 127:20
deemed 125:19
defendant 1:11 2:12
defendant's 28:23 105:14 107:23 116:22
defendants 1:8 29:3,12
delivery 12:24
denied 52:3 83:10 83:12,20 85:16 88:23
department 9:1 11:2 12:23 14:13 14:15 15:23 21:5 21:13 50:4,17,22 52:13 56:20 59:22 60:2 61:10 62:4,8 62:13,19,24 64:15 66:5 71:13 74:11 74:15,17,20 94:14 109:20 125:22
deposition 1:10 4:19,20,24 22:9,12 22:17,20 23:2 28:20 116:19 123:13,19,22 125:8,11 126:1,3 127:1,3
describe 16:16 44:10 59:1 75:8 82:23
described 27:2 106:8
describes 16:1,4

describing 15:13
desk 16:20
device 75:5
diagnose 18:16,24 33:6
diagnostic 69:9,13
difference 77:13
different 15:5 51:13 104:5,6
differently 87:14
dimensions 46:6
dinner 44:24
direct 3:4 6:5 117:11
directing 113:2
direction 123:17
directions 59:15 76:19
directly 124:2
disability 82:23
disabled 82:21 83:2,24 84:3,14 85:13
disciplinary 19:11
discuss 100:21,24
discussed 22:13 56:3 118:15 119:1
district 1:1,1,13 4:17,17
division 1:2 4:18
doctor 19:8 23:23 26:12 64:6,10 66:21,23 67:1,3,3 67:4,5,6,7,10,19 67:22,23 68:8,11 70:3,5,12,18 71:7 71:22,24 73:13,16 74:1,9,22 75:24 81:13,16 82:1 88:22 94:2,8,10,18 94:20 95:7,10 96:8,10 97:17,18 98:22 103:18 112:9 119:7
doctor's 66:24 96:6
doctors 54:19 57:10 59:8 60:18 60:18 64:3,11 94:1,6
document 29:22 105:15
documents 3:8 22:16 88:5
doing 17:16 19:18 21:19 25:24 34:23 35:3 64:1 69:23 76:20 78:14 81:5 81:5 82:10 83:6,7 96:17 98:4 109:1 109:17 118:10
dr 4:11,15 30:10 30:11 31:19 32:4 32:6,22 33:1,15,16 34:9,12 36:6,20 37:5,12 39:1,16 40:1,24 48:14 49:1,2,3,5,10,10 49:20 51:1,5 52:14 70:13,14 83:23 84:2,13,21 85:1,2,7,14,22 86:6,13,20,23,24 87:4,7,12,24 88:2 88:6,9,13,21 89:6 89:9,18 90:15 91:1,6 94:2,8,8 97:19 98:16 99:15 100:11 119:7,9,11 119:21 120:23 121:12,17,20
drink 101:16 104:3
drive 10:5 20:21
driveby 24:15
driver 20:14
driver's 10:1,2,4,6
dropped 102:11
drowsy 66:12
drug 94:13,17
drugs 103:22
dui 10:15 13:19,21
duly 6:2 123:11
duties 21:19

e

e 3:1 7:22 94:4 102:17 109:9,14
earlier 13:18 14:2 44:1 106:8
east 8:16
eastern 1:2 4:18
economic 115:21
education 18:10 19:3,23
effect 24:17
either 111:16 114:9
elapsed 80:4 100:7 100:13
electronic 72:6
email 125:17
emotional 115:23 116:1 117:13,15 117:19,20 118:11
employed 85:14
employee 89:18 90:16 91:1,6 123:23,24
employees 91:18 91:22
employer 30:15
enclosed 125:11
ends 76:22
entered 127:9
entire 117:12 126:5 127:5
entirely 60:7
errata 125:13,18 127:7,10,18 128:1
established 66:19
et 125:6 126:3 127:3
eu 103:1
event 39:10
eventually 40:6 73:13
exact 49:21
exactly 17:18 37:4 47:19 51:18,21 84:2 93:20
exam 57:15
examination 1:11 3:4,5,5 6:5 119:4 120:21 123:10
examined 6:3 34:15 35:11,17
examining 35:20
example 46:1
excuse 23:19 43:12 65:12
executed 127:10
execution 126:14 127:19
exercise 54:7,11
exercises 53:1,3,5 53:15,18,21 54:4 54:14 56:9 67:20 76:20 77:5 78:17 78:20,23 79:4 80:11,18 82:10
exhibit 3:8,8,9 28:23 105:14

107:24 116:19,22
exhibits 3:7 28:20
expect 5:18
expiration 126:19 127:25 128:25
explain 10:3,14 75:4
explained 5:4 70:5
extent 23:2 25:3 26:8 50:10

f

facility 14:16 15:5 30:13 36:5 51:10 104:24 105:1
fact 93:15 103:7
fair 5:15 7:2,13 15:19 18:20 19:6 35:2 51:14 78:22 81:6 82:9,14 93:8
fall 96:12
familiar 15:19 16:7
far 59:7
faster 87:15
february 14:14 41:20 43:20,23 44:1,4,15 47:12 48:10 94:7 95:6 95:21
federal 1:12 4:22
feeling 4:3 62:7
feet 46:11 53:24 53:24,24
fell 62:23
felt 31:5 36:1
female 67:3
figure 6:22
file 16:11 18:14 121:19
filed 23:14
fill 38:5 43:16
filled 38:7 94:24 105:8 106:4,12
filling 105:6
finally 40:19
find 107:12 125:11
finish 7:1
firm 116:9
first 6:2 14:12,15 33:18 43:19 49:5 50:24 67:1,5,10 68:10,17,18,20,23 69:4 70:17 73:21 76:5 80:13 93:23 95:7 96:23 98:18 100:5,11 115:19 119:14,21 120:23 123:10
fit 107:5
five 20:23 42:20 42:22 43:2 48:9 56:18,19 62:12 66:6,14
fixed 111:13 115:17
flaxman 2:2,3 3:5 10:14,16,21 20:20 21:1 26:14 29:6 29:21 42:4 46:5,8 46:13 48:16 85:18 85:20 89:15,19,23 90:4,12,20 91:4,12 92:1,15 93:21 94:4 112:24 113:4 119:5 120:20 121:19 122:6 125:5
folded 75:5
follow 15:22 52:5 57:5 62:20 73:8 73:18,21 81:19 113:10,12 114:16
following 51:7 71:24 75:20 101:4
follows 6:4
food 21:20
foregoing 123:13 126:13 127:18
forever 75:15,16
forgot 9:4
forklift 20:14,22 21:10
form 38:5,7 43:16
forth 15:5
forty 7:24
forward 125:15
forwarded 113:17 113:23
foundation 29:6 48:16 85:18 93:21
four 9:18 36:2 72:22 73:2,10 87:2 95:22 102:8 110:18 115:17,18
frame 37:11 50:6 83:17
free 27:14,16 57:24 126:14 127:20
friend 101:24 110:8
friend's 104:20
friends 109:6,7
front 16:20 107:23
full 7:18 74:15
fully 117:3
future 98:22

g

game 104:18,19
gap 78:8,10,13
garden 115:23 116:1 117:13,14
ged 17:20,21
general 60:8 106:6
getting 36:7 41:7 48:21,21 49:9 58:4 67:9 80:8 85:16 94:14 96:3 98:18 108:19 112:14
give 5:7,9 22:5,7 24:20,24 41:21 47:20 53:1,5,18 54:20 55:2,3,16,17 56:9 58:7 59:15 61:10 73:13,16 76:19 83:19 84:4 85:23 86:14 88:2 88:6,9,13 90:4 92:4,15 116:21 119:14
given 4:24 21:22 22:8 67:11,18 75:19 123:18
giving 96:4 97:4 115:3 119:24
go 5:4 11:23,24 14:16,21,23 16:14 23:23 24:1 33:21 37:19,22 38:2 41:14,16 44:18,21 44:24 45:13,15 47:9,10,13,18,18 60:8 63:3,6,9 67:6 67:7 69:18 72:6 79:7 85:23 86:8 88:1 90:14 96:19 98:6 102:13,15,20 102:22 104:8,9,13 104:17,18,19,23 104:24 105:1 119:17 120:10 121:3

god 25:11
going 5:6,7,22 6:14,18,21,22,24 7:2,4 10:12 11:1 11:12 19:6 20:10 20:12 22:11 28:22 40:9 41:9 46:10 46:11 48:24 49:11 49:12 50:2 52:14 57:4 69:19 75:22 96:23 97:6,17 108:11 109:1 116:21 117:11
good 4:2 46:16 81:3
gotten 30:16 84:21
grievance 3:8 16:1 16:11 105:9,17,22 106:5,12,14 107:3 107:9,10,18,19,20 107:21,23 108:3 108:10 111:8,24 112:4,7,10,13 113:9 114:18
grievances 105:7 115:4,10
ground 7:15 31:13
group 44:24 45:2 45:2,3,13,14,19 46:24 47:9,10
guard 31:12,12 55:5,5,18
guards 55:22,24 56:7 57:20
guess 5:3 46:10,11 72:15 99:18 114:8
guessing 46:8
guestimate 46:16
gunshot 24:10,11 24:14,17 25:7,12 27:1,2
gym 45:1,4,15 47:18

h

h 94:4 109:9
half 13:12 48:9 74:12
hallucinate 61:18
hand 105:21 124:5
handbook 15:8,10 15:13,15 16:1
handle 61:22
handwriting 106:2
happen 48:24
happened 17:7 24:13 31:2,23 32:15 38:9,17 70:6 121:2
happening 86:3
hardware 75:8
hcu 113:17,24
head 5:10,11 27:22 46:7 110:23 111:4
health 1:6 4:10,15 27:5,7 30:10,14 31:14,16 33:19,21 36:7,17,18 37:2,14 37:17,20,22 38:2,4 38:10,11,14,16,18 38:21 39:5,7,11 55:21 57:22 125:6 126:3 127:3
healthcare 31:18 34:4 35:7
hear 55:12 56:2
heard 31:5
held 47:6
help 52:23 54:15 56:13 72:4,7,9 118:7
helped 31:13 72:10
helping 57:6
henry 109:8,22,24
hereto 124:2
hereunto 124:4
high 17:19
hinge 59:2,5 75:8
hinged 59:6 74:10 75:3
hold 47:5
holes 69:20
home 65:1,4 71:18 76:20 82:10 102:9 104:17,23 108:22
hoped 69:22
hospital 24:1 25:4 25:17 28:14 114:24 115:2
hospitalizations 26:9
hospitalized 24:5 24:9,19 25:16
hour 21:4 32:21 51:20 60:11 73:3
hours 21:23
house 101:11,14 103:1 104:20
housed 45:21 51:7 51:11,16
huh 5:11 108:13

i

ibuprofen 33:5
identification 28:21 116:20
idoc 11:12
illinois 1:1,16 2:4 2:10 4:18 8:4,17 12:1,2 41:18 123:1,7 124:6
imaging 27:19 41:10
immediately 76:11
important 5:14
improperly 86:20 86:23
improve 50:16
inability 17:15
incarcerated 92:5 105:5
incarceration 19:17 20:6 23:17 23:21,24 24:3 26:19 27:18
incisions 69:20
included 125:13
incorporated 127:12
indicated 66:5
indicating 125:13
indirectly 124:2
infirmary 51:8,19 52:1 53:22 60:10 115:3
information 117:5
informed 87:1
initial 7:21
injured 26:21,23 34:2 35:23,24 42:9 44:14 49:19
injuries 27:22 86:15 117:20 118:11,14
injury 30:19 31:2 44:9 47:17,18,22 48:3 52:18 87:1 87:22 100:16 105:9 115:13,18 117:19
inmate 15:8

inmates 108:9
inside 25:22 45:21
instructing 90:3
instruction 54:20
instructions 54:10 54:13,15,17 71:21 71:23 73:8,24 77:9
insurance 18:14 27:5,7 78:7 79:22 80:1 118:21
interested 124:2
interrogatories 3:9 6:3 116:12,24 117:2
interrupt 7:4,5
introduced 4:7
involved 41:6
issue 91:19,21

j

jail 13:10 14:19
james 1:7 4:11,16 30:10,11 31:19 32:4,6,22 33:1,15 33:16 34:9,12 36:6,20 37:5,12 39:1,16 40:1,24 48:14 49:10,10,20 51:1,5 52:14 83:23 84:2,13,21 85:14,22 86:6,13 86:20,23 87:4,7,12 87:24 88:2,6,9,13 88:21 89:6,9,18 90:15 91:1,6 94:8 99:15 121:17
january 113:16,23
jap 2:5
job 20:9,19 21:24 108:23
jobs 21:15
joel 2:3 125:5
jog 45:5
jogging 45:9
john 4:20 7:20 28:14
johnny 1:3,10 3:3 4:14 6:1 7:22 123:10 125:6,8 126:3,4,9 127:3,4 127:13 128:20
jones 1:3,10 3:3 4:2,14,20,24 6:1 7:20,22,23 28:3 60:24 66:4 119:6 123:10 125:6,8 126:3,4,9 127:3,4 127:13 128:20
july 63:15,20,23 65:20,23 66:20
june 11:3 63:12,19 65:23 98:13,15,15

k

k 123:3
kedzie 105:2
keep 15:17 59:17 59:18,19,20 74:2 81:5
kenlaw.com 2:5
kenneth 2:2
kept 97:4
kids 9:12,14 23:12 65:16 101:16,22 102:3
kind 19:19 24:19 26:5,13 33:4 63:24 72:3 96:11 109:3 111:5
kitchen 20:11,20 21:16,18
knee 33:12 36:11 42:10,12 47:22 49:9,19 50:8 58:8 67:20 68:1,6,14,21 70:4,19,22 72:7,7 72:9,10 73:13,16 73:22 74:1,9,16,19 74:24 75:1,2 81:7 81:11,17 96:3 115:13 120:6,7 122:2
kneel 50:11
knew 15:22 16:10 16:13 37:16 105:6
know 4:7 7:2,9 10:10 12:23 14:1 19:16 21:4 23:12 29:15 33:16 41:6 41:9 46:5 48:17 48:18,22 58:10 68:13 71:7 72:15 85:20 87:10 88:4 89:1,3,7,8,13 91:13 93:15 96:6 99:22 103:18 105:22 108:3 109:23 116:2 117:16,17 119:19 121:24
knowledge 43:24 48:20 87:21

l

l 2:8 94:4 109:9,14
labor 19:18,19 109:2,3,4
landed 31:9,10
landscaping 109:18
laundry 104:22,24 105:1
law 8:10 116:9
lawndale 98:1
lawsuit 23:10,14 29:19,20 30:3 116:8 121:20
lawsuits 23:15
lawyer 10:11 22:14 23:1 29:15
lay 72:1
learn 18:11
leave 11:24 47:7,9 79:20 102:5,9
led 83:23
left 24:12 25:15 28:16 44:16,17 47:11 79:24 80:5 93:2 105:21 122:2
leg 24:12,18,24 28:15,16 34:14 49:4 52:24 54:16 56:10,14,17 58:12 59:3,4 60:20 67:9 69:20,20,24 72:4 74:3,18 84:21 99:4,13 110:16 111:12 115:17
legal 89:19,23 90:22 125:1 128:1
length 74:16
letter 125:19
level 47:21 48:4,8
license 10:1,6 13:18 124:9
licensed 19:7
life 75:23
lift 45:5
lifting 45:9
limitations 44:10 49:24
limp 30:5,7,17,18

line 21:20 125:13 127:7 128:3
lined 108:23 109:23 110:3,9
listed 127:7,17
listing 127:7
little 14:1 17:24 106:19 117:24 118:2,3,3
live 8:1,7,13,18 9:21,23
lived 8:11 9:1,4
llp 2:8
loaded 31:13
local 4:23
located 16:19 45:19 46:22,24 47:4 95:4 102:19
locked 26:14
lodged 26:2
long 8:11 21:24 32:19 39:24 40:13 58:13 67:14 72:23 73:1,19 74:6,14 75:13 76:21 78:11 79:7 82:24 83:1 92:11 95:15 98:11 103:13 104:15 121:13,18
look 18:14 55:17 105:16,21
looked 107:11
looking 29:21
losses 115:21
lot 35:7 94:21
lucky 25:10
lunch 44:24
lungs 25:19

m

m 109:14
m.d. 1:7
ma'am 77:20 108:15
machine 72:1,3,5 72:11,14,16
madam 125:10
madison 103:1
making 20:5 29:12
male 67:3,4
management 96:20,22 98:17,19
manager 96:5 97:4 98:6
manner 86:15
manufacture 12:24
march 96:16 97:1 97:9,15 98:9 116:6
marked 28:21,22 105:13 116:20
marking 116:22
married 9:10
marshall 1:7 4:15
mart 95:1,2,4
matter 4:20
matters 123:12
mccule 109:12
mean 10:3 20:20 35:4 66:11 70:7 70:10 74:13 108:6 115:15
means 18:13 32:9 44:22
meant 44:3 49:14 108:7
medicaid 27:12
medical 18:7,12 18:15,19,21,24 19:3,8,24,24 20:3 23:6 24:2 33:11 42:11,13 43:2,4 49:8 51:20,22 52:2,3 57:16 70:11 71:8,12 83:23 84:5 88:23 96:13 108:8 112:14 118:17 121:13
medication 6:17 14:1 33:3,4 38:20 39:13 61:14,15 94:1,7 95:8 97:13 98:2 118:7
medications 6:13 14:4
medicine 26:13
meet 49:5
meeting 23:1 47:6 47:9 55:20 68:10 102:12
meetings 45:3,19 47:5 102:13,15,21 102:22 103:8,8
memory 37:1 115:9
mentioned 119:6
message 110:2
messed 60:20
michigan 1:16 2:3
middle 7:21
midwest 41:17 43:19 52:6,12,17 53:9 54:18,19 55:2,14,15,21 56:6 57:5,11,17 58:3 59:8 60:18 61:6 62:21 63:16,20 64:6 65:19,23 66:20 70:5,15 71:8 85:3 86:17 86:19,24 93:24 125:17 128:1
mine 86:15 87:1 110:8
minute 73:2
minutes 34:19 35:9,17 73:4,6 77:17,19
mobile 108:21
mobility 59:6 67:9 69:24 72:4
mom 65:16
monday 33:23 34:5,6,8
money 22:5,7
month 12:6 39:22 44:2,7 58:18 67:15 74:6,8 79:4 79:11 80:12 99:22
monthly 12:10
months 8:12 12:15 12:17 22:1 26:2,4 40:15,16,18,20,23 78:12,13 80:7,8 95:22 98:12 110:18 115:17,18 119:23 120:24 121:10
morning 4:2 101:12
motion 52:24
motivated 82:10 82:11,12,17
move 84:4
moved 87:15
moving 59:18 68:6 74:2 94:21
mri 39:14,14,15 39:17 40:3,6,8,9 40:13,14,19,22

41:4,7,9,16 42:10 43:10,13,17,23 44:1,6 48:12,21 49:6,16 68:14 69:12 84:8,12,21 85:23 88:1 99:15 99:20,24 100:7,13 100:17,19 101:4
mris 18:18 27:19
multiple 121:6

n

n 2:2 3:1 109:9
name 7:18,21 8:9 8:20 12:14,20 32:1 66:24 94:3 96:6 109:13 125:6 126:3,4,15 127:3,4 127:21
names 57:1 109:7
narcotic 95:15
nauseous 66:12
need 5:10 7:9,10 10:12 21:1 42:4,7 52:19 81:3 84:19 111:12,21 120:2
needed 16:10,13 17:17 57:18 58:1 84:5,10 110:17,24 111:19
neglected 70:4,19 70:23
never 20:3 29:11 44:16,17,23 47:11 52:11 56:15 70:18 75:7 85:15 100:6 100:12,19,22,24 101:1,2,3
new 12:19
nod 5:10
norco 62:6,11 66:6 95:12,24 103:17 103:21
norcos 94:12
normal 19:3 81:8 101:7
northern 1:1 4:17
notarized 125:14
notary 1:14 123:5 125:24 126:10,18 127:15,23 128:23
note 125:12
notes 82:17
notice 1:12 4:21
november 31:24 32:5 33:19,22 37:6,13 38:8,14 44:14,19 47:12,17 47:21 96:19 97:10 98:19 125:4
nrc 14:21,22,23
number 4:16 8:5 11:13 49:22 79:12 80:24 110:22 111:3 116:22 117:12 125:7,13
numbers 127:7
nurse 31:22 32:1,3 32:19,20 33:8 52:23 53:4 55:5 56:13 112:9
nurses 54:15,17,20 55:1,3 56:7,16 57:2 92:3,7,9,12 92:14 93:16

o

o 109:9 123:3,3
o'clock 1:17
oath 6:7 116:17
obamacare 27:12
object 10:19 29:6 48:16 92:1
objection 85:18 89:15,19 90:20 93:21 112:24
objections 90:5,12 91:4
obtain 71:12
obtained 71:7
obviously 67:11
occur 41:19
occurred 31:3 121:23
october 1:18 70:2 75:19 83:16,17 124:6
offered 43:7 61:5
office 18:2,5,7,12 19:24,24 20:3 124:5
officer 12:5,14,21
officers 12:18
official 17:15 126:15 127:21
offsite 41:14,15
ohio 125:2
okay 4:5 5:12,23 22:14 90:7 111:10 117:10
old 7:23 9:16
once 12:6 54:3 61:11 77:6,12,14 83:10 92:20 93:11 93:13 102:23 110:12
one's 60:14
ones 115:10
opinion 87:11,20 87:21 88:15,17 90:10
options 114:8
oral 6:3
order 40:3,8,9 84:8,12
ordered 33:14,16 33:17 34:20 35:11 35:18 40:22,23 41:4,7 48:14,18 75:24 76:11
ordering 88:1
orientation 15:12
orthopedics 41:17 43:20 52:6,18 53:9 55:14,16 62:21 63:16,20 66:20 70:15 71:8 85:4 86:18,19,24 93:24
orzinga 97:19,23 97:23 98:16
outcome 124:3
ozinga 119:7,9,11 119:21 120:23 121:12,20

p

p.m. 101:20 104:16
page 3:7 5:5 105:14,16 125:13 125:15 127:7 128:3
paid 118:20
pain 30:5,8,17,18 33:3,4 38:3,19,20 39:13 47:22 48:4 48:8 61:17 81:22 81:22 94:22 96:2 96:5,17,19,21 97:4 97:8,12,16 98:2,4 98:6,16,17,19 112:1,8 115:14,16 119:12,24 120:3,4 120:24

pair 32:13
paper 17:8 105:23
paperwork 55:1,2 55:4,6,16 56:6
parole 11:15,18 12:5,14,18,20 14:12
part 22:14 51:14 127:9
parties 124:1
passed 37:8 99:19
patellar 30:20,21 70:9
patient 56:8
patients 95:15
pay 20:19 21:4 22:5,7
pc 2:2
pending 4:16 7:12 10:18 23:12
people 35:7 56:6
percent 111:1
perfect 46:13
performed 49:3
period 9:5 39:8 64:4 65:8,11 67:17 79:4,10 80:12 97:13 100:6 100:8,12,14,20,23
permanently 82:20 84:14
permit 10:2,4
permitted 10:5
person 108:7
personal 123:16
personally 126:11 127:15
phone 11:19 44:18 65:20,23 125:3
physical 49:24 52:19,21 53:8,11 53:14,15,17 54:19 56:8 57:6,10,16 58:4 63:24 64:13 65:18,24 66:1 67:20 70:21 71:2 71:4 75:24 76:3 77:22,22 78:1,2,14 78:15,22 79:5,7,20 80:5,9,11,13,21 81:6,10 82:16 92:4,9,12 109:4 110:16 115:4
physically 24:16
physician 23:18 23:20 30:12
pick 101:17
picks 103:3 104:4
pierced 26:3
place 60:18 111:8 123:20
placed 10:7,9
places 10:5 103:5
plaintiff 1:4 2:6 4:19
plaintiff's 3:8,9
plans 98:21
play 45:5 60:23 61:1
playing 28:12 30:22 31:4 45:9
please 125:11,11
point 58:4,7 69:6
pointing 109:18
policies 89:2,4,11
policy 95:14
popped 26:3
population 60:8 106:6
porsche 8:21,22
possession 13:15 13:16 55:7
post 96:11
potentially 21:10
preparation 22:12 22:17 23:2
prepare 22:19
prescribe 94:10 95:8,11,13,15,16 95:20
prescribed 14:9 94:1,6
prescribing 98:2
prescription 94:23
present 41:4 43:10 43:13
pressure 53:24
pretty 12:12
previous 123:9
previously 51:11
primary 23:18,20 26:12 97:17,18 119:6
printed 105:22
prior 8:13 19:17 20:5 23:17,21,23 24:3 27:18 44:19 47:17,24 62:19
prison 19:10 30:23 31:12,12 44:20 51:14 103:16,22
privileged 10:17 10:20
probably 10:19,21 36:4,15 54:3 96:16 102:8,11,14 102:23
problem 119:19
problems 77:8
procedure 1:13 4:22 16:2,5,16 107:9 126:5 127:5
procedures 16:8 85:23 86:9 89:2,4
proceed 4:5
proceedings 123:18
process 41:6 83:6 89:7,9 105:6 107:21 111:12,22 121:9
product 90:1,14 90:21
production 125:15 125:17,22
professional 18:21
professionals 55:21
program 20:15
prohibit 17:16 59:23 60:1 86:3
prohibited 86:6
proper 30:4,6,17 70:8,10 85:23 86:9 92:4
properly 86:10,12 87:4,7,11 93:19
properties 109:6
provide 88:22
provider 24:2
providers 51:22 57:17,22
psychiatrist 118:5
psychologist 118:4
public 1:15 123:6 126:10,18 127:15 127:23 128:23
pulaski 102:20
purpose 59:11,13
pursuant 1:11,12 4:21,21
push 53:24

pushed 76:23
put 16:17 34:14 39:15,16,19,24 40:18 42:13 50:3 53:23,24 69:20 76:22 93:18 112:2 112:6 119:15,17
putting 39:13 90:5

q

question 5:17,21 5:22 6:22 7:1,12 7:12 10:13,18 19:7 29:23 38:17 57:14 61:23 87:5 90:24 91:2,5,8,24 92:2 100:18 113:4 117:11
questions 5:7,20 7:15 22:11 116:3 116:9,15 120:20 121:24 122:5
quick 84:12
quickly 87:23
quite 49:21 69:11

r

r 102:17
raises 72:7
ray 33:13,14,17 34:20 35:11,18 36:3,5,7,10,11,13 36:14,16,19 37:2,7 37:14 38:9 39:2,5 39:12,18 68:14,15 69:10,12
rays 18:18 27:19 38:15
read 15:10 126:5,6 126:12 127:5,6,17
reading 123:21 125:19
ready 16:21
real 66:12
really 21:4 84:10 87:5
reason 11:5 29:18 29:19 30:2 67:6 79:24 83:19 90:18 91:3,8,16 125:14 127:8 128:3
reasonable 46:12 100:16
reasoning 89:22
reasons 91:12,14
rebound 31:5
recall 17:5 54:12 56:24 57:1 59:13 68:4 70:24 81:12 81:18,21 82:5 83:13 92:8,11,19 92:23 93:4,6,12,14 94:3 95:18 96:13 96:14 98:8 99:23 105:11 107:20 115:8 119:15,21
receipt 125:18
receive 15:7 19:11 32:11 38:13 52:20 62:17 72:16
received 32:13 33:12 38:22 97:8 113:19 114:22 118:17,18
recess 27:24 66:3
recommend 68:8 69:7
recommendations 77:21 99:12
recommended 68:22 79:13 80:24 101:3
reconstructed 84:23
reconstructing 70:9
record 4:8 7:19 10:16 28:1 90:6 94:4 123:17 127:9
records 23:7 71:8 71:12 96:14
recover 110:18
rectangle 46:14
redirect 3:5 120:21
reduce 47:24
reduced 123:15
reference 125:7 126:2 127:2
referenced 126:11 127:15
referral 63:16 65:19 66:21 67:11 67:15,18 81:22 98:5 119:12,14,15 119:16,22 120:1 121:2
referred 64:6 120:23
refuse 43:4 61:4,9 61:19 62:11 66:9 94:17,20 95:11,13 95:16,20
refused 39:7 61:23 62:2,6 66:6,13 95:8
regain 72:4
regarding 19:3 43:16 74:1 76:20 99:13
rehabilitation 76:4 102:16,24
related 33:12 59:15
relation 39:18 45:20 47:3 87:22 95:19 105:9 116:8
relative 123:23,24
relaying 110:2
release 11:7,10 50:18 51:4 62:19 63:19,23 65:18 66:19 103:15,22
released 9:1 11:2 50:4,21 51:17 56:20 62:4,16,24 64:9,15,16,18,20 64:23 65:22 71:18 108:11,17,20 110:12 111:1
relevant 118:24
relief 111:9
remember 8:15 12:22 19:13,22 20:23 21:7,12,14 21:17 26:16,18 28:17 31:23 32:1 34:13,13,14,23 35:1,3,14 36:22 37:10,12,21,24 38:24 39:3,6,10,20 39:23 41:3,23,24 42:3,15 43:3,18,21 49:15,21 53:7,20 55:24 56:5 66:23 66:24 67:2,14,16 68:18,23 69:5,14 69:15 70:3 72:13 76:10,13,14 77:24 78:5 82:3 99:14 114:6,7,7,11,12 115:1 116:3,11

remembered 28:4
remove 24:23 25:24 26:6
removed 25:23
rent 22:6,7
repaired 70:8 84:22
repeat 29:23 38:12 86:4 100:10
rephrase 5:19 50:2
replicate 79:3
reported 123:14
reporter 5:11 21:2 123:7 126:7
represent 4:10,11
request 7:11 16:17 16:19 17:1,2,12 37:14,19 39:13,14 39:15,16,19,24 40:19 42:13 111:9 112:2 127:9,11
requested 38:16 38:18,21 40:13 52:2
requesting 88:22
requests 42:23 43:2
require 21:21
required 125:24
reserve 122:6
response 31:11 113:14,15,15,16 113:18,24 122:1
rest 75:23
restate 90:12
restricted 10:2,4 13:19 57:9
restrictions 10:7,9 11:22 12:3 60:17
result 24:13 115:12
resulted 84:3,14 85:12
results 36:14,16 37:7,14 38:1,9,15 39:1,4,12,19 41:21 42:1,2 99:15,20
return 114:4,5
returned 114:2 125:18
review 22:16 23:6 125:12 126:1 127:1
rewriting 107:20
rhonda 8:10
rid 69:18
right 6:8 43:22 53:9 80:10 86:14 93:7,10 97:6 99:17 101:7 103:1 108:12 111:9,14 113:17,20,21,22 114:1,6,9 116:13 118:13 119:2 120:9 121:4
road 8:16
robbery 13:15
rocks 1:14 123:5 124:9
rockwell 95:5
rod 24:24 25:1
room 45:24 46:3,6 55:22 57:15,20 104:10
rooms 45:23
roosevelt 102:20 104:12 105:2
roughly 46:19 58:16,17 102:5
rubberband 76:21 76:22
rubberbands 78:17,23 80:15
rule 4:22
rules 1:12 4:22,23 5:4 7:16 11:17 15:22 126:5 127:5
run 50:13 117:23
runaround 97:5
rupture 28:11
ruptured 28:10
rush 64:6,10 66:21 70:18 71:7 74:23 75:24 76:4,5,7,8 76:11 77:23 78:1 78:15,23 79:23 80:2,6,14,20 81:7 81:13,17,23 94:2,9 94:10,18 95:10 96:5 97:1,4 99:11

s

s 1:16 2:3 109:9 125:15 127:8,8 128:3
sandra 2:8
sandwich 41:17
sandy 4:10
saturday 34:2,3
saturdays 104:21
saw 29:7 31:22 32:5,19 37:5,12 40:1 51:1 53:14 54:8,8 64:10 65:10,13 67:5,10 81:16,21 99:11,20 119:9
saying 5:13 7:6 34:1 70:3
says 105:24 113:17
sbyrd 2:11
scale 47:20,23 48:7
scans 27:19
scar 67:24 68:2,13 68:21 69:18,21 70:20 71:5
schade 2:8
schedule 96:24
scheduled 12:7,9 43:11,14 62:21 63:12 96:18 99:2 99:6
scheduling 43:17
school 17:19 20:10 20:12
schwab 76:4,6,8 78:2 79:8,21,24 80:5
seal 124:5 126:15 127:21
second 68:24 71:15,24 80:20 83:14 95:19
security 83:3,7
see 22:21 26:11 31:19,21 34:7 39:16 49:20 51:4 52:12 53:11 54:22 54:24 59:7 64:3 64:10 67:1,7,8,19 67:22 81:13 82:1 96:10 98:21 99:16 114:3 118:4
seeing 26:18 36:6 56:5 96:8
seen 29:9,11 35:8 43:1 88:5 89:11 108:8
segregation 19:14

self 82:10,17
send 52:14 107:12
sent 32:14,16 33:8 72:2 107:15 116:9
sentence 13:5 15:2
separate 51:10,13
separated 9:11
serve 13:9
served 15:2
service 120:13,17
serving 21:20
sessions 79:9,12 79:15
set 124:4
seven 7:24 13:5 79:9 82:2,6 104:4
shake 5:10
sheet 17:8 125:13 127:7,10,18 128:1
shelton 109:8
sheridan 14:17,24 15:2,7 19:10 20:8 20:13 21:16 30:12 41:13 42:1 49:8 53:22 58:5 59:24 105:5 107:9
shift 107:11
short 9:4
shorthand 123:7
shot 24:15 25:8
shots 96:3,4
show 12:8,12 28:22
showed 36:19 37:3 115:10
shower 44:17 47:13
showing 105:13
shown 125:16
sick 16:4,14,16 17:1,1,12,15 43:7 44:18 47:14 112:3
side 25:15 59:6
signature 122:6 124:8 125:14
signed 126:13 127:18
significant 67:24
signing 123:21 125:19
simply 89:17
sincerely 125:21
single 77:18
sir 125:10
sister 8:8,10
sister's 8:9 103:6
sit 82:24 101:11 106:13 117:23 118:2,3 120:12,18 120:19
situations 86:11
six 8:12 9:15 110:18 119:23 120:24 121:9
size 46:3,19
skin 26:6
slip 17:1,2,16
slips 16:19
snap 31:5,6
social 83:2,7
solution 17:10
solutions 125:1 128:1
soon 85:24
sooner 101:4
sorry 47:15 73:5 98:24 118:1
sort 15:12 59:5 75:7,8
sound 19:6 46:12 116:13
sources 1:6 4:11 4:15 125:6 126:3 127:3
space 111:16,19
speak 21:1
specialist 26:19 81:23
specialists 26:11
specializes 26:13
specific 56:9 85:7 96:11
specifically 60:24 88:12 92:14
specified 123:20
speed 111:12,22
spell 97:20 109:13
spent 34:17 35:9
spoken 23:9
ss 123:2
st 8:16
staff 49:8 108:8
staffed 51:22
stage 83:9
stand 21:21 42:4,8 77:1 83:1 117:24 118:2 120:18,18
standing 78:17,24 80:15
standpoint 39:11
started 121:9
state 1:15 7:18 12:1 123:1,6,8 126:10 127:15
statement 82:14 82:14,18,19 86:16 86:22 87:3,19 126:13,14 127:19 127:19
states 1:1,13
stateville 14:20,21 14:23
stay 44:12 60:9 101:14
stenographically 123:14
steps 23:4 42:9,11 65:17,23 66:1 67:19 86:7 97:12 113:10,12 114:14 114:15,19,22
stopped 94:22 103:20 112:19
straight 14:18 31:15
straps 59:4
stream 8:14,16
street 2:9
stretch 59:7
stroger 28:14 96:20,22 97:1,7,10 119:12,22,24
strong 66:10
studies 27:19
stuff 115:1
stupid 19:7
subcontract 109:16,17
subscribed 126:10 127:14 128:21
substance 13:1,16
substances 103:16
suffer 25:12 118:12
suffered 105:10 115:16 117:21 118:11
suffering 112:1 115:14
suing 30:9 89:14 89:17,21 90:2,10 90:18 91:3,9 121:12,17

suite 1:16 2:4,9 125:2
sunday 104:8
sundays 120:10
superior 125:1
supporting 22:2
supposed 52:23 70:20 72:18 75:13 76:15 77:4,7 79:16
sure 5:5 26:15 46:13,18 69:11 91:23 105:12 108:16
surgeon 49:3 52:11 55:20 86:17 86:19 99:11,12,16 99:21 100:5,11
surgeons 52:6,17
surgery 24:21,22 25:20 26:1 28:4,7 28:13 43:24 44:6 44:10,15 48:1,4,11 48:15,21 49:4,9,11 49:13,13,19,23 50:3,18,21,24 51:3 51:7,17 56:19 58:13,19,22,23 61:20 62:3,15 68:5,9,22 69:1,4,7 69:16 70:1 71:15 71:16,19,24 72:12 73:19 74:4,7,8 75:18,20 76:12 81:24 82:7 83:14 85:5,5,6 93:1,23 95:7,19 96:11 100:1,6,8,12,14,19 101:4 108:17,20 110:19 115:19
swift 84:4,6
swifter 87:16
switch 12:16,17,18
switched 97:7
sworn 4:1 6:3 123:11 126:10,13 127:14,18 128:21

t

t 109:9
take 5:12 6:17 7:10,13 18:18 23:4 44:17 47:13 58:13 60:4 65:1 65:17,24 66:1,13 66:14,17 67:19 113:10 114:14,15 114:19,23 118:7
taken 1:14 4:21 6:7 36:13 38:10 38:11 87:2 95:24 97:12 123:19
takes 103:4 108:3 108:7 110:18
talk 49:13 57:21 109:19,21,21
talked 14:1 33:1
talking 120:4,7 122:2,3
tear 30:21
tech 21:7,13
technically 121:24
technician 36:5
technology 18:3,5
telephone 32:10 32:23 33:2 47:4,8 47:13
tell 5:18 6:8,11 18:1,13 22:6,13 29:19,21 31:2 32:8,15 35:22,23 35:24 36:21 40:9 42:10 44:22 52:18 52:21 57:5,17,18 57:24 58:1,3 59:11 60:3,21 61:1,3 65:15 67:23 68:2,5 69:16 70:14,22 73:7 81:10 84:18 84:20 85:2,20 89:1,5 93:24 98:7 115:15
telling 104:2
ten 42:18,22 43:2 47:21,23,24 48:5 112:8,8
tendon 30:20,21 70:9
terminology 18:19
terms 18:15
test 69:9,13
testified 6:4 47:11
testify 123:11
testimony 43:22 48:11 49:7 53:17 123:18 126:6,7 127:6,9,12
testing 32:17
thank 25:11
therapies 79:5
therapist 53:12,14 53:15,18 77:22,23 78:15,22 81:7,10 82:16
therapists 54:20 57:11
therapy 52:19,22 53:8 56:8 57:7,16 58:5 63:24 64:13 65:18,24 66:2 67:20 68:7 70:21 71:2,5 76:1,3 78:1 78:2,14,24 79:7,20 80:5,9,11,13,21 92:4,10,12 115:4
thigh 74:19
thing 45:7,8 103:3
things 45:10 47:16 77:13 97:6 108:2 108:4 110:17 111:5 112:17,20 112:23 113:6
think 7:2 16:17 21:6 33:23 34:3 34:17 37:8 38:19 41:3,20 42:21 43:15 44:1,8 49:1 61:20 72:24 79:9 80:23 86:8 87:13 95:14 105:11 107:17 118:23 119:2
third 105:16
thirty 73:4,6 125:18
threatened 57:21
three 12:15,17 13:12 22:1 36:2 40:15,16,18,20,23 45:16,18 51:6 54:3 64:22 66:18 72:22 73:2,7,10 77:12,14,16,19 80:7,8,12 98:12 105:14
tickets 19:11
time 7:7,10 9:5 13:8 16:24 21:22 32:22 33:18 34:17 37:7,11,15,20,23 38:16 39:5,8 40:18 43:5,7,19 50:3,4,6,17,24

51:16 52:1,2,11 55:9,13 61:21,22 61:24 62:3,3,15,15 62:23 63:11 64:4 64:9,10 65:8,11 67:10,17 69:6 70:16,17 73:1 78:8 79:10 80:4 80:21 81:14,16,21 82:3 83:17 85:15 92:5 93:1,2 96:15 96:23 97:13 98:18 99:11,19 100:6,9 100:12,14,16,18 100:20,23 101:12 101:18 104:13 108:3,7 114:13,14 114:24 119:9 123:20
timely 86:15
times 6:21 10:5 17:6 37:19,24 43:1 45:16,18 49:18 51:4,6,23 53:11 56:18,19 59:18,19,20 62:6 62:11 66:7,14,14 66:18 72:22 73:2 73:10 77:12,14,16 77:19 81:24 82:2 82:6 92:18,22,24 96:21 121:6
tip 53:23
tippy 77:1 80:15
tissue 68:1,2,13,21 69:18,21 70:20 71:5
today 4:3 6:15,19 22:17,22 48:8,8 93:24 95:7 96:11 101:8,9 118:15 119:1 120:8
toes 76:22 77:1 78:18,24 80:16
told 36:18 37:2 39:1 48:23 49:1 49:10,12 52:21 54:7 68:21 70:12 70:18 86:20 88:9 88:12 98:5,8,16 100:6,19,22 106:14,22 111:15 112:9 117:15 120:2,10
top 46:6 110:23 111:4
torn 30:20
towel 53:23
town 11:24
train 86:13 87:4,7 87:12
trained 86:10,20 86:23
training 18:15 86:14 89:5,7,8
tramadol 61:13
transcribed 126:7
transcript 123:14 123:22 125:11,12 126:5,12 127:5,11 127:17
transcription 123:16
transferred 15:4 78:1 79:22 80:1
transition 78:9
transportation 63:11
transported 55:9 55:11,13
treatment 24:20 32:11 33:11 42:11 43:4 57:16 61:4,9 62:2,14,17 85:16 88:23 97:8,16 118:18
tried 61:10 119:21
true 123:17
truth 6:8,11 123:11
try 72:10 79:3
trying 67:8 97:3 97:14
tube 25:18
tuck 109:18
tv 54:8,9 101:11
twenty 20:23
twice 25:8 46:3 53:13 102:2,14 108:10 119:17,18
twins 9:18
two 8:24 21:23 27:1,2 33:24 45:23 58:11,15,16 58:17,19,21,23 61:20 72:24 73:11 73:20 77:5,13 78:12,13 79:4,5 87:2 103:4 111:5 114:8 119:10
typewriting 123:15
typical 44:20

u

u 109:14
u.s. 4:16
uh 5:11,11,11 108:13
ultimately 69:1
undergo 27:19
understand 5:6,18 6:7,14,18 30:9 87:5
understanding 28:3 75:22 77:8 107:8
understood 5:22 77:7 91:24
unit 31:14,16,18 33:19,22 34:4 35:7 37:2,17,20,23 38:2,4,10,11 41:10 43:2 45:21,22 46:19
united 1:1,13
unreasonable 100:8,14,20,23
untrue 82:18,19
upcoming 97:9
upper 104:10 105:21
use 44:18 47:13 48:7 65:4 72:1,18 103:6 106:17
usually 12:10 104:19

v

v 125:6 126:3 127:3
vague 92:1
variety 115:23 116:1 117:13,15
vasectomy 99:8
veritext 125:1,7 128:1
veritext.com. 125:17
versus 4:15
victoria 1:14 123:5 124:9
visit 12:5,7 81:19 97:1
visiting 57:13

visits 12:9 37:15 57:5 69:8 76:10
vs 1:5

w

w 2:9
wait 114:17
waiting 35:7
waived 123:22 125:19
wal 95:1,2,4
walk 50:8
walking 74:2
want 15:17 22:13 52:12 90:12 91:23 117:9
wanted 16:24 67:7 69:17 106:14,20 106:23 108:16,21
washington 8:10
washtenaw 104:10 104:12
watch 101:11 104:18,19
way 26:5 105:23
we've 122:3
wear 65:10 75:13
wearing 65:7,13
week 11:19 20:7 33:13 36:4,15 37:8,9 39:21 45:16,18 48:12 51:6 66:18 77:12 77:15,16,18,19 93:11 100:1 102:2 102:8,14,23 104:4
weekend 104:6
weekends 104:5,7 105:3
weeks 58:11,15,16 58:17,20,21,23 72:24 73:11,20 87:2 119:10
weight 74:3
weights 45:5,9
went 14:18 18:2 31:4,7,15 33:18 34:4,7 38:19 43:8 43:19 45:14 48:20 57:4 67:18,22 70:15 76:8 78:9 80:5,8,20 81:2
west 8:2
wexford 1:6 4:10 4:15 30:10,14 52:13 85:10,12,14 85:16,22 86:2,5,12 86:20,23 87:4,6,11 87:13,17,22 88:6,9 88:13,16,22 89:6,9 89:11,14,17 90:3 90:11,19 91:3,9,18 91:22 92:3 125:6 126:3 127:3
wexford's 85:21 89:1,3
whereof 124:4
wide 46:11
wife's 110:1
witness 3:3 4:1,4,6 4:13 5:2,8,16,24 6:2 10:15 20:23 26:16 29:23 42:5 48:18 85:22 90:8 90:15 91:6,14 92:3,16 121:21 123:10,22 124:4 125:8,11 126:1,4 126:11 127:1,4,15
witness' 125:14
words 5:10,14 29:19 85:7 86:8 87:9 100:3 106:17
work 19:18,19,20 19:23 26:21 89:24 90:14,21 92:3 101:17,18 108:22 109:23 110:3,9,12 117:23
worked 11:7,9 20:3,10 26:5
working 10:23 19:16,17,21 22:3
works 107:9
worn 75:16,20
wound 24:10,11 24:14,17 25:7,12
wounds 27:1,2
wrapped 59:3,4
write 7:6 106:13 106:15,19,22,23 107:2,6,10 111:16 111:21,24 112:4 112:10,13,23 113:6 115:4,6
writing 5:13 29:13 54:21,22 112:19 115:9 116:4
written 40:19 111:18 112:16
wrong 105:23
wrote 82:16 107:14,22 108:2,6 108:10 110:24 111:11 113:9,20 113:23 114:13

x

x 3:1 18:18 27:19 33:13,14,17 34:20 35:11,18 36:3,5,7 36:10,11,13,14,16 36:19 37:2,7,14 38:9,15 39:2,5,12 39:18 68:14,15 69:10,12

y

yard 19:20 45:1,6 45:17 47:18
years 13:5,12
yesterday 22:24 23:1

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

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

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EXHIBIT B

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

JOHNNY JONES,)
Plaintiff,)
vs.) No. 17-CV-8218
WEXFORD HEALTH SOURCES,)
INC., a foreign corporation,)
and DR. MARSHALL JAMES,)
Defendants.)

The deposition of MARSHALL JAMES, 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 MARLENE L. KING, a notary public within and for the County of Cook and State of Illinois, at 200 South Michigan Avenue, Suite 201, Chicago, Illinois, on December 14, 2018, at the hour of 9:00 o'clock a.m.

REPORTED BY: MARLENE L. KING, C.S.R.
LICENSE NO.: 084-003326.

APPEARANCES:

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I N D E X

WITNESS EXAMINATION
MARSHALL JAMES, M.D.
By Mr. Flaxman 4, 71
By Ms. Byrd 68

E X H I B I T S

NUMBER MARKED FOR ID
(NO EXHIBITS MARKED.)

MR. FLAXMAN: Will you swear the witness, please?
(WHEREUPON, the witness was duly sworn.)
MARSHALL JAMES, M.D.,
called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. FLAXMAN:

Q. Could you please state and spell your name, please?

A. Marshall James, M-a-r-s-h-a-l-l, James, J-a-m-e-s.

Q. And how are you currently employed?

A. I am currently a clinician at Marram Health Clinic in Gary, Indiana.

Q. How do you spell Marram?

A. M-a-r-r-a-m, Health Clinic.

Q. Dr. James, my name is Joel Flaxman. I represent a man named Johnny Jones in a lawsuit captioned Jones versus Wexford, 17 CV 8218.

I'm going to be asking you some

questions about the treatment of Mr. Jones at Sheridan Correctional Center in 2015 and 2016. Do you understand that?
A. Yes.
Q. Have you ever had your deposition taken before?
A. Yes.
Q. When was the last time?
A. Don't recall. It's been a while.
Q. More than five years?
A. Probably, yes.
Q. Well, the few things I'll ask you for the deposition is to be sure to give a verbal "yes" or "no" answer to each question. Do you understand that?
A. Yes.
Q. And also I will attempt to wait for you to finish each answer before I ask another question, and I'll ask you to do the same, to wait until I finish the question before you answer. Do you understand that?
A. Yes.
Q. And if you don't understand a question, please ask me to rephrase it. Do you understand

that?
A. Yes.
Q. And because we're going to be talking about some medical terms, I may -- or I'm sure I will try to ask you to spell some of the words just to make sure the reporter gets everything accurately. Is that okay?
A. Try my best.
Q. Is there any reason you would not be able to answer my questions fully and accurately today?
A. No.
Q. Besides being a clinician at the Marram Health Clinic, do you have any other employment?
A. Not at this time, no.
Q. Okay.
A. Well, let me correct that. I'm currently still employed with Wexford, which I found out, as I told my lawyer, as PRN, but I haven't worked for them probably in a couple years now.
So they told me, "Oh, you still active with us." But no, I haven't done any work for them in a long time. I'm just primarily

employed at Marram Health Clinic at this time.
Q. And what did you say, you said you worked for --
A. I was working as traveling medical director for Wexford Health in Indiana. I was in Illinois, and I did some PRN work for them in Indiana.
Q. What's PRN?
A. As needed. Sorry.
Q. When was the last time that you did work for Wexford?
A. In Indiana? Probably a year ago, year and a half ago.
Q. And you learned today that you're still active --
A. Active.
Q. -- meaning that they might call you at any time.
A. Sure. I hope not, but yes.
Q. Do you receive any payment from Wexford --
A. Oh, yes.
Q. -- at this time?
A. No, nothing right now, because I

haven't done any work for them. When I did, of course I did, yes.
Q. And the last time you said is --
(WHEREUPON, there was a short interruption.)
(WHEREUPON, a discussion was had off the record.)
(WHEREUPON, the record was read by the reporter as requested.)
BY MR. FLAXMAN:
Q. The last time you were paid for Wexford, would that have been probably a year ago when you did some work in Indiana?
A. Yes.
Q. And your title at that time was traveling medical director?
A. Yes.
Q. What's a medical director?
A. Well, for Indiana they call me to go to the state medical correctional facility to look at patients. I think at the current time the last time I did work with them the medical director was out on vacation or leave, and they needed somebody to fill in, so I would go there

and look at patients, inmates, I guess.
Q. Okay. And at some time you were employed by Wexford in Illinois, is that right?
A. Yes.
Q. When was the last time that you worked for Wexford in Illinois?
A. Now, according to Wexford I was employed as a traveling medical director starting January I think the 4th or 24th, I don't remember, of 2017. And I was with them for approximately another maybe 12 months, and I got the job with Marram Health Clinic, and I consequently resigned. So maybe about a year. I don't know the exact time I was with them in Illinois.
Q. I'm looking at the CV that I have. Well, I expect you gave me accurate information on your CV.
A. Yes.
Q. Your CV says you were the medical director for a few different correctional centers in Illinois --
A. Yes.
Q. -- from August 2014 to May of 2017?

A. Yes. That would be correct.
Q. And the correctional centers listed on your CV are Sheridan, Stateville, Dixon, and NRC correctional center.
A. Correct.
Q. Are those the correctional centers where you were the medical director?
A. Yes.
Q. And did you have a regular schedule for when you were at each one?
A. Could you clarify the question?
Q. Sure. Between August of 2014 and May of 2017 you were the medical director at four different prisons in Illinois, correct?
A. Yes. I can break it down for you.
Q. Sure. Please.
A. I was actually medical director -- actually, I was traveling medical director at Sheridan for approximately a month, and then I was made the permanent medical director at Sheridan probably September 4th or something of '14.
And consequently from there I was medical director at Sheridan up until

approximately I would say maybe end of October of 2016, and I took a couple months off, and I was still employed with Wexford, but I was not working. I took a leave for a couple months.
And then again I started with Wexford again at NRC, Stateville, and Dixon. I was traveling between both approximately January 24th or so of 2017 up until I guess according to my CV to May of 2017. So six months additional as a traveling medical director.
Q. So between about September of 2014 and October of 2016 you were the permanent medical director at Sheridan?
A. Yes.
Q. And during that time were you at Sheridan every day?
A. Yes.
Q. Well, every workday.
A. Yes.
Q. You weren't there seven days a week.
A. No.
Q. Was your regular schedule Monday to Friday?
A. Yes.

Q. And why did you take a leave starting in about October '16?
A. Well, to be honest with you --
MS. BYRD: Object as to relevance.
Go ahead.
THE WITNESS: Well, the health care administrator and I were bumping heads, didn't agree on certain things, and consequently she had me escorted out the facility because of some disagreement over some patient care.
So Wexford didn't agree with it. That's why they didn't let me go. But if you don't get along with the health care administrator, that's what happens.
BY MR. FLAXMAN:
Q. This is the health care administrator at Sheridan?
A. Robin Rose, yes.
Q. Do you know if Robin Rose is still the health care administrator at Sheridan?
A. Actually, she's not. I asked when I inquired about my time there. I understand she left.
Q. What did you disagree with Robin Rose

about?
A. Patient care, basically. She's R.N., and I'm M.D., and I feel like my clinical judgment trumps that, and we just did not agree. Since I didn't go along with her recommendations, she, for lack of better words, trumped up some things, it stuck, and I had to leave.
Q. What things did she "trump up"?
MS. BYRD: Objection. Relevance.
Go ahead.
THE WITNESS: Answer?
MS. BYRD: Yeah.
THE WITNESS: Medical recordkeeping. I would like to pre-chart, which is very common with clinicians, especially if you know the inmates. And apparently one of the inmates I thought was there presently to see me was not there.
So I said, oh, I had to go in there, you know, and cross out, did not show, no show, and all of that. For some reason a nurse at the time who was helping me showed this to Robin, and somehow she interpreted as me trying to falsify information, which I have never done and

never will do. Somehow she interpret that as falsification of the medical records, and clearly I was not.
But just to add it had been building all the time. I would make clinical judgment. She would go back and try to verify it. It just wasn't the best relationship at the time.
BY MR. FLAXMAN:
Q. Did Wexford make any investigation into the charges against you?
A. Not that I'm aware of, but I would assume they did because if they agreed with it, of course they would not have kept me on board. So I assume they did look into it.
Q. But you're not aware of that investigation.
A. Absolutely not. Not aware of them conducting any investigation at that time.
Q. Did any other registration body do an investigation of the charges against you?
A. Not that I'm aware of, no.
Q. And after you took time off, you did work again for the -- I'm sorry. After you took time off, you worked again for Wexford in the

Illinois Department of Corrections.
A. Yes, I did. Yes.
Q. Were any of your disagreements about patient care with the health care administrator related to Johnny Jones?
A. No.
Q. Do you remember Johnny Jones?
A. Yes.
Q. What do you remember?
A. I remember the gentleman had a left knee injury while playing basketball.
Q. Do you remember what type of injury it was?
A. Well, when he presented to me approximately November of -- I'm not sure -- was it '14? I'm not sure. He presented to me and told me that he was playing ball, he landed awkwardly on his left knee.
At the time when I examined the knee, it was slightly swollen. No deformities noted. There was a little laxity with the patella, laxity meaning movement, with the patella. But also examined his right knee, and it was pretty similar in presentation, but there was some

swelling there. And he said at the time he had some pain probably about a eight out of ten pain.
At that time I gave him some pain meds, and I think I might have given him an Ace wrap. I'm not sure at the time. But at that time I felt like conservative treatment was appropriate, and that's pretty much how it worked, yes.
Q. And you said laxity with his patella?
A. Meaning some movement.
Q. I just wanted to ask you to spell patella to make sure we have it right.
A. P-a-t-e-l-l-a.
Q. And what did you mean by conservative treatment?
A. Well, the swelling wasn't huge, and there was no deformity noted at that time, and I felt like until I had a chance to present it to my superior at collegial --
(WHEREUPON, there was a short interruption.)
THE WITNESS: Collegial. It's a conference we have every week with a senior doctor that

pretty much determines where we going to go forth with the management of the particular patient in question.
BY MR. FLAXMAN:
Q. You got cut off. You said until we got a chance to present at collegial --
A. Conservative treatment, yes, with pain meds. I'm not sure if we were allowed to give Ace wrap. I seem to recall perhaps that might not have been allowed in the infirmary because it can be used for other things. And of course, you know, complete rest and no weightbearing on the affected knee.
Q. You said that the collegial is something that you do every week?
A. Yes, weekly.
Q. And is it done with a senior person --
A. At Wexford.
Q. -- at the Wexford corporate headquarters?
A. Yes.
Q. So you're on the phone.
A. Yes.
Q. Was there a day that you had it

regularly?
A. Probably Wednesday or Thursday. It's always the same day of the week. I think it was Wednesday.
Q. And when you were the director at Robinson --
A. Sheridan.
Q. I'm sorry. When you were the director at Sheridan -- I'm thinking of a different case.
When you were the director at Sheridan, where would you see patients?
A. In the health care unit. And I had my own office, and the patients or inmates would be in the lobby of the health care unit, and I would have the charts there, and I would have the guard to call the inmate or I would go out there and call them up, come see me in my office. Get the exam table and all the appropriate equipment there, yes.
Q. And is the infirmary the same thing as health care unit?
A. Well, infirmary is the facility where actual inmates who can't be out in the general population stay, have beds and rooms there.

Then there is a regular health care unit.
Q. Are they connected?
A. Yes. All in one building.
Q. Do you see patients -- would you have seen patients in the infirmary?
A. Daily, I did.
Q. Did you order an X-ray for Mr. Jones?
A. Yes.
Q. Do you remember what the X-ray showed? And if you don't, we can look at your records.
A. I think from review of the records it showed maybe a riding patella or something. I'm not exactly sure. I don't recall exactly.
Q. Sure. Okay. And I'm going to -- in a minute I'll just show you the records, and we can ask you some questions about that. Have you looked at the records before, recently?
A. Yes. I went through some of them, quite a number of them.
Q. And those are the medical records that were from the prison?
A. Yes.
Q. Did you look at anything other than those medical records relating to Mr. Jones?

A. No.
Q. How is -- the records that I have have a lot of handwritten charts.
A. Yes. We did not go into electronic medical records.
(WHEREUPON, there was a short interruption.)
THE WITNESS: We did not go or transition into electronic medical records. We were still doing handwritten notes at that time.
MS. BYRD: And if I could -- if the court reporter asks you a question, it's because she didn't understand what you were saying. She is not asking you to answer her questions. Okay? So just clarify what you said, and don't act as if she's inquiring of you to expand on your answer.
THE WITNESS: Okay. Okay.
MS. BYRD: Thank you.
THE WITNESS: Sure.
BY MR. FLAXMAN:
Q. When you would handwrite something on a chart, is that -- are those the words you would use? When you would see a patient, would

you handwrite -- what would you handwrite on the chart?
A. My encounter with the patient. It's something called SOAP notes, S standing for subjective, what the patient came in for, objective, O, standing for objective meaning exactly what I actually had found during my exam, A stands for my assessment, what I think was going on at the time, and P stands for plan as far as what I decide to do to address the issue.
Q. And you would put those notes on paper.
A. Yes.
Q. And what would you do with them after you put them on paper?
A. If I had decided to give some medicine, I would have a prescription written, and the inmate was able to go to the pharmacy to get his medicine at designed times.
Or if I had made a recommendation of X-ray, of course I would order that, and it would be placed with the chart, and the auxiliary staff would take care of that and get X-ray ordered. Fortunately we had an antiquated

A. Okay. What's the question?
Q. Can you tell me what this document is?
A. It's my encounter with the patient, my medical note.
Q. I understand that these are your notes. I want to be sure that I'm referring to them in the vocabulary that you use and not making anything confused. These are notes you made about an encounter with Johnny Jones.
A. Yes.
Q. What was the date of the encounter?
A. It seemed like it was April the 7th, 2015.
Q. August 7?
A. Oh, I'm sorry. August 7, 2015.
Q. And is this your handwriting?
A. Yes.
Q. And what was this encounter regarding?
A. Well, it seems at the time the inmate was complaining of nausea, and I noticed his blood pressure was slightly elevated. But I also reported that at this time the patient now reports no problems now.
My assessment was at the time head to

X-ray system on spot, so we were actually able to do X-rays in the facility.
Q. And what did you mean when you referred to the auxiliary staff?
A. I had assistants, nurses, and secretary and things that would be with me doing collegials at different times, and they would make sure any orders were taken.
Q. I'm going to give you a big pile of records, and they're not in very good order, so I think it will be best to go through them chronologically which unfortunately is not the order that they're in.
A. Okay.
Q. But if you look at the bottom right, each one has a page number. Starts with IDOC Medical.
A. Okay.
Q. If you could turn to Page 24.
A. Yes.
Q. Page 24 -- and just for the record we're going to go through page numbers that are in documents that have been produced with Bates label IDOC Medical. What is Page 24?

toe was grossly within normal limits. I put on there assessment, nausea, which is what he came to see me for, and I said now resolved for him, telling me this. And my plan included no refills today, meaning no refills on medications, and no followup needed.
Q. And at the bottom right of this page there is a stamp with your name?
A. Yes.
Q. What does it mean for the stamp to be on this chart?
A. My initials sometimes you can't read, so I just wanted to make sure they knew it was me who was actually conducting the encounter at the time.
Q. Are those your initials around the stamp?
A. Yes.
Q. And then below that there is some writing? What is that?
A. I'm not exactly sure who that is. Maybe it was the nurse who also -- because she's the one who calls the patients and takes their blood pressure and vitals and things,

and then he comes into my office to see me. So it's probably her just signing there --

Q. Okay.

A. -- signing off.

Q. And nurses make notes, too, right?

A. Well, as you can see at the top, the weight, the blood pressure, the pulse, and the respiratory rate was all recorded by the nurse. You can see her initials on the right side. So it's the same person who also initialed down here at the bottom.

Q. I see. And then your writing is under the word that say --

A. Vitals, right.

Q. Under the vitals it has the words --

A. M.D. note.

Q. -- M.D. note. Just let me finish so we can get it.

A. Sure.

Q. And do you write M.D. note?

A. Sometimes I do. It's just a habit.

Q. Well, it's helpful.

A. Yes.

Q. Do you know what nurse these initials

knee and rule out patellar rupture. And I gave him Motrin, 600 milligrams twice a day for pain times six weeks and also put in a special order for crutches times six weeks and lay-in times four weeks. And read my writing here.

No -- oh, no class, no group classes. I think that's what they're saying. Usually if they are confined to their room, they don't have to go to classes with the crutches and things like that for four weeks.

Q. Underneath you wrote inmate reports injury occurred playing basketball. Do you see that?

A. Yes.

Q. Underneath that what was the first word that you read?

A. Extremities.

Q. And then you said lower left?

A. The L circled stands for left. That's some shorthand. LE stands for lower extremity.

Q. Okay. And then the last thing in the subjective side was you said -- did you rule out patellar rupture?

A. No, I did not.

are?

A. No. Actually, I do not.

Q. Okay. And in this case would you have looked at the vitals that the nurse recorded?

A. Of course. That's why I circled it.

Q. And you circled the blood pressure.

A. Yes.

Q. Let me ask you to turn a few pages to 28. All right. And does this also have a notation of M.D. note and then your writing?

A. Yes. That's my writing, yes.

Q. And that's for the date of November 16, 2015?

A. Yes.

Q. And could you read what you wrote under M.D. note?

A. Sure. Inmate complained of injury to head and left knee. Patient reports injury occurred playing B ball, which is basketball. My assessment at the time, left lower extremity with increased knee swelling and pain.

My assessment was left knee derangement, rule out patella rupture. And my plan was at the time to get X-ray of the left

Q. What did you mean by rule out?

A. That's just a knee jerk reaction because the way he said the injury occurred, I just wanted to make sure there was not a patellar rupture. I didn't rule it out at the time because we hadn't got the X-ray back yet.

So I think according to my assessment at the time I was just filling it, and it was a little loose, little extra movement, but also I could compare it to the right knee. It also had the same amount of movement. So I just wanted to get the X-ray back to see, to be for sure.

But the way the injury occurred and the way he said he landed, I just wanted to make sure it was that. Knee jerk rule out meaning let's see what's going on, right.

Q. And that's why you got the X-ray, to see.

A. To see if that would show.

Q. Okay. The following page number 29 has an R.N. note. Do you see that?

A. Yes.

Q. It says see injury report. Do you see that?

A. Yes.
Q. Would you have looked at the injury report before seeing Mr. Jones on November 16?
A. Yes, I would have. I don't know where it would be.
Q. I can tell you. It's much further through the record, Page 312.
A. Okay. 312. Oh, yes. Okay.
Q. And so this is a report that you would have reviewed before seeing Mr. Jones?
A. I do not recall whether it was before or afterwards or during the exam, sir. I don't recall. Usually it was before the exam. I usually review it before, but I don't recall.
Q. Okay. Well, the page before that, which is 311 --
A. 311? Yes.
Q. -- is that part of the injury report?
A. Yes.
Q. I guess they are out of order, but that one says Side 2, and then Page 312 says Side 1.
A. Yes.
Q. Okay. Did you complete anything on Side 2?

A. No. That's not my writing at all, and look like just from reading the notes she pretty much put in her notes what I had recommended at the time, only on the 16th, which is kind of odd, because it says 14th, this combination.
Just reading treatment Motrin 600, which is what I recommended, and crutches, which is again what I recommended. Dr. James notified of orders. See above. So actually maybe she could have given him that in anticipation I was going to give crutches and Motrin because that's pretty much what we give when we have injuries like that, so. . .
Q. So it does look --
A. But I did sign it here, so I did review it. So yes. Signature at the bottom.
Q. What date did you write for when you reviewed it?
A. Well, it looked like according to here it says 11-30.
Q. You think you might have reviewed it sooner?
A. I'm not sure.
MS. BYRD: Objection. Speculation.

THE WITNESS: I'm not sure, sir.
BY MR. FLAXMAN:
Q. Do you know the name of the nurse who completed this?
A. Torres, Kristin Torres. I do remember her.
Q. T-o-r-r-e-s?
A. Yes.
Q. And Kristin with a K?
A. I think so, yes.
Q. Do you know if she was a Wexford employee?
A. No. She was IDOC.
MR. FLAXMAN: Let's go off the record while I try to get the pages back.
(WHEREUPON, there was a short pause.)
BY MR. FLAXMAN:
Q. From your November 16, 2015 assessment, followup on the X-ray, so that was something you ordered on November 16, 2015, correct?
A. It was actually done on the 16th.
Q. And how can you tell that?
A. Because note below there you can see,

X-ray left knee done.
Q. And can you tell who it's noted by?
A. I forgot the technician's name.
Q. You said X-rays could be done on site, correct?
A. Yes.
Q. X-ray report I believe is at Page 280.
A. 280.
Q. If you want, I can find it.
A. Other side. I got it. Okay. All right. There you go.
Q. Did you say wow?
A. Oh, I don't recall. He had intramedullary rod in his distal femur.
Q. What does that mean?
A. Evidently, this is purely assumption, evidently he had a previous injury, gunshot wound, motor vehicle accident which required a placement of a metal rod in his femur, which is the upper bone of his left leg.
Q. And the word you said was intra' --
A. Intramedullary rod. So it's actually inserted into the actual bone, bone marrow.
Q. I'm going to spell intramedullary.

I-n-t-r-a-m-e-d-u-l-l-a-r-y. Did I get that right?
A. Yes.
Q. And what we're looking at, Page 280, is what?
A. Want me to explain the -- interpret it for you?
Q. Well, before you interpret it, tell me what is it?
A. It's X-ray report that was done actually on the 16th. Apparently wasn't read by the radiologist until the 18th.
Q. And was it read by somebody offsite?
A. Yes.
Q. But the X-ray was taken onsite.
A. Yes.
Q. Do you know how it gets transmitted to the person reading it?
A. Electric -- oh, no. I'm sorry. The X-ray films are taken, and they're sent Fed-Ex to the radiologist who was on duty at the time.
Q. And that looks like N. Yousef, Y-o-u-s-e-f?
A. Yes.

Q. How does this report then get transmitted to Sheridan?
A. Electronic. Actually either through fax or by computer. I'm not exactly sure. Occasionally I would ask the technician, "Did we get a report back yet for Johnny Jones," and she would check her either fax notes to see if anything was transmitted back.
Q. So you would have reviewed this report.
A. Absolutely.
Q. And now can you tell me what you see in the report?
A. Okay. My interpretation or just read verbatim?
Q. Yeah. What's your interpretation?
A. At the time it showed -- it did show some osteoarthritis of his knee joint, which is very common when you have a previous injury. Small knee joint effusion, so mild swelling of the left knee. Patella is slightly riding high, meaning that it's slightly displaced, but by not much.
No loose body seen, and no convincing evidence of acute boney fracture. So in other

words, it was no fracture, there was no loose bodies floating in the knee compartment, which would pretty much direct you to think that maybe some bone chip or something might have occurred of his bone, but that was not the case.
Q. And there's two versions of this, Page 280 and 281.
A. It's the same, sir.
Q. Okay. Does one of them have your initials?
A. Initials on the second one meaning I reviewed it.
Q. Does it have a date for when you reviewed it?
A. No.
Q. Do you know what the date is on the bottom of 281, SE something, SEN, 11-25? Is that what you're referring to? Are those somebody's initials?
A. I don't know. I don't know.
Q. But your signature -- your initials are at the top of that page.
A. Yes. Meaning that I reviewed it, yes.
Q. What did you do after you reviewed this

X-ray report?
A. I don't recall after the notes. I think we pretty much continued conservative treatment at the time after interpretation of the X-ray.
Q. And what do you mean by conservative treatment?
A. Definitely confined to the infirmary. He wasn't allowed to go back out to the general population due to an injury. Continued bedrest and physical therapy that I had initiated for him.
Q. Let me ask you to go back to notes on Page 31.
A. 31. Yes.
Q. Does this page contain your notes about Mr. Jones?
A. Yes.
Q. And they start underneath M.D. note?
A. Yes.
Q. And this is from an encounter from December 8th of 2015?
A. Yes.
Q. Can you tell me what you wrote down on

the chart?
A. Want me to read my note?
Q. Yes, please.
A. Okay. Inmate with persistent left knee pain and swelling. Notable displacement of patella. Patient extremity left knee with probable patella, tendon rupture. My assessment was rule out tendon rupture. X-ray consistent with patella riding high.
Referral for ortho intervention versus MRI of the left knee. Continue -- well, Motrin 600 milligrams twice a day for four weeks. Zantac 150 milligrams twice a day for four weeks. Followup status post med writ.
(WHEREUPON, there was a short interruption.)
THE WITNESS: Med writ, w-r-i-t.
(WHEREUPON, a discussion was had off the record.)
BY MR. FLAXMAN:
Q. What do you mean by med writ?
A. Well, usually when that occurred, that means that an order had already been placed for either MRI or an orthopedic consultation. So at

the time, I'm not exactly sure what was approved, so med writ means that once he goes out to the orthopedic to be seen or he goes out for the MRI, then I will see him after he returns to talk about the management plan to find out what was done at the time.
Q. And what did you mean when you said the referral was for ortho intervention versus MRI?
A. Well, either I had discussed it with Wexford, Dr. Ritz, who was my superior who approves whether he goes to ortho, or gets an MRI. So I am not exactly sure exactly what was the disposition at the time.
Usually in this particular case they would say, well, let's get the MRI first. So if he has to see orthopedics, already have an MRI in place to review. So most likely he probably was approved for MRI before he saw orthopedics.
Q. And when you made this note, you were recommending one or the other.
A. Yes.
Q. You didn't have --
A. I'm not sure if I had a chance to speak with collegial -- I'm sorry I cut you off. What

were you going to say, sir?
Q. Well, I'm asking you, this is a record of collegial that's after this, and what I wanted to understand was what you meant when you wrote the VS for versus. Did you mean that you didn't have a preference between an ortho intervention and an MRI?
A. Well, I don't quite understand the question. What do you mean by that, sir?
Q. Well, you believe that Mr. Jones needed a referral.
A. Yes.
Q. And did you think he needed a referral for an ortho intervention or for an MRI?
A. Well, I'm pretty much trying to gauge exactly how Dr. Ritz usually likes to operate. I have been working with him for almost two years. I guess at the time I was thinking he's either going to recommend orthopedic consultation or MRI.
But in hindsight I think I probably just should have put MRI instead of orthopedic consultation. But at the time I knew both were going to take place eventually. Either MRI

first and then go see ortho or perhaps the ortho first and then recommended MRI.
Q. And one of the earlier things you wrote on this chart was the notable displacement of patella. What did you mean by notable?
A. Well, again, we got some slight movement of the patella as I examined it.
Q. Were you also relying on the X-ray?
A. The X-ray also said slightly riding patella, high riding patella.
Q. And in making this assessment on December 8, 2015, were you relying on the X-ray?
A. Well, not on the X-ray and the patient's continued persistent pain at the time and not able to have any weightbearing on the knee. We had had him rested for about four weeks at the time, and he was still complaining of significant pain even though the swelling had decreased, but still significant pain was notable.
Q. If you turn to the next page.
A. 32?
Q. 32, please. This has another note created by you, is that correct?

A. Yes.
Q. And that's from December 15, 2015?
A. Yes. That's when we actually had our collegial meeting.
Q. Okay. And what did you write?
A. On December 15 the M.D. note says, "Approved by collegial for MRI locally of left knee. Rule out patella tendon rupture."
Q. What does locally mean?
A. Mean that he went to a local facility, the closest facility within the area of which we're allowed to have our patients go to that has an MRI machine to get it done. I think it was Valley West or something like that. I'm not -- I don't recall the hospital. I think that's the closest facility to Sheridan that has an MRI machine.
Q. And when you wrote down rule out patella tendon rupture, you didn't mean that you had ruled that out, right?
A. No.
Q. What did you mean?
A. I want them to rule it out, in other words, with the X-ray, with the MRI of course.

A. Well, I think it was created in response to the medical record on the previous page. I have to manually write out what I recommend, and this note was created in response to my note for special services referral.
Q. And that's -- that had to be approved by Dr. Ritz --
A. Yes.
Q. -- at Wexford.
A. Yes
Q. R-i-t-z?
A. Yes.
Q. And for that approval that was a phone conversation you had with Dr. Ritz, right?
A. Right. We have weekly.
MS. BYRD: Joel, is this a good time to take a short break?
MR. FLAXMAN: Oh, sure.
We're going to take a short break.
(WHEREUPON, a short recess was taken.)
BY MR. FLAXMAN:
Q. So the collegial that we were just discussing resulted in the approval of an MRI

Q. And then this has your stamp and your initials, correct?
A. Yes.
Q. And next to your stamp it says noted. Do you see that?
A. Yes.
Q. Who wrote that?
A. Looks like a nurse. Jana. I don't remember who that is.
Q. Do you know what it means for it to be noted?
A. I guess she noted it on the 20th. I'm not sure.
Q. What does it mean that she noted it?
A. Don't know, sir.
Q. Okay. If I could have you turn to Page -- if I could have you turn to Page 189.
A. Okay. Yes.
Q. Is that a record of the collegial that you described to us?
A. I would assume so, yes.
Q. Have you ever seen this record before?
A. Yes. Yes.
Q. Did you create it?

for Mr. Jones, correct?
A. Yes.
Q. What happens next to get Mr. Jones the MRI?
A. What do you want to know?
Q. I'll show you some of the records in a moment.
A. Sure.
Q. I'm just asking at this time in December of 2015 what was the procedure for getting an inmate who needed an MRI to get that MRI?
A. Once it's approved of course I put a request in, and the office, health care office that I work in, they take the request, and I assume they contact the local facility that has an MRI machine to try to schedule an MRI when possible.
Q. And that scheduling process is not something you're involved in?
A. No.
Q. And who works in the health care office?
A. I don't recall the personnel that was

there at the time, the names.
Q. Are some of them Wexford employees?
A. No. IDOC as far as I know, yes.
Q. And did they keep you informed about that schedule?
A. Yes.
Q. How did they do that?
A. They would let me know, and of course they would let the inmate know when he's scheduled so we can make arrangements for them to go out with guards and transportation, the whole getup, so to speak.
Q. Okay. Why don't we go back to the charts on Page 33.
A. Okay.
Q. Does this have your note from January 6 of 2016?
A. Yes.
Q. Can you please read it to us?
A. "M.D. note. MRI scheduling form completed with inmate. Refills" -- probably -- I'm not sure exactly what. Oh, it says right there. "Refills on Zantac and antacid tablets times six weeks."

Page 33.
A. Yes.
Q. Can you read your note?
A. Sure. On January 18, 2016 my note says Status post, meaning that he had returned from a visit to Valley West Hospital, for MRI of left knee. Objective finding again, left lower extremity swelling and pain with range of motion, meaning when we move the leg, some pain with it.
Assessment, again, rule out patella derangement, rule out patella rupture versus -- I don't know what that says.
Q. It's covered by a stamp.
A. Derangement. Okay. Dislocation I think or something to that effect. Plan, possible followup with ortho if MRI is abnormal. Refills on Motrin, 600 milligrams twice a day for two months. Followup status post MRI results.
Q. So Mr. Jones had gone out for the MRI on January 18?
A. Yes.
Q. But you didn't have the results of the

Q. Those are your notes, correct?
A. Yes.
Q. And that has your stamp and your initials below it?
A. Yes.
Q. Okay. What was the form that was completed with the inmate?
A. I'm not sure, sir, what the form was.
Q. Do you know why you had to complete a form?
A. For the scheduling MRI, I would assume. I don't know exactly what it involved. It's pretty customary, usually how it happens. Actually, I don't recall, sir, exactly how.
Q. Based on your notes do you believe that after the MRI was approved, for it to be scheduled you needed to complete that form with the inmate?
A. I'm not sure. I'm not sure.
Q. The note below this one is another note dated January 18, 2016. Is that your note as well?
A. Yes.
Q. Okay. Just for the record I'm still on

MRI yet.
A. No.
Q. So these assessments that you just read to us were based on your observations of Mr. Jones.
A. Yes.
Q. Go back to Page 14.
A. Yes.
Q. Are these your notes from January 25, 2016?
A. No.
Q. Whose notes are these?
A. Nurse notes.
Q. Page No. 14 has your stamp at the bottom?
A. Yes.
Q. Why does it have your stamp?
A. Meaning I reviewed her note. I looked over it.
Q. And I'm sorry if I asked a confusing question. Page 15, are those also nurse notes?
A. Yes.
Q. And again, it has your stamp because you reviewed those?

A. Yes.
Q. Page 16?
A. Yes.
Q. Again nurse notes from January 25, 2016 with your stamp because you reviewed them.
A. Yes.
Q. Did you know the name of the nurse who made these notes?
A. No.
Q. Now, if you go back to Page 13, does this have your notes at the top?
A. Yes. M.D. note, yes.
Q. And the date of that is January 26, 2016, is that right?
A. Yes.
Q. What did you write there?
A. Approve by collegial for orthopedic consult.
Q. And do you recall why Mr. Jones needed an orthopedic consult?
A. Well, if I were to assume that we got the MRI results back and showed that he had a complete tear, so we knew we had to go see ortho for recommendations.

Q. Page 187. I believe it was an MRI report.
A. Okay. Yes.
Q. Is that the MRI report that you were just referring to?
A. Yes.
Q. And it states that you're the doctor who ordered that MRI?
A. Yes.
Q. And it looks like it was -- has a fax header. Would this have been faxed to the prison?
A. Yes.
Q. And it has some initials at the top. Are those your initials?
A. Yes.
Q. Meaning that you reviewed this.
A. Yes.
Q. And based on reviewing this you determined that Mr. Jones needed an orthopedic consult?
A. Yes.
Q. What in here told you that he needed an orthopedic consult?

A. Say that again, sir?
Q. Was there a finding in this MRI report that caused you to believe he needed an MRI consult?
A. Yes.
Q. What was it?
A. No. 2 says complete tear of patellar tendon at its origin at about 1.6 centimeters separation between interior patella and superior aspect of the torn tendon.
Q. And after reviewing this, what did you do to get Mr. Jones to an orthopedic consult?
A. Well, as you could see on the previous page, I filled out a referral report to have him be seen by Midwest Ortho. That's the orthopedic facility that we use. And put in there the rationale for the referral, as you can read.
Q. I'm sorry. You're talking about the previous page here?
A. Yes. Yes.
Q. We might have jumped ahead because this one is dated -- are you looking at Page No. 186?
A. Yes. I'm not sure why it's out of

order. I wouldn't have wrote this until I interpreted the X-ray first.
Q. Well, I think we jumped ahead. I think maybe the page after the MRI is what you should be looking at, Page 188.
A. Uh-huh.
Q. And I'm looking at Page 188.
A. Yes.
Q. Is this a referral and report that has your handwriting at the top?
A. Yes.
Q. And what did you -- there is one line for referred to?
A. Yes.
Q. What did you write there?
A. Ortho local Midwest Orthopaedic practice, I guess, yes.
Q. What did you write for rationale for referral?
A. Status post MRI of left knee consistent with complete tear of the patellar tendon at its origin. See MRI report.
Q. And that has your signature for referring practitioner's signature?

A. Yes.
Q. And what's the date?
A. 1-18-2016.
Q. And did you make this after having a collegial with Dr. Ritz?
A. I'm not sure. I'm not sure if that was written after or before. I'm not sure.
Q. Would it need to go through collegial before Mr. Jones went to Midwest Orthopedics?
A. Absolutely needs approval.
Q. So just I mean before he would go out, it would need to be approved in collegial.
A. Right.
Q. You are just not sure when you wrote this form.
A. Not sure.
Q. And below it says -- underneath report of referral there is some handwriting?
A. Yes.
Q. And that's from another doctor, right?
A. It's from another doctor, yes.
Q. Is it Dr. Behl, B-e-h-l? Do you see that?
A. Yes.

Q. And when this came back from Dr. Behl, did you review it?
A. Yes.
Q. And you saw that Dr. Behl recommended surgery as soon as possible?
A. Yes.
Q. What did you do after you saw Dr. Behl's recommendation?
A. I'm sure that another referral was submitted to get the surgery.
Q. And that might have been the one we were just looking at.
A. Okay.
Q. Going back to Page 186.
A. Yes.
Q. Take a look at 186. Is that the referral for surgery?
A. Yes.
Q. And that was a referral you created on February 8, 2016?
A. Yes.
Q. And again, that surgery would have happened only after a collegial, correct?
A. Correct.

Q. Bottom of this page has a signature by someone named Joseph Maides, M-a-i-d-e-s.
A. Yes.
Q. Do you know who that is?
A. Yes. That's the doctor that was working with me, Dr. Maides.
Q. Where was Dr. Maides located?
A. In the facility. There were two docs there at the time.
Q. And was he a Wexford employee?
A. You know, that's an odd thing. He was actually, which he had benefits of both, Wexford and IDOC. I didn't quite understand how that works. He was actually employee of Wexford and employee of IDOC, which is kind of nice, actually.
Q. Why was it nice?
A. Well, he got certain benefits at IDOC that I wasn't allowed, but that's neither here nor there.
Q. Do you know why -- and how do you say his name?
A. Maides, M-a-i-d-e-s.
Q. Why did Dr. Maides have to approve this

referral?
A. Well, actually, I don't know. He might have been on call seeing patients for that at the time. Sometimes we would switch off and do different duties. So at the time perhaps he was the one who saw Johnny Jones that day.
Q. And it looks like he approved it on the day after surgery.
A. Right, to approve the recommendations. Yes.
Q. Oh, meaning recommendations from Dr. Behl.
A. Right.
Q. Okay. I was confused about whose recommendations.
A. He already had surgery at this time, right.
Q. Okay. Is it the same health care office that scheduled the MRI that was responsible for scheduling the surgery?
A. Repeat that again?
Q. Who was responsible for scheduling the surgery?
A. I think the health care office again

put the recommended he call and see what's the next available for surgery.

Q. Do you recall examining Mr. Jones after the surgery?

A. Not exactly, but I have to go by my notes. I'm sure I did. Don't recall.

Q. Sure. Why don't you look at Page --

A. Either I did or Dr. Maides.

Q. Can you turn to Page 58?

A. Sure. Yes.

Q. What's this? What's Page 58?

A. It seems to be an infirmary progress note from a nurse progress note.

Q. This was something that was created by a nurse?

A. Yes.

Q. Is any of this your handwriting?

A. No.

Q. Does M.D. notified, Dr. James, do you see that?

A. Where?

Q. At the top right under plan.

A. Yes. Um-um.

Q. And does that mean that the nurse

notified you about these notes?

A. Yes.

Q. How would the nurse notify you?

A. At the bottom you can see telephone order. T/O means telephone order. That means they contacted me by phone, and I approved the notes.

Q. And it says T/O Dr. James?

A. Yes, telephone order.

Q. What does it say after Dr. James?

A. I think -- I'm not sure. Just from looking it says Rudolph maybe?

Q. You think that would be the name?

A. Name of the nurse, perhaps.

Q. Okay. But you don't know what that name is.

A. No.

Q. Let me ask you about a document that's at Page 301.

A. 301? This is something called a specialty appointment document request form.

Q. What's that?

A. I really don't know. I never seen this before.

Q. Do you see your stamp at the bottom for provider requesting appointment?

A. Yes. Just don't recall, but I'm sure if I stamped it, I looked at it.

Q. You don't recall what this form was for?

A. I can take a look at it and see. I think that when we send inmate out, we have to send packet of different forms, and this is probably one of the documents that has to be sent out when he goes out or when he returns. Multiple forms that has to be sent out when he goes out. Upon completion of his medical, writ forms have to be returned, just from looking at it.

Q. So you think it's just something about transmitting forms --

A. Yes.

Q. -- but you don't have a specific recollection of what it is.

A. No, sir.

Q. Can you go back to Page 95?

A. 95.

Q. Are these notes that you created about

Mr. Jones?

A. Yes.

Q. And are they dated February 24, 2016?

A. Yes.

Q. It looks like there is something written next to M.D. notes on this. Do you see that?

A. Chronic.

Q. Why did you write chronic?

A. I don't know.

Q. Can you read for me what you wrote underneath M.D. notes?

A. Sure. Status post left knee patella reconstruction. Doing well with good pain control. Extremity. Left lower extremity five out of five motion of toes. Good sensory. Assessment. Left knee patellar reconstruction. Oh, card in place or -- I'm not sure.

Q. Would that be cast?

A. There you go. Good. Better than I. Cast in place. Clean dressings and all that, you know. I forgot what C/D/I stand for. Wow. That's abbreviation. Let me see. Haven't did urgent care in a while. In cast -- I forgot.

Q. Okay. We can look. So the abbreviation C/D/I --
A. Something, dressing cleans, incision cleans. I don't remember. Sorry.
Q. What's the word after C/D/I?
A. Dressings.
Q. What did you write?
A. Continue dressing changes or something. I'm not sure.
Q. Then right column under plan, can you tell me?
A. Schedule for ortho followup next with possible cast removal. So perhaps they had the cast on. Continue present plan of management. CPM stands for continue present management.
Q. You stamped and initialed this page, correct?
A. Yes.
Q. So one of the things in the plans was that Mr. Jones was scheduled for a followup with the orthopedist.
A. Right.
Q. Is it orthopedic surgeon, orthopedist?
A. Orthopedist is fine.

Q. Okay. And that's something that he was going to have to go offsite for, correct?
A. Back to the same facility.
Q. I think he went there a few times, is that right?
A. According to the notes, yes.
Q. When he was seen by the orthopedic specialist, would they send back a report for you to look at?
A. Yes. Usually they would, yes.
Q. One of those I think is at Page 199.
A. Okay.
Q. Is that a report that was sent from the orthopedic specialist back to the prison?
A. Yes.
Q. And there is a stamp at the bottom I think that says M.D. review, is that right?
A. Yes.
Q. And it has your name?
A. Has my name, yes.
Q. Okay. Does that mean that you reviewed this on February 16, 2016?
A. Yes. According to the top upper right that's my initial.

Q. And that's also your initial.
A. Yes.
Q. Okay. What did you understand this report to mean?
A. Well, I think it was just pretty much described as post surgical changes after the surgery, nothing really outstanding.
Q. Did it state whether the surgery was a success?
A. It appears that, yes. Yes.
Q. Surgery was a success.
A. I don't know, to be honest with you.
Q. Oh, okay. This report doesn't say.
A. No.
Q. Do you recall seeing a report that stated whether the surgery was a success?
A. No, I do not.
Q. Did you form an opinion that the surgery was a success?
A. No.
Q. Why not?
A. I assume they knew what they were doing, so I don't know.
Q. When you say "they," who do you mean?

A. Orthopedics, Midwest Orthopedics.
Q. Did anyone from Midwest Orthopedics ever tell you that Mr. Jones' outcome was affected by the delay in getting him surgery?
A. No.
Q. Did you ever learn that his outcome was affected by the delay in getting surgery?
A. No.
MS. BYRD: Objection. Assumes facts not in evidence.
BY MR. FLAXMAN:
Q. Do you believe that Mr. Jones received surgery in a timely fashion?
A. Yes.
Q. Why do you believe that?
A. Actually, I think he received surgery a lot quicker than those in the private sector. I think it was timely.
Q. And when you say a lot quicker, are you going based on when --
A. Quick.
Q. What time are you comparing it to?
A. Well, I think during the time was during the holiday season. December. So I

think for him to get it done at the time, I think it's pretty quick. It's awfully difficult to schedule different things when holiday season.

Q. So from December to February you believe it was pretty quick.

A. I do. For corrections, yes.

Q. Did you also think it was quick for the private sector?

A. Yes. Absolutely.

MR. FLAXMAN: Let me take a quick break. Almost done.

THE WITNESS: Okay.

(WHEREUPON, a short recess was taken.)

BY MR. FLAXMAN:

Q. Doctor, we looked at a lot of notes that you made in the charts.

A. Yes.

Q. And there are a lot in the stack in front of you that we didn't look at.

A. Right.

Q. I just wanted to ask generally your practice when you're charting notes is to create

the record at around the time you're seeing the patient, is that right?

A. Yes.

Q. And you created based on your knowledge at that time, correct?

A. Yes.

Q. And that's what you regularly did when you created records at Sheridan when you worked for Wexford, correct?

A. Yes.

Q. And then those records were stored at the prison, right?

A. Yes.

Q. Are you aware that Mr. Jones claims that his knee is permanently disabled?

A. No. I'm not aware of that. Now I know.

Q. Do you believe that getting the surgery quicker for Mr. Jones would have prevented that disability?

A. No.

Q. Why not?

A. I think that Mr. Jones was not very cooperative with the recommendations made at the

time as far as physical therapy. I had at that time had printed out some rehab recommendations, which he did not abide by at all. Even after he got the surgery, he was recommended that he kept the knee brace on pretty much, maybe not 24/7 but certainly throughout the day, and several occasions he had taken the knee brace off and was not -- I think it was even reported by the nurses and all personnel that he hardly wore the knee brace as often as he should.

Also before the surgery I had made recommendations and even gave him printouts about the rehab, he did not abide by. Also made recommendations about staying off the knee, which he did not abide by. So I think his actions and I found recommendations probably was not the best interest for his rehab, for his knee. So I think no.

Q. And to be clear you're talking about recommendations you made both before the surgery and after the surgery.

A. And after the surgery. Yes. Not very cooperative with the recommendations.

Q. Did he ever tell you why he was not

being cooperative?

A. No. He would just go back and put the brace back on or he would see me coming and all of a sudden acting like he's doing rehab and all.

Q. Was he housed in the infirmary for some time after the surgery?

A. He was housed in the infirmary before the surgery occurred and continued to be housed in the infirmary until he was released because he had a knee brace on, and he couldn't be out in the general population with that type of brace because, unfortunately, guys can use that as a weapon.

Q. Do you know what kind of brace it was?

A. It had metal compartments, jointed type brace, yeah.

MR. FLAXMAN: I don't have anything else.

EXAMINATION

BY MS. BYRD:

Q. Dr. James, at the very beginning of your deposition when you were talking about whether you were still employed by Wexford --

A. Yes.

Q. -- and Mr. Flaxman asked you if you learned today that you are still employed by Wexford, you didn't learn that today, correct?

A. No. It was last week. I think you had asked me when I was actually there at Wexford -- I mean Sheridan, and I couldn't recall, so I contacted Sheridan, a Wexford employee there, Cathy Stock, and she gave me a number with Human Resources with Wexford because she didn't recall.

So I contacted Wexford and said, "Hey, do you know the time frame where I was actually physically there at Wexford," and according to this payroll document she didn't have a date.

But I guess you could tell when I got my last check from Sheridan. He told me I think November 16th of 2016, so I go back two weeks thinking perhaps I left around the end of October. That's why I said between those times.

And then before even shared that information, "You're still active with us." Okay. Still traveling PRN medical director. I said okay. So I did not know that because I hadn't done any work for them within the past

year, year and a half.

Q. And Robin Rose, who you testified about, she's an IDOC employee, correct?

A. Not anymore.

Q. Well, at the time that she was an IDOC employee, not a Wexford employee, correct?

A. Yes, yes. She was an IDOC employee, yes.

Q. On Page 189, which you were asked about, Wexford -- at the top it says Wexford Health Sources, Incorporated. This is not a form that you create, correct?

A. No, I don't create. That's something I guess that's created when the referral is put in.

Q. Okay. But without assuming anything, it's just something that you do not create, correct?

A. No, I do not.

Q. Okay. And same with inmate injury report that was on Pages 311 and 312. That is not a report that you create, correct?

A. No. That's just a report that I review. What page is that?

Q. 311 and 312.

A. Yes. I review it and sign off on it, yes.

Q. And you were asked whether you formed an opinion whether Mr. Jones' surgery was a success. You are not an orthopedic surgeon, correct?

A. Right.

Q. You don't have any specialty training in orthopedics, correct?

A. Right.

Q. So you were relying on the opinions of the experts in orthopedics, correct?

A. Yes.

MS. BYRD: I don't have anything further.

FURTHER EXAMINATION

BY MR. FLAXMAN:

Q. Sounded like you thought of something relating to Page 189.

A. No.

MS. BYRD: Is that a question?

THE WITNESS: Oh, it's just --

MS. BYRD: I'm going to object. There is no question.

BY MR. FLAXMAN:

Q. What did you think of related to Page 189?

A. Well, I was just going to say that's something that's created after we have a collegial report. That's something that's created right after pretty much showing what was done. That's all.

Q. Okay.

A. What was approved, and they have to document and just shows. That's all.

MR. FLAXMAN: Thank you for your time. I'm done.

MS. BYRD: Thank you.

So Dr. James, you can review your transcript and make sure that it was reported correctly.

THE WITNESS: Okay.

MS. BYRD: You don't get to change your answers. Do you want to do that when the transcript is done or do you want to waive reviewing it and signing off on it?

THE WITNESS: I think I need to? I could waive and just sign off on it. Recommend I

should -- I would like to review it.
MS. BYRD: I will handle signature.
(WHEREUPON, the deposition was concluded at 11:21 o'clock a.m.)

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

JOHNNY JONES,)
Plaintiff,)
vs.) No. 17-CV-8218
WEXFORD HEALTH SOURCES, INC.,)
a foreign corporation,)
and DR. MARSHALL JAMES,)
Defendants.)

I, MARSHALL JAMES, M.D., being first duly sworn, on oath say that I am the deponent in the aforesaid deposition taken on December 14, 2018; that I have read the foregoing transcript of my deposition, and affix my signature to same.

_____
MARSHALL JAMES, M.D.

Subscribed and sworn to
before me this day
of , 2018

Notary Public

STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)

I, MARLENE L. KING, a notary public within and for the County of Cook County and State of Illinois, do hereby certify that heretofore, to-wit, on December 14, 2018, personally appeared before me, at 200 South Michigan Avenue, Suite 201, Chicago, Illinois, MARSHALL JAMES, M.D., in a cause now pending and undetermined in the United States District Court for the Northern District of Illinois, Eastern Division, wherein JOHNNY JONES is the Plaintiff, and WEXFORD HEALTH SOURCES, INC., a foreign corporation, and DR. MARSHALL JAMES are the Defendants.

I further certify that the said MARSHALL JAMES, M.D. was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by said witness was reported stenographically by me in the presence of the said witness, and afterwards reduced to typewriting by Computer-Aided Transcription, and

the foregoing is a true and correct transcript of the testimony so given by said witness as aforesaid.

I further certify that the signature to the foregoing deposition was reserved by counsel for the respective parties and that there were present at the deposition the attorneys hereinbefore mentioned.

I further certify that I am not counsel for nor in any way related to the parties to this suit, nor am I in any way interested in the outcome thereof.

IN TESTIMONY WHEREOF: I have hereunto set my hand and affixed my notarial seal this 18th day of December, 2018.

Marlene L King
_____
NOTARY PUBLIC, COOK COUNTY, ILLINOIS

McCORKLE LITIGATION SERVICES, INC.
200 N. LaSalle Street Suite 2900
Chicago, Illinois 60601-1014

DATE: December 18, 2018

MS. SANDRA L. BYRD,
CASSIDAY, SCHADE, LLP,
222 West Adams Street,
Suite 2900,
Chicago, Illinois 60606

IN RE: Jones vs. Wexford
COURT NUMBER: 2017 CV 08218
DATE TAKEN: December 14, 2018
DEPONENT: Marshall James, M.D.

Dear Ms. Byrd:

Enclosed is the deposition transcript for the aforementioned deponent in the above-entitled cause. Also enclosed are additional signature pages, if applicable, and errata sheets.

Per your agreement to secure signature, please submit the transcript to the deponent for review and signature. All changes or corrections must be made on the errata sheets, not on the transcript itself. All errata sheets should be signed and all signature pages need to be signed and notarized.

After the deponent has completed the above, please return all signature pages and errata sheets to me at the above address, and I will handle distribution to the respective parties. If you have any questions, please call me at the phone number below.

Sincerely,

Cindy Alicea Court Reporter Present:
Signature Department MARLENE L. KING
cc: Mr. Joel A. Flaxman.

77

1
1 29:21
1-18-2016 53:3
1.6 51:8
11-25 35:17
11-30 30:20
11:21 73:5
12 9:11
13 49:10
14 10:22 15:16 48:7,14
14th 30:5
15 41:2,6 48:21
150 37:13
16 12:2 26:12 29:3 31:19,21 49:2 62:22
16th 30:4 31:22 33:11 69:17
17 4:23
18 46:21 47:4,22
186 51:23 54:14,16
187 50:1
188 52:5,7
189 42:17 70:9 71:19 72:3
18th 33:12
199 62:11

2
2 29:21,24 51:7
2014 9:24 10:12 11:11
2015 5:2 23:13,15 26:13 31:19,21 36:22 40:12 41:2 44:10
2016 5:2 11:2,12 45:17 46:21 47:4 48:10 49:4,14 54:20 60:3 62:22 69:17
2017 9:10,24 10:13 11:8,9
20th 42:12
24 22:19,21,24 60:3
24/7 67:5
24th 9:9 11:8
25 48:9 49:4
26 49:13
28 26:9
280 32:7,8 33:4 35:7
281 35:7,17
29 28:20

3
301 58:19,20
31 36:14,15
311 29:16,17 70:21 71:1
312 29:7,8,21 70:21 71:1
32 40:22,23
33 45:14 47:1

4
4th 9:9 10:21

5
58 57:9,11

6
6 45:16
600 27:2 30:6 37:12 47:18

7
7 23:14,15
7th 23:12

8
8 40:12 54:20
8218 4:23
8th 36:22

9
95 59:22,23

A
a.m. 73:5
abbreviation 60:23 61:2
abide 67:3,13,15
abnormal 47:17
Absolutely 14:17 34:10 53:10 65:10
accident 32:18
accurate 9:17
accurately 6:7,10
Ace 16:5 17:9
act 20:15
acting 68:4
actions 67:16
active 6:22 7:15,16 69:21
actual 18:23 32:23
acute 34:24
add 14:4
additional 11:9
address 21:10
administrator 12:7,14,16,20 15:4
affected 17:13 64:4,7
agree 12:8,11 13:5
agreed 14:12
ahead 12:5 13:11 51:22 52:3
allowed 17:8,10 36:9 41:12 55:19
amount 28:11
answers 72:20
antacid 45:23
anticipation 30:10
antiquated 21:24
anymore 70:4
apparently 13:17 33:11
appears 63:10
appointment 58:21 59:2
approval 43:13,24 53:10
approve 49:17 55:24 56:9
approved 38:2,18 41:7 43:6 44:13 46:16 53:12 56:7 58:6 72:10
approves 38:11
approximately 9:11 10:19 11:1,7 15:15
April 23:12
area 41:11
arrangements 45:10
asks 20:12
aspect 51:10
assessment 21:8 23:24 24:2 26:20,22 28:7 31:19 37:7 40:11 47:11 60:17
assessments 48:3
assistants 22:5
assume 14:12,14 42:21 44:16 46:11 49:21 63:22
Assumes 64:9
assuming 70:16
assumption 32:16
attempt 5:17
August 9:24 10:12 23:14,15
auxiliary 21:23 22:4
aware 14:11,15,17,21 66:14,16
awkwardly 15:18

B
B-E-H-L 53:22
back 14:6 28:6,12 31:15 34:6,8 36:9,13 45:13 48:7 49:10,22 54:1, 14 59:22 62:3,8,14 68:2,3 69:17
ball 15:17 26:19
based 46:15 48:4 50:19 64:20 66:4
basically 13:2
basketball 15:11 26:19 27:12
Bates 22:23
bedrest 36:10
beds 18:24
beginning 68:21
Behl 53:22 54:1,4 56:12
Behl's 54:8
benefits 55:12,18
big 22:9
blood 23:21 24:24 25:7 26:6
board 14:13
bodies 35:2
body 14:19 34:23
bone 32:20,23 35:4,5
boney 34:24
bottom 22:15 24:7 25:11 30:16 35:17 48:15 55:1 58:4 59:1 62:16
brace 67:5,7,10 68:3,11, 13,15,17
break 10:15 43:17,19 65:11
building 14:4 19:3
bumping 12:7
BYRD 12:4 13:10,13 20:11, 19 30:24 43:16 64:9 68:20 71:15,21,23 72:14,19 73:2

C
C/d/i 60:22 61:2,5
call 7:17 8:19 18:16,17 56:3 57:1
called 4:6 21:4 58:20
calls 24:23
captioned 4:22
card 60:18
care 12:6,10,13,16,20 13:2 15:4 18:12,14, 21 19:1 21:23 44:14, 22 56:18,24 60:24
case 18:9 26:3 35:5 38:14
cast 60:19,21,24 61:13, 14
Cathy 69:8
caused 51:3
center 5:2 10:4
centers 9:22 10:2,6
centimeters 51:8
chance 16:19 17:6 38:23
change 72:19
charges 14:10,20
chart 20:23 21:2,22 24:11 37:1 40:4
charting 65:24
charts 18:15 20:3 45:14 65:18
check 34:7 69:16
chip 35:4
chronic 60:8,9
chronologically 22:12
circled 26:5,6 27:19
claims 66:14
clarify 10:11 20:15
class 27:6
classes 27:6,9
Clean 60:21
cleans 61:3,4
clear 67:19
Clinic 4:17,19 6:14 7:1 9:12
clinical 13:3 14:5
clinician 4:16 6:13
clinicians 13:16
closest 41:11,16
collegial 16:20,23 17:6,14 38:24 39:3 41:4,7 42:19 43:23 49:17 53:5,8,12 54:23 72:6
collegials 22:7
column 61:10
combination 30:5
common 13:15 34:18
compare 28:10
comparing 64:22
compartment 35:2
compartments 68:16
complained 26:17
complaining 23:20 40:17
complete 17:12 29:23 46:9,17 49:23 51:7 52:21
completed 31:4 45:21 46:7
completion 59:13
computer 34:4
concluded 73:4
conducting 14:18 24:14
conference 16:23
confined 27:8 36:8
confused 23:8 56:14
confusing 48:20
connected 19:2
conservative 16:7,15 17:7 36:3,6
consistent 37:8 52:20
consult 49:18,20 50:21,24 51:4,12

consultation 37:24 39:20,23
contact 44:16
contacted 58:6 69:7,11
continue 37:11 61:8,14,15
continued 36:3,10 40:14 68:9
control 60:15
conversation 43:14
convincing 34:23
cooperative 66:24 67:23 68:1
corporate 17:19
correct 6:17 10:1,5,14 31:21 32:5 40:24 42:2 44:1 46:1 54:23,24 61:17 62:2 66:5,9 69:3 70:3,6,12,18,22 71:7,10,13
correctional 5:2 8:20 9:21 10:2,4,6
corrections 15:1 65:7
correctly 72:17
couple 6:20 11:2,4
court 20:11
covered 47:14
CPM 61:15
create 42:24 65:24 70:12,13,17,22
created 40:24 43:1,4 54:19 57:14 59:24 66:4,8 70:14 72:5,7
cross 13:20
crutches 27:4,9 30:7,11
current 8:21
customary 46:13
cut 17:5 38:24
CV 4:23 9:16,18,20 10:3 11:9

D

Daily 19:6
date 23:11 26:12 30:17 35:13,16 49:13 53:2 69:14
dated 46:21 51:23 60:3
day 11:16 17:24 18:3 27:2 37:12,13 47:18 56:6,8 67:6
days 11:20
December 36:22 40:12 41:2,6 44:10 64:24 65:5
decide 21:10
decided 21:16
decreased 40:19
deformities 15:20
deformity 16:18
delay 64:4,7
Department 15:1
deposition 5:5,13 68:22 73:3
derangement 26:23 47:12,15
designed 21:19
determined 50:20
determines 17:1
difficult 65:2
direct 35:3
director 7:5 8:16,18,23 9:8, 21 10:7,13,17,18,20, 24 11:10,13 18:5,8, 10 69:22
disability 66:20
disabled 66:15
disagree 12:24
disagreement 12:10
disagreements 15:3
discussed 38:9
discussing 43:24
discussion 8:6 37:18
Dislocation 47:15
displaced 34:21
displacement 37:5 40:4
disposition 38:13
distal 32:14
Dixon 10:3 11:6
docs 55:8
doctor 16:24 50:7 53:20,21 55:5 65:17
document 23:2 58:18,21 69:14 72:11
documents 22:23 59:10
dressing 61:3,8
dressings 60:21 61:6
due 36:10
duly 4:4,7
duties 56:5
duty 33:21

E

earlier 40:3
effect 47:16
effusion 34:19
Electric 33:19
electronic 20:4,9 34:3
elevated 23:21
employed 4:15 6:18 7:1 9:3,8 11:3 68:23 69:2
employee 31:12 55:10,14,15 69:8 70:3,6,7
employees 45:2
employment 6:14
encounter 21:3 23:3,9,11,18 24:14 36:21
end 11:1 69:18
equipment 18:19
escorted 12:9
eventually 39:24
evidence 34:24 64:10
evidently 32:16,17
exact 9:14
exam 18:18 21:8 29:12,13
EXAMINATION 4:9 68:19 71:16
examined 4:7 15:19,23 40:7
examining 57:3
expand 20:16
expect 9:17
experts 71:13
explain 33:6
extra 28:9
Extremities 27:17
extremity 26:20 27:20 37:6 47:8 60:15

F

facility 8:20 12:9 18:22 22:2 41:10,11,16 44:16 51:16 55:8 62:3
facts 64:9
falsification 14:2
falsify 13:24
fashion 64:13
fax 34:4,7 50:10
faxed 50:11
February 54:20 60:3 62:22 65:5
Fed-ex 33:20
feel 13:3
felt 16:7,19
femur 32:14,19
fill 8:24
filled 51:14
filling 28:8
films 33:20
find 32:9 38:6
finding 47:7 51:2
fine 61:24
finish 5:18,20 25:17
Flaxman 4:1,10,20 8:10 12:15 14:8 17:4 20:21 31:2,14,18 37:20 43:18,22 64:11 65:11,16 68:18 69:1 71:17 72:1,12
floating 35:2
followup 24:6 31:20 37:14 47:17,19 61:12,20
forgot 32:3 60:22,24
form 45:20 46:6,8,10,17 53:15 58:21 59:5 63:18 70:12
formed 71:4
forms 59:9,12,14,17
Fortunately 21:24
found 6:19 21:7 67:16
fracture 34:24 35:1
frame 69:12
Friday 11:23
front 65:21
fully 6:10

G

Gary 4:17
gauge 39:15
gave 9:17 16:4 27:1 67:12 69:8
general 18:23 36:9 68:12
generally 65:23
gentleman 15:10
get along 12:13
getup 45:12
give 5:13 17:8 21:16 22:9 30:11,12
good 22:10 43:16 60:14, 16,20
grossly 24:1
group 27:6
guard 18:16
guards 45:11
guess 9:1 11:8 29:20 39:18 42:12 52:17 69:15 70:14
gunshot 32:17
guys 68:13

H

habit 25:21
half 7:13 70:1
handle 73:2
handwrite 20:22 21:1
handwriting 23:16 52:10 53:18 57:17
handwritten 20:3,10
happened 54:23
head 23:24 26:18
header 50:11
headquarters 17:20
heads 12:7
health 4:17,19 6:14 7:1,5 9:12 12:6,13,16,20 15:4 18:12,14,21 19:1 44:14,22 56:18, 24 70:11
helpful 25:22
helping 13:22
Hey 69:11
high 34:20 37:9 40:10
hindsight 39:21
holiday 64:24 65:3
honest 12:3 63:12
hope 7:19
hospital 41:15 47:6
housed 68:6,8,9
huge 16:17
Human 69:9

I

I-N-T-R-A-M-E-D-U-L-L-A-R-Y 33:1
IDOC 22:16,24 31:13 45:3 55:13,15,18 70:3,5,7
Illinois 7:6 9:3,6,15,22 10:14 15:1
incision 61:3
included 24:4
Incorporated 70:11
increased 26:21
Indiana 4:17 7:5,7,12 8:13, 19
infirmary 17:10 18:20,22 19:5 36:8 57:12 68:6,8,10
information 9:17 13:24 69:21
informed 45:4
initial 62:24 63:1
initialed 25:10 61:16
initials 24:12,16 25:9,24 35:10,11,19,21 42:2 46:4 50:14,15
initiated 36:11
injuries 30:12
injury 15:11,12 26:17,18 27:12 28:3,13,23 29:2,18 32:17 34:18 36:10 70:20
inmate 18:16 21:18 23:19 26:17 27:11 37:4 44:11 45:9,21 46:7, 18 59:8 70:20
inmates 9:1 13:16,17 18:13, 23
inquired 12:22
inquiring 20:16
inserted 32:23
interest 67:17
interior 51:9
interpret 14:1 33:6,8

interpretation 34:13,15 36:4
interpreted 13:23 52:2
interruption 8:5 16:22 20:7 37:16
intervention 37:10 38:8 39:7,14
intra' 32:21
intramedullary 32:14,22,24
investigation 14:9,16,18,20
involved 44:20 46:12
issue 21:11

J

J-A-M-E-S 4:14
James 4:5,13,20 30:8 57:19 58:8,10 68:21 72:15
Jana 42:8
January 9:9 11:7 45:16 46:21 47:4,22 48:9 49:4,13
jerk 28:2,15
job 9:12
Joel 4:20 43:16
Johnny 4:21 15:5,7 23:9 34:6 56:6
joint 34:17,19
jointed 68:16
Jones 4:21,22 5:1 15:5,7 19:7,24 23:9 29:3,10 34:6 36:17 39:10 44:1,3 47:21 48:5 49:19 50:20 51:12 53:9 56:6 57:3 60:1 61:20 64:12 66:14, 19,23
Jones' 64:3 71:5
Joseph 55:2
judgment 13:4 14:5
jumped 51:22 52:3

K

kind 30:4 55:15 68:15
knee 15:11,18,19,23 17:13 26:18,21,22 27:1 28:2,10,15 32:1 34:17,19,20 35:2 37:5,6,11 40:16 41:8 47:7 52:20 60:13,17 66:15 67:5,7,10,14, 18 68:11
knew 24:13 39:23 49:23 63:22
knowledge 66:4
Kristin 31:5,9

L

label 22:24
lack 13:6
landed 15:17 28:14
lawsuit 4:22
lawyer 6:19
laxity 15:21,22 16:10
lay-in 27:4
LE 27:20
learn 64:6 69:3
learned 7:14 69:2
leave 8:23 11:4 12:1 13:8
left 12:23 15:11,18 26:18,20,22,24 27:18,19 32:1,20 34:20 37:4,6,11 41:8 47:7 52:20 60:13,15, 17 69:18
leg 32:20 47:9
likes 39:16
limits 24:1
listed 10:2
lobby 18:14
local 41:10 44:16 52:16
locally 41:7,9
located 55:7
long 6:24
looked 19:17 26:4 29:2 30:19 48:18 59:4 65:17
loose 28:9 34:23 35:1
lot 20:3 64:17,19 65:17, 20
lower 26:20 27:18,20 47:7 60:15

M

M-A-I-D-E-S 55:2,23
M-A-R-R-A-M 4:19
M-A-R-S-H-A-L-L 4:13
M.D. 4:5 13:3 25:16,17,20 26:10,16 36:19 41:6 45:20 49:12 57:19 60:6,12 62:17
machine 41:13,17 44:17
made 10:20 21:20 23:8 38:19 49:8 65:18 66:24 67:11,13,20
Maides 55:2,6,7,23,24 57:8
make 6:6 14:5,9 16:13 22:8 24:13 25:5 28:4,14 45:10 53:4 72:16
making 23:7 40:11
man 4:21
management 17:2 38:5 61:14,15
manually 43:3
Marram 4:16,18 6:13 7:1 9:12
marrow 32:23
Marshall 4:5,13
meaning 7:17 15:22 16:11 21:6 24:5 28:15 34:21 35:11,23 47:5, 9 48:18 50:17 56:11
means 37:23 38:2 42:10 58:5
meant 39:4
med 37:14,17,21 38:2
medical 6:4 7:4 8:16,18,20, 22 9:8,20 10:7,13, 17,18,20,24 11:10, 12 13:14 14:2 19:20, 24 20:5,9 22:17,24 23:4 43:2 59:13 69:22
medications 24:6
medicine 21:16,19
meds 16:4 17:8
meeting 41:4
metal 32:19 68:16
Midwest 51:15 52:16 53:9 64:1,2
mild 34:19
milligrams 27:2 37:12,13 47:18
minute 19:15
moment 44:7
Monday 11:22
month 10:19
months 9:11 11:2,4,9 47:19
motion 47:9 60:16
motor 32:18
Motrin 27:2 30:6,11 37:11 47:18
move 47:9
movement 15:22 16:11 28:9,11 40:7
MRI 37:11,24 38:4,8,12, 15,16,18 39:7,14,20, 22,24 40:2 41:7,13, 17,24 43:24 44:4,11, 12,17 45:20 46:11, 16 47:6,17,19,21 48:1 49:22 50:1,4,8 51:2,3 52:4,20,22 56:19
Multiple 59:12

N

named 4:21 55:2
names 45:1
nausea 23:20 24:2
needed 7:9 8:24 24:6 39:10, 13 44:11 46:17 49:19 50:20,23 51:3
nice 55:15,17
normal 24:1
notable 37:5 40:4,5,20
notation 26:10
note 23:4 25:16,17,20 26:10,16 28:21 31:24 36:19 37:2 38:19 40:23 41:6 43:4,5 45:16,20 46:20,21 47:3,4 48:18 49:12 57:13
noted 15:20 16:18 32:2 42:4,11,12,14
notes 20:10 21:4,12 23:5,8 25:5 30:2,3 34:7 36:2,13,16 46:1,15 48:9,12,13,21 49:4, 8,11 57:6 58:1,7 59:24 60:6,12 62:6 65:17,24
noticed 23:20
notified 30:8 57:19 58:1
notify 58:3
November 15:15 26:12 29:3 31:19,21 69:17
NRC 10:3 11:6
number 19:19 22:16 28:20 69:9
numbers 22:22
nurse 13:21 24:22 25:8,24 26:4 31:3 42:8 48:13,21 49:4,7 57:13,15,24 58:3,14
nurses 22:5 25:5 67:9

O

object 12:4 71:23
Objection 13:10 30:24 64:9
objective 21:6 47:7
observations 48:4
Occasionally 34:5
occasions 67:7
occurred 26:19 27:12 28:3,13 35:4 37:22 68:9
October 11:1,12 12:2 69:19
odd 30:5 55:11
office 18:13,18 25:1 44:14, 23 56:19,24
offsite 33:13 62:2
onsite 33:15
operate 39:16
opinion 63:18 71:5
opinions 71:12
order 19:7 21:21 22:10,13 27:3 29:20 37:23 52:1 58:5,9
ordered 21:24 31:21 50:8
orders 22:8 30:9
origin 51:8 52:22
ortho 37:10 38:8,11 39:6, 14 40:1 47:17 49:24 51:15 52:16 61:12
Orthopaedic 52:16
orthopedic 37:24 38:3 39:19,22 49:17,20 50:20,24 51:12,16 61:23 62:7, 14 71:6
orthopedics 38:16,18 53:9 64:1,2 71:10,13
orthopedist 61:21,23,24
osteoarthritis 34:17
outcome 64:3,6
outstanding 63:7

P

P-A-T-E-L-L-A 16:14
packet 59:9
pages 26:8 31:15 70:21
paid 8:11
pain 16:2,3,4 17:7 26:21 27:2 37:5 40:14,18, 19 47:8,9 60:14
paper 21:12,15
part 29:18
past 69:24
patella 15:21,22 16:10,13 19:12 26:23 34:20 37:6,7,9 40:5,7,10 41:8,19 47:11,12 51:9 60:13
patellar 27:1,23 28:5 51:7 52:21 60:17
patient 12:10 13:2 15:4 17:3 20:24 21:3,5 23:3,22 26:18 37:6 66:2
patient's 40:14
patients 8:21 9:1 18:11,13 19:4,5 24:23 41:12 56:3
pause 31:17
payment 7:20
payroll 69:14
permanent 10:20 11:12
permanently 66:15
persistent 37:4 40:14
person 17:17 25:10 33:18
personnel 44:24 67:9
pharmacy 21:18
phone 17:22 43:13 58:6
physical 36:11 67:1
physically 69:13
pile 22:9
place 38:17 39:24 60:18, 21
placement 32:19
plan 21:9 24:4 26:24 38:5 47:16 57:22 61:10, 14
plans 61:19
playing 15:11,17 26:19 27:12
population 18:24 36:10 68:12
post 37:14 47:5,19 52:20 60:13 63:6
practice 52:17 65:24
practitioner's 52:24
pre-chart 13:15
preference 39:6

prescription 21:17
present 16:19 17:6 61:14,15
presentation 15:24
presented 15:14,16
presently 13:18
pressure 23:21 24:24 25:7 26:6
pretty 15:23 16:8 17:1 30:2,12 35:3 36:3 39:15 46:13 63:5 65:2,6 67:5 72:7
prevented 66:19
previous 32:17 34:18 43:2 51:13,20
primarily 6:24
printed 67:2
printouts 67:12
prison 19:21 50:12 62:14 66:12
prisons 10:14
private 64:17 65:9
PRN 6:19 7:6,8 69:22
probable 37:7
problems 23:23
procedure 44:10
process 44:19
produced 22:23
progress 57:12,13
provider 59:2
pulse 25:7
purely 32:16
put 21:12,15 24:1 27:3 30:3 39:22 44:13 51:16 57:1 68:2 70:14

Q

question 5:14,19,20,23 10:11 17:3 20:12 23:1 39:9 48:21 71:21,24
questions 5:1 6:10 19:16 20:14
quick 64:21 65:2,6,8,11
quicker 64:17,19 66:19

R

R-I-T-Z 43:11
R.N. 13:2 28:21
radiologist 33:12,21
range 47:8
rate 25:8
rationale 51:17 52:18
reaction 28:2
read 8:8 24:12 26:15 27:5,16 33:11,13 34:13 37:2 45:19 47:3 48:4 51:18 60:11
reading 30:2,6 33:18
reason 6:9 13:21
recall 5:9 17:9 19:13 29:11,13,14 32:13 36:2 41:15 44:24 46:14 49:19 57:3,6 59:3,5 63:15 69:7,10
receive 7:20
received 64:12,16
recently 19:17
recess 43:20 65:14
recollection 59:20
recommend 39:19 43:4 72:24
recommendation 21:20 54:8
recommendations 13:6 49:24 56:9,11, 15 66:24 67:2,12,14, 16,20,23
recommended 30:3,7,8 40:2 54:4 57:1 67:4
recommending 38:20
reconstruction 60:14,17
record 8:7,8 22:21 29:7 31:14 37:19 39:2 42:19,22 43:2 46:24 66:1
recorded 25:8 26:4
recordkeeping 13:14
records 14:2 19:10,11,15,17, 20,24 20:2,5,9 22:10 44:6 66:8,11
referral 37:10 38:8 39:11,13 43:5 51:14,17 52:9, 19 53:18 54:9,17,19 56:1 70:14
referred 22:3 52:13
referring 23:6 35:18 50:5 52:24
refills 24:5 45:21,23 47:18
registration 14:19
regular 10:9 11:22 19:1
regularly 18:1 66:7
rehab 67:2,13,17 68:4
related 15:5 72:2
relating 19:24 71:19
relationship 14:7
released 68:10
relevance 12:4 13:10
relying 40:8,12 71:12
remember 9:10 15:7,9,10,12 19:9 31:5 42:9 61:4
removal 61:13
Repeat 56:21
rephrase 5:24
report 28:23 29:3,9,18 32:7 33:10 34:1,6,9,12 36:1 50:2,4 51:2,14 52:9,22 53:17 62:8, 13 63:4,13,15 70:21, 22,23 72:6
reported 23:22 67:8 72:16
reporter 6:6 8:9 20:12
reports 23:23 26:18 27:11
represent 4:21
request 44:14,15 58:21
requested 8:9
requesting 59:2
required 32:18
resigned 9:13
resolved 24:3
Resources 69:9
respiratory 25:8
response 43:2,4
responsible 56:20,22
rest 17:12
rested 40:16
resulted 43:24
results 47:20,24 49:22
returned 47:5 59:14
returns 38:5 59:11
review 19:11 29:14 30:15 38:17 54:2 62:17 70:24 71:2 72:15 73:1
reviewed 29:10 30:18,21 34:9 35:12,14,23,24 48:18,24 49:5 50:17 62:21
reviewing 50:19 51:11 72:22
riding 19:12 34:20 37:9 40:9,10
Ritz 38:10 39:16 43:7,14 53:5
Robin 12:18,19,24 13:22 70:2
Robinson 18:6
rod 32:14,19,22
room 27:8
rooms 18:24
Rose 12:18,19,24 70:2
Rudolph 58:12
rule 26:23 27:1,22 28:1, 5,15 37:8 41:8,18,23 47:11,12
ruled 41:20
rupture 26:23 27:1,23 28:5 37:7,8 41:8,19 47:12

S

schedule 10:9 11:22 44:17 45:5 61:12 65:3
scheduled 45:10 46:17 56:19 61:20
scheduling 44:19 45:20 46:11 56:20,22
season 64:24 65:4
secretary 22:5
sector 64:17 65:9
SEN 35:17
send 59:8,9 62:8
senior 16:24 17:17
sensory 60:16
separation 51:9
September 10:21 11:11
services 43:5
shared 69:20
Sheridan 5:2 10:3,19,21,24 11:13,16 12:17,20 18:7,9,10 34:2 41:16 66:8 69:6,7,16
short 8:5 16:22 20:7 31:16 37:16 43:17,19,20 65:14
shorthand 27:20
show 13:20 19:15 28:19 34:16 44:6
showed 13:22 19:9,12 34:16 49:22
showing 72:7
shows 72:11
side 25:9 27:22 29:21,24 32:10
sign 30:15 71:2 72:24
signature 30:16 35:21 52:23, 24 55:1 73:2
significant 40:18,19
signing 25:2,4 72:22
similar 15:24
sir 29:12 31:1 35:8 39:1,9 42:15 46:8,14 51:1 59:21
site 32:4
slight 40:6
slightly 15:20 23:21 34:20, 21 40:9
Small 34:19
SOAP 21:4
somebody's 35:19
sooner 30:22
Sounded 71:18
Sources 70:11
speak 38:23 45:12
special 27:3 43:5
specialist 62:8,14
specialty 58:21 71:9
specific 59:19
Speculation 30:24
spell 4:11,18 6:5 16:12 32:24
spot 22:1
stack 65:20
staff 21:23 22:4
stamp 24:8,10,17 42:1,4 46:3 47:14 48:14,17, 23 49:5 59:1 62:16
stamped 59:4 61:16
stand 60:22
standing 21:4,6
stands 21:8,9 27:19,20 61:15
start 36:19
started 11:5
starting 9:9 12:1
Starts 22:16
state 4:11 8:20 63:8
stated 63:16
states 50:7
Stateville 10:3 11:6
status 37:14 47:5,19 52:20 60:13
stay 18:24
staying 67:14
Stock 69:8
stored 66:11
stuck 13:7
subjective 21:5 27:22
submitted 54:10
success 63:9,11,16,19 71:6
sudden 68:4
superior 16:20 38:10 51:9
surgeon 61:23 71:6
surgery 54:5,10,17,22 56:8, 16,20,23 57:2,4 63:7,8,11,16,19 64:4,7,13,16 66:18 67:4,11,20,21,22 68:7,9 71:5
surgical 63:6
swear 4:1
swelling 16:1,17 26:21 34:19 37:5 40:18 47:8
switch 56:4
swollen 15:20
sworn 4:4,7
system 22:1

T

T-O-R-R-E-S 31:7
T/o 58:5,8
table 18:18
tablets 45:23
takes 24:23

talk
38:5
talking
6:3 51:19 67:19 68:22
tear
49:23 51:7 52:21
technician
34:5
technician's
32:3
telephone
58:4,5,9
telling
24:4
ten
16:2
tendon
37:7,8 41:8,19 51:8, 10 52:21
terms
6:4
testified
4:7 70:2
therapy
36:11 67:1
thing
18:20 27:21 55:11
things
5:12 12:8 13:7,9 17:11 22:6 24:24 27:9 40:3 61:19 65:3
thinking
18:9 39:18 69:18
thought
13:17 71:18
Thursday
18:2
time
5:8 6:15,24 7:1,10, 18,23 8:3,11,15,21, 22 9:2,5,14 11:15 12:22 13:22 14:5,7, 18,22,24 15:19 16:1, 4,6,18 20:10 21:9 23:19,22,24 24:15 26:20,24 28:6,8 30:4 33:21 34:16 36:4 38:1,6,13 39:18,23 40:14,17 43:16 44:9 45:1 55:9 56:4,5,16 64:22,23 65:1 66:1,5 67:1,2 68:7 69:12 70:5 72:12
timely
64:13,18
times
21:19 22:7 27:3,4 45:24 62:4 69:19
title
8:15
today
6:11 7:14 24:5 69:2, 3
toe
24:1
toes
60:16
told
6:19,22 15:17 50:23 69:16
top
25:6 35:22 49:11 50:14 52:10 57:22 62:23 70:10
torn
51:10
Torres
31:5
training
71:9
transcript
72:16,21
transition
20:8
transmitted
33:17 34:2,8
transmitting
59:17
transportation
45:11
traveling
7:4 8:16 9:8 10:18 11:7,10 69:22
treatment
5:1 16:7,16 17:7 30:6 36:4,7
trump
13:9
trumped
13:7
trumps
13:4
turn
22:19 26:8 40:21 42:16,17 57:9
type
15:12 68:12,16

U

Uh-huh
52:6
Um-um
57:23
underneath
27:11,15 36:19 53:17 60:12
understand
5:3,15,21,23,24 12:22 20:13 23:5 39:4,8 55:13 63:3
unit
18:12,14,21 19:1
upper
32:20 62:23
urgent
60:24

V

vacation
8:23
Valley
41:14 47:6
vehicle
32:18
verbal
5:13
verbatim
34:14
verify
14:6
versions
35:6
versus
4:22 37:10 38:8 39:5 47:12
visit
47:6
vitals
24:24 25:14,15 26:4
vocabulary
23:7

W

w-r-i-t
37:17
wait
5:17,20
waive
72:21,24
wanted
16:12 24:13 28:4,11, 14 39:4 65:23
weapon
68:14
Wednesday
18:2,4
week
11:20 16:24 17:15 18:3 69:4
weekly
17:16 43:15
weeks
27:3,4,5,10 37:12,14 40:17 45:24 69:17
weight
25:7
weightbearing
17:12 40:15
West
41:14 47:6
Wexford
4:22 6:18 7:5,11,21 8:12 9:3,6,7 11:3,5 12:11 14:9,24 17:18, 19 31:11 38:10 43:9 45:2 55:10,12,14 66:9 68:23 69:3,6,7, 9,11,13 70:6,10
word
25:13 27:15 32:21 61:5
words
6:5 13:6 20:23 25:15 35:1 41:24
wore
67:9
work
6:23 7:6,11 8:1,13, 22 14:23 44:15 69:24
workday
11:18
worked
6:20 7:3 9:5 14:24 16:9 66:8
working
7:4 11:4 39:17 55:6
works
44:22 55:14
wound
32:18
wow
32:12 60:22
wrap
16:5 17:9
writ
37:14,17,21 38:2 59:13
write
25:20 30:17 41:5 43:3 49:16 52:15,18 60:9 61:7
writing
24:20 25:12 26:10, 11 27:5 30:1
written
21:17 53:7 60:6
wrote
26:15 27:11 36:24 39:5 40:4 41:18 42:7 52:1 53:14 60:11

X

X-RAY
19:7,9 21:21,24 22:1 26:24 28:6,12,17 31:20 32:1,7 33:10, 15,20 36:1,5 37:8 40:8,9,12,13 41:24 52:2
X-RAYS
22:2 32:4

Y

Y-O-U-S-E-F
33:23
year
7:12 8:13 9:13 70:1
years
5:10 6:21 39:18
Yousef
33:22

Z

Zantac
37:13 45:23

EXHIBIT C

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

Johnny Jones,)
)
Plaintiff,)
)
vs.) No. 17-cv-8218
)
Wexford Health Sources, Inc., a)
foreign corporation, and)
Dr. Marshall James,)
)
Defendants.)
)
_____)

VIDEOCONFERENCE DEPOSITION OF NEIL FISHER, M.D.
Phoenix, Arizona
January 7, 2019
9:02 a.m.

Reported by:
SHANNON STEVENSON, RPR, CCR
Certificate No. 50461

INDEX

(WITNESS) PAGE LINE
NEIL FISHER, M.D.
By: Mr. Flaxman..... 4 12

* * *

EXHIBITS

NO. DESCRIPTION PAGE LINE
(No exhibits were offered.)

VIDEOCONFERENCE DEPOSITION OF NEIL FISHER, M.D., commenced at 9:02 a.m. on January 7, 2019, at the offices of BARTELT NIX REPORTING located at 111 West Monroe Street, Suite 425, Phoenix, Arizona, before SHANNON STEVENSON, Certified Court Reporter, Certificate No. 50461, for the State of Arizona.

* * *

APPEARANCES:

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Phoenix, Arizona
January 7, 2019
9:02 a.m.

NEIL FISHER, M.D.,
called as a witness herein, having been first duly sworn, was examined and testified as follows:

* * *

EXAMINATION

BY MR. FLAXMAN:

Q Could you please state and spell your name for the record.

A Dr. Neil Fisher, N-e-i-l, F-i-s-h-e-r.

Q Dr. Fisher, my name is Joel Flaxman. I represent a man named Johnny Jones in a case in the Northern District of Illinois captioned Jones versus Wexford, Case No. 17-cv-8218. I want to ask you some questions today as the representative of Wexford. Do you understand that?

A Yeah.

Q Because we are communicating by phone and video, it's extra important for this deposition that I'll wait for you to finish an answer and ask you to wait for

me to finish my question before speaking. Is that all right?
A I understand.
Q Okay. And as you've been doing, please give verbal answers yeses and nos instead of shakes of the head or nods.
A Yes.
Q Is there any reason that you would be unable to truthfully and accurately answer my questions today?
A No.
Q Dr. Fisher, have you reviewed the deposition notice in this case?
A Yes.
Q Okay. And is it correct that Wexford Health Sources has designated you as to the matters addressed in the deposition notice?
A Yes.
Q Okay. What have you done to prepare for today's deposition?
A I looked at parts of patient Jones' medical record, I discussed the case with my attorney, I read the complaint, looked at the deposition notice, and I also read the WexCare utilization notes -- W-e-x-C-a-r-e utilization management notes in this case.
Q Can you tell me what the utilization notes are?

A They are screen shots from our software system that helps us track authorizations.
Q Since I'm sitting in a different city, I can't hand you a piece of paper. Sandy, do you have a copy of those in front of you and we could put on the record what the Bates numbers are?
MS. BYRD: I don't have a copy of it in front of me, and that's what I'm looking at to see if I can figure out what the Bates numbers are. Looks like Wexford 134 through 145.
MR. FLAXMAN: Okay. So could we stipulate that the WexCare utilization notes in this case have the Bates numbers you just read?
MS. BYRD: Yes, unless you have something different in front of you. I'm looking at my responses to the interrogatories, and that's where they're numbered. I don't remember producing something after, nor do I believe anything different exists. But just in case you have something different in front of you, I want to make sure.
MR. FLAXMAN: I don't. Those are the exact pages I'm holding. If you go back to your office and it changes, just let me know.
MS. BYRD: Okay.
MR. FLAXMAN: We'll understand, okay.

Q BY MR. FLAXMAN: Dr. Fisher, was there anything else you did to prepare for the deposition?
A Not that I recall.
Q And when you said you talked to your attorney, I'm not going to ask you, of course, what you talked about, but did you mean Ms. Byrd who is sitting next to you?
A Yes.
Q And I want to ask you more about the utilization notes. You said that they're screen shots from software that tracks -- I'm sorry, I didn't hear what you said. They track what?
A The authorizations.
Q What's an authorization?
A When someone is going off-site for a procedure, a test to see a consultant, we will receive a bill in afterwards, so we authorize that prior so that the place that's doing the study -- the consultant or the hospital or the place where the procedure is being done -- will know that they are going to be paid for that which is authorized.
Q And you said you'll get a bill in afterwards?
A Yeah. We will receive a notice for payment, a bill.
Q Okay. I thought that might have been a buzz

word that I didn't understand. I understand now.
And how is -- how is an authorization created?
A Well, it starts with the generation of a consult by the site.
Q Meaning that a medical professional at the prison does the consult?
A Yes. So either a nurse practitioner, a physician assistant, or a physician or a dentist or an optometrist would write a request for either an off-site study or an off-site consult or an off-site procedure. And that would be sent to our corporate utilization management department.
Q And to be clear, the procedures and policies and practices that I'm asking you about and that you are answering are what were in place at Sheridan Correctional Center in November of 2015?
A Yes.
Q How does the person at the site write the request?
A It's written -- handwritten on an Illinois Department of Corrections' form.
Q And then you said they transmit it to the corporate utilization management?
A Each site has a slightly different way of doing it, but it would be given to typically an individual

Page 9

who's an administrative assistant, consult coordinator who would be in communication with that site's corporate utilization management nurse. And it's either scanned and sent via email or faxed to that nurse.

Q The administrative assistant who transmits it, is that person a Wexford employee?

A Typically an IDOC employee.

Q And it gets transmitted to a nurse at corporate; is that right?

A Yes.

Q And so that nurse to whom it's transmitted, that person is a Wexford employee; right?

A Yes.

Q And what's the next step after that?

A Well, along with that consult form should come supporting documentation to explain the consult. If it's following up on a fracture, we would want to receive the X-ray report detailing what the radiologist says about the fracture. If it's sending someone to a cardiologist, we'd like to see an EKG, we would like to see a chest X-ray. If we're sending to different specialists, it's relevant information related to that consult. Including, if the person has been to that consultant beforehand, any prior notes from that consultant.

Q When you say we would like to see, who are you

Page 10

referring to?

A Corporate UM.

Q And for the record what does "UM" mean?

A Utilization management department.

Q After that material that you described is transmitted to corporate UM, what happens next?

A If it's a routine referral, then a collegial review call would be -- is on the schedule. We have collegial review conference calls once per week where we discuss these routine off-site consultations.

Q What's a collegial review call?

A It is typically the UM nurse, the UM medical director assigned to that contract or that individual site, the site medical director, the consult coordinator, and frequently the healthcare unit administrator who is an IDOC employee are on a scheduled conference call to discuss the off-site consultations.

Q And do the participants in the collegial review make a decision about the off-site requests?

A Yes.

Q Meaning they decide whether to send the person for the off-site care or not?

A It's either approved or an alternative treatment plan is developed.

Q Okay. And is that -- well, how is the decision

Page 11

made?

A The case is discussed among clinicians and also the participants in the call and trying to determine medical necessity, medical appropriateness, staging of different items, guidelines, policy.

Q And is there a vote on what to do? How is the final decision reached?

A It's clinicians talking to clinicians. So typically the case is discussed, the UM director is typically the one that leads the call, but the on-site clinician or clinicians present the case and the case is discussed. There are some at the time of the collegial call that are just approved off the top. Dr. Ritz who was involved in this case is our corporate director for utilization management and he's very experienced with doing these collegial calls. If someone has cancer and they have had scans and they need to see their oncologist back, you don't have to do a lot of discussion about that. So you approve things off the top. So a new fracture -- displaced fracture will need to see a bone doctor, will need to see an orthopedic physician, so that's approved off the top.

Q In your review of the collegials related to Mr. Jones, did you see any that were approved off the top?

Page 12

A It doesn't say that in there. It would just say the case was approved during collegial because it's happening during the collegial call.

Q Based on the notes, you can't tell if it was approved off the top as you were describing?

A I can't tell that in a typical note written from UM.

Q Okay. What we were just discussing I believe you said was for a routine referral; is that right?

A Yes.

Q What would a non-routine referral be?

A If something is emergent where you are calling 911 or sending someone to the emergency room, no type -- no prior authorization is needed. So we review those retrospectively for appropriateness, but no prior authorization is needed for them. If something is requested in an urgent manner, which means that the review needs to occur before the next scheduled collegial call, if you had someone see an eye doctor today and they say I want to see the person tomorrow, and your collegial is not until Friday, you send it in as an urgent consultation, it's reviewed, and the observation would be given for the follow-up tomorrow.

Q Okay. And in describing that you said you send it in. Who do you mean by "you"?

A The site sending it in requesting that.
Q Okay. And to be clear, you described an emergent situation which would be a 911 call sending someone to a hospital?
A Sending someone to a hospital ER particularly.
Q Okay. And then the other situation was an urgent situation; right?
A Urgent consultation prior to the next collegial review. If your -- if you get notice back at 11:00 in the morning that ophthalmology wants to see the person tomorrow and your call is at noon, you would still send it in urgently because usually we prepare for these things in advance, but you would have some time to put it on the schedule for the noon call.
Q And if there wasn't a call scheduled the next day, what would happen to an urgent request?
A We review those without having typically a collegial review call. We review on the appropriateness. If there's a question, questions can be emailed back and forth to the clinician or to the site or the UM doctor can call the clinician requesting additional information.
Q In reviewing the material for Mr. Jones, did you see any urgent referrals?
A I did not, not that I recall.
Q Would an urgent referral be reflected in the

notes? Where in the documents would an urgent referral be reflected?
A It would typically be written on the consult itself.
Q What do you mean? What's the consult?
A The form from IDOC, and they would write on there the word urgent.
Q And who do you mean by "they"?
A The clinician involved with writing the consult.
Q Would that be the clinician on-site?
A Yes.
Q Okay. So in the example you gave me of the ophthalmologist who says I need to do surgery tomorrow, is that what you are referring to?
A They ask for follow-up the next day. So an off-site consultant makes recommendations. So they may make recommendations to the primary care physicians on-site or clinicians on-site. And then the clinicians if they wish to follow through with that plan of care would be the ones completing the IDOC paperwork -- on-site clinicians. Based on the recommendations from the off-site consultant.
Q Where is that paperwork kept?
A Which paperwork?

Q The -- you just referred to the IDOC paperwork that the clinician on-site would create.
A That is kept in the patient's medical record, IDOC medical record.
Q And it's also transmitted to Wexford to review?
A Yes, along with supporting documentation that would also be in the patient's record.
Q Okay. The word I was missing was sent to the utilization management department; right?
A Yes.
Q Very early you told me that one issue -- one reason for these consultations is to authorize a procedure and appointment so that the provider will know that they will be paid?
A Yes.
Q Are there any other reasons for this process of approving off-site care?
A Well, we also will accrue for the expenses that are going to be involved with it. We are a business and we will accrue for potential expenses of what we anticipate for a particular off-site visit. Our contract also with the IDOC expects us to monitor off-site care and utilize off-site care services appropriately and in clinically appropriate ways. There are significant costs to our client to transport someone off-site also. So we

are expected to do care on-site of what we are capable of doing and then utilize off-site services when it's a procedure or specialty that is needed that is not available on-site.
Q And the client is the Illinois Department of Corrections; right?
A Yes.
Q After a referral for off-site care is approved, what is the next step?
A That the UM nurse will type a note into the utilization management WexCare system explaining that the authorization was approved, the system generates an authorization, and that is sent to the site. Many consultants will require an authorization number prior to scheduling an appointment.
Q Meaning a number from Wexford?
A An authorization number, yes. And it details in the authorization what services are being approved.
Q We've been talking about the WexCare system --
A Yes.
Q -- correct?
A Yes.
Q Is that a -- is there a name for that software or is WexCare system the name of it?
A WexCare is our UM software system.

Q And how is the authorization sent to the site?
A Electronically.
Q And what happens next?
A The site when they have authorization has on that printed authorization what services are being authorized, they can -- the site then schedules the appointment with the hospital, with the specialist, with the radiology provider, whatever it is.
Q And do you know who at -- well, do you know who at Robinson in November of 2015 was responsible for making the scheduling?
MS. BYRD: Do you mean Sheridan? I'm going to object. He was at Sheridan, not Robinson.
Q BY MR. FLAXMAN: Oh. Do you know who at Sheridan was responsible for making that scheduling in November of 2015?
A I don't know the individual person.
Q Okay. What was it a Wexford employee or IDOC employee?
A Typically it would be an IDOC employee.
Q And would the person scheduling also have to coordinate with IDOC to arrange transportation?
A Yes.
Q You said you looked at Mr. Jones' medical records; is that right?

A Parts of his records, yes.
Q And you also looked at the WexCare utilization notes related to Mr. Jones?
A Yes.
Q Were the policies, practices, and procedures we've been discussing properly applied to Mr. Jones?
A I didn't review them to that level of detail to say that everything was in compliance. I didn't look at it in terms of that. I can say I didn't see anything out of line, but I didn't look at it to that level of detail.
Q I just want to ask the question more narrowly in terms of reviewing the WexCare utilization notes. In those notes were the referrals and the approvals done in line with Wexford policies and procedures?
A And, again, I did not review them to that level of detail to check line by line. I looked at them for general familiarity with dates, general familiarity with what we were authorizing.
Q Okay. And based on your general familiarity, did you observe anything that was out of line with Wexford policies and procedures?
A I did not.
Q Are there written guidelines or policies that describe the procedure we've been discussing about off-site care?

A Yes.
Q What are those?
A There's two sets of policies. One is the Illinois Department of Corrections administrative directives that reference off-site care, there's also the Wexford Utilization Management Guidelines, Region Illinois that describe the process in more detail. There may also be some site institutional directives related to that. Site meaning Sheridan and institutional directives would be written by IDOC employees, but I don't know those if they exist or not.
Q Have you taken any steps to determine if there are site institutional directives?
A Those are IDOC and it would be state at the site level, so I would not have access to those.
Q Who would have access to them?
A If there are institutional directives, the person to ask would be the healthcare unit administrator of the individual site.
Q Is that person a Wexford employee?
A No. It would be an IDOC employee.
Q Are there Wexford employees who have to follow those institutional directives?
A If there are institutional directives related to off-site care at an individual site, that's part of

the guidance that we are following. So Wexford's clinicians would be following that if there is something particular in there. I think it would be unusual for a site to have institutional directives related to off-site care, but it's a possibility. And instead of unusual, I should say uncommon would probably be the better word.
Q Those are the site directives. You also referred to IDOC administrative directives; is that right?
A Yes.
Q And are those directives that apply throughout the Illinois correction system?
A Yes.
Q And some of those are about off-site care; is that right?
A Yes.
Q Have you reviewed those?
A I didn't for this deposition. I'm generally familiar with them. They are relatively vague describing this process. The Wexford guidelines go into much more detail related to this.
Q Is the collegial process described in the IDOC directives?
A I don't believe so.
Q Is any kind of authorization process described

in the IDOC directives?
A I did not review it as part of this deposition, and I am not an expert at IDOC administrative directives, so I wouldn't want to guess.
Q The authorization process through the collegial is contained in the Wexford utilization management guidelines; correct?
A The collegial review process is described within those UM guidelines, yes.
Q I just want to ask about the utilization notes generally. Do you remember the utilization notes?
A The WexCare notes, yes.
Q And I believe you said that a utilization nurse is responsible for creating those notes; is that right?
A Yes. There's parts of it that are generated by the software, but the typed portion within the body of those screen shots is written by a utilization management nurse. It could also -- we have people within our utilization management department who add some additional information who may not be nurses but work within the Wexford corporate office. For Illinois only Wexford corporate staff have access to that system.
Q Okay. That was my question. Are there any other notes created related to the consideration of a request for a referral?

A We encourage our clinicians to also document it in a medical record that the collegial review occurred and the decision of the collegial review, the approval or the alternative treatment plan.
Q What about the -- there's a doctor in the utilization management department who is involved in the collegial; is that right?
A Yes.
Q Does that doctor create notes about the collegial?
A No. It's all part of that discussion and that UM nurse is summarizing the discussion during the collegial review, or the off-the-top approval.
Q I think you mentioned it before that it was Dr. Ritz who was the doctor reviewing for Mr. Jones' referrals?
A Yes.
Q And in 2015 and 2016 was Dr. Ritz based in Pittsburgh?
A Yes.
Q Does he still work for Wexford?
A Yes.
Q Is he still based in Pittsburgh?
A Yes.
MR. FLAXMAN: I don't have any other questions.

MS. BYRD: I don't have anything.
MR. FLAXMAN: You want to waive?
THE WITNESS: Yes, we'll waive.
(Whereupon the deposition of NEIL FISHER was concluded at 9:44 a.m.)

* * *

(Signature was not requested.)

STATE OF ARIZONA)
) ss
COUNTY OF MARICOPA)

BE IT KNOWN that the foregoing deposition was taken before me, SHANNON STEVENSON, a Certified Reporter in and for the County of Maricopa, State of Arizona; that the witness before testifying was duly sworn to testify to the whole truth; that the questions propounded to the witness and the answers of the witness thereto were taken down by me in shorthand and thereafter reduced to computer-aided transcription under my direction; that the foregoing 23 pages are a true and correct transcript of all proceedings had upon the taking of said deposition, all done to the best of my skill and ability.
I FURTHER CERTIFY that I am in no way related to any of the parties hereto, nor am I in any way interested in the outcome hereof.
( ) Signature was requested.
(XXX) Signature was not requested.
DATED at Phoenix, Arizona, this 10th day of January, 2019.

_____
SHANNON STEVENSON, CR, RPR
Certified Reporter
Certificate No. 50461

EXHIBIT D

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

JOHNNY JONES,)
Plaintiff,)
vs.) Case No. 17 CV 8218
WEXFORD HEALTH SOURCES,)
INC. and DR. MARSHALL)
JAMES,)
Defendants.)

The deposition of DR. ANKHUR BEHL, called for examination pursuant to the Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before CHRISTINE M. PINA, a Certified Shorthand Reporter within and for the County of Cook and State of Illinois, at 1310 N. Main Street, Sandwich, Illinois, on July 12, 2019 at the hour of 2:25 o'clock p.m.

Reported by: CHRISTINE M. PINA, CSR, RPR
License No.: 084-003785

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I N D E X

WITNESS	EXAMINATION
DR. ANKHUR BEHL	
By Ms. Byrd	5
By Mr. Flaxman	42
Further By Ms. Byrd	44

E X H I B I T S

NUMBER	MARKED FOR ID

NO EXHIBITS MARKED BY REPORTER

(Whereupon, the witness was duly sworn.)

MS. BYRD: Dr. Behl, I know I introduced myself before we went on the record, but my name is Sandy Byrd, and I am an attorney from Cassiday Schade --

THE WITNESS: Okay.

MS. BYRD: -- and we represent Wexford Health Sources, we represent Dr. James in this matter, okay?

THE WITNESS: Okay.

MS. BYRD: I'm assuming you've given a deposition before?

THE WITNESS: Yes.

MS. BYRD: And you know the rules then of making sure all of your answers are outloud?

THE WITNESS: Written, yes, or said, yes. Okay.

MS. BYRD: And that you'll wait for me to finish my question before you answer, and I will try and wait for you to finish your answer before I start my next question. If there's anything you have a question about, let me know, but you understand all the rules upfront?

THE WITNESS: Yes.

DR. ANKHUR BEHL,

having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. BYRD:

Q. What is your education, Doctor?

A. So, I did my undergraduate at the University of Oklahoma, did my medical school at the University of Oklahoma. I trained in orthopedic surgery, five years in Fort Worth at Fort Worth Affiliated Hospitals. I did a year of fellowship in sports medicine in Indiana University, I'm sports medicine trained, and I've been in practice here for the last -- this is going to be my sixth year.

Q. When you were -- I went to IU, so I have to ask IU questions. Were you in Bloomington or Indianapolis?

A. Indianapolis, yes.

Q. Your practice here is all orthopaedics?

A. It's orthopedic, yes. So, I have a general practice that's probably more catered towards sports medicine which is arthroscopies,

sports-related injuries, ligaments, tendons, you know, those are kind of my primary. The other 50 percent which is, again, more tailored towards sports. But I do a lot of general practice stuff as well, so total knees, fractures including anywhere from your bread-butter wrist-forearm, femur fractures, tibia fractures, ankle fractures.

Q. The case that we're here, Mr. Jones, he was an inmate at Sheridan?

A. Yes.

Q. How many inmates do you deal with here? Do you get a lot of inmates from --

A. I do. I get inmates from Wexford, I get inmates from Stateville, so both. I've probably operated on, what's a good estimate here, I would say maybe 15 inmates. I've probably seen 10 more than that, so maybe 25 inmates I would say from both facilities.

Q. That's over the last five or --

A. Five years, yes.

Q. The inmates that you treat when they come to your practice, they come obviously with guards, correct?

A. Yes.

Q. How familiar are you with the prison system and the medical care within the prison system?

A. So, you know, I would say I've gotten different experiences from different patients. It seems that the last few patients have more access to physical therapy on-site. You know, I know that there is a process for -- because most of the time the patients they send me are acute injuries, and so a lot of those patients do need surgical intervention. And so the process for getting that surgery approved seems to be more streamline, but, again, you know, I assume that they go through a general practice doctor there who decides that they need more subspecialty care and that's how I get the referrals.

Q. In your experience with that, you said it seems like things are more streamlined now. Are you getting that information from your conversations with the inmates or in your experience with dealing with getting the surgeries scheduled, et cetera?

A. In my experience with getting the surgery scheduled.

Q. So, you're not basing that opinion off of what you're told by the inmates?

A. I am not.

Q. The surgery we're dealing with here was a patella rupture, right?

A. Yes.

Q. How many of those surgeries have you done on inmates?

A. On inmates? Probably not very many. I would say less than five, yes.

Q. The ones that you have done on inmates, how quickly after the injury have you seen the inmate?

A. Typically within -- like any of those -- I mean not only inmates, but I guess typically with these injuries, I see them in the next -- in a few weeks, within a few weeks due to the fact that the patellar tendon is -- when you rupture your patellar tendon or you rupture your quad tendon, anywhere in your extensor mechanism that you rupture, you can't really walk with it very well because you have to be able to extend your knee to ambulate. And so most of the time patients are coming in quite early in the process just because

they can't walk.

Q. Is that always the case with a ruptured patellar tendon that you can't walk?

A. You can't walk well without a brace. That is always, yes. I mean there's -- without a patellar tendon, you can't extend your knee or without a -- well, without an intact patellar tendon, you can't extend your knee. And so if you can't extend your knee, you're going to be unstable. With a brace, you could get away with probably walking without a patellar tendon -- an intact patellar tendon. You're always going to have a patellar tendon, but an intact patellar tendon.

Q. So, someone who ruptures their patellar tendon, tell me exactly what that means. Does it detach, what does that mean?

A. Sure. So, the whole extensor mechanism -- so, the ability for you to straighten your knee which is the crucial component to walking, to holding yourself up as you take -- as a normal gait involves the quadriceps, the patella, the kneecap, the patella tendon, and the tibia tubercle where it attaches. So, any break in that mechanism being a

quadriceps tear, a patella fracture, a patella tendon rupture, or a fracture from the tibia will not allow you to extend your knee and allow you to have a normal gait. A patellar tendon rupture can refer to tearing the patella tendon in -- anywhere from the very top of it, so where it's torn from the top of the -- or the bottom of the patella to the midsubstance to it being torn right off the bone. Typically, these things when they rupture, they rupture to a point where there's not a good -- they rupture a lot of times midsubstance, so they rupture right in the middle. And they're not torn cleanly, they're torn severely on both sides. So, it's almost like a -- you would say almost like a mop end on both sides rather than a clean cut that you would imagine the way they tear. They're usually degenerative. They usually have some sort of tendinopathy involved in it because they're usually diseased. They typically occur under 40-year old patients opposed to quadriceps tendon ruptures that usually occur over 40, but I've seen both occur in both age groups.

Q. You said that they're usually degenerative?

A. So, what I mean -- I guess I would clarify that. I think there's usually disease within the tendon -- there's preexisting disease within the tendon for them to rupture. They don't -- you won't get a completely normal tendon before they rupture, but it does take a -- it takes a load for it to happen. Even if they have disease, they could have patellar -- just like Achilles tendonitis or other tendinopathies, they're quite frequent, it's only based on the mechanism. Eccentric -- usually it tears when there's an eccentric load to the tendon meaning that usually the knee is going the opposite direction that the quadriceps or patella tendon is supposed to go. So, usually the function of the extensor mechanism is to extend the leg so it's to straighten the leg. So, instead of doing that, the leg goes into a more bent position but it's still contracting, and that's where the most force is placed on the patella tendon.

Q. So, when you say the disease within the tendon, what do you mean?

A. So that there is I would call it more like tendinopathy, so there's inflammation within the

tendon. With inflammation, there may be partial intrasubstance tearing. You won't ever know about it. Patients may or may not ever complain about knee pain. It may just be inherent within the tendon itself.

Q. What causes that? What causes the --

A. So that -- you know, it's a variable. It's activity level. Sometimes you can -- if there's a genetic component to it, athletic activity. It can happen from, you know, overuse. It's very common -- I see it very commonly in patellar tendinopathy in basketball players, volleyball players. In athletic patients, you'll see that.

Q. Would someone having a rod in their femur, would that affect their --

A. The rod in the femur, there's no direct correlation between having a broken leg and a patellar tendon rupture; there's no direct correlation between the two. The only direct -- now, I don't remember if his was retrograde or antegrade. Let me see here. I have to look back and see what --

Q. Generally, before we --

A. It makes a difference, and the reason I say that is if the rod was placed from the hip, then there's no direct communication. If the rod was placed through the knee, then you do make a midline incision in the tendon so you can weaken it. I don't remember -- as far as I remember, I think his rod went the other direction. So, let me see. Femur fracture. Let me see. It will probably have it here. I wrote status post intramedullary nailing. I don't know if I wrote which way it was going. As far as I remember, I think it is -- his femur was fixed from the hip rather than from the knee. And I think, yeah, when he got it done in '91 is what I think I was reading -- yes. When he got it done in '91, we didn't do retrograde nails. So, that doesn't have a direct correlation.

Q. Retrograde meaning the one that is coming through --

A. Through the knee, yes. And you actually split the tendon, so there would be some relationship there. I've never seen it weaken, but you could theoretically say that it could weaken it, but not through the hip because it's the other

direction.

Q. I know you said you've done probably fewer than five surgeries on these inmates. Overall, how many have you done?

A. Probably 30 to 40. 30 to 40.

Q. Do you have independent recall of Mr. Jones?

A. I remember his clinical picture. I remember the timeframe from when he came in. I remember the surgery because of the timeframe from when the surgery occurred to when I operated on him. I remember the way I fixed it in terms of using the graft to do a reconstruction rather than a repair primarily. I don't remember, obviously, every visit, and I don't remember the last -- I did look back and review the last time that I saw him and how many times I saw him, to be honest, and kind of what his last rehab day was.

Q. You said there was a time between when you saw him and when the surgery --

A. The biggest timeframe is when the injury and when I saw him, yes.

Q. What is your understanding of that timeframe?

A. So, I have -- I remember it was at least a few months. And I'm looking back at my note. The injury occurred -- appeared to be November of 2015, and then, his first -- my first visit with him was February 8, 2016, so approximately three months.

Q. From November until February 8, 2016, you don't have any independent knowledge of the care that he received or anything else, correct?

A. I do not.

Q. You saw him on February 8, 2016 for the first time and then did the surgery on February 16, 2016, is that correct?

A. Let me check. Yes.

Q. And that timeframe from February 8 to February 16, is that a typical timeframe from the time you see a patient with this type of an injury until you do the surgery?

A. Yes, eight days. I don't remember if we had to get his MRI at the time or did he come with an MRI? So, that would be the question. It may have been a -- let me see here. The question I have is did we end up getting an MRI on him or just we basically knew the diagnosis. So, I will still occasionally get an MRI in those circumstances just

to see what the quality of the tendon is, where the tendon is torn. I'm just trying to see if I ended up getting -- oh, you know, he may have had an MRI that was -- he may have come with an MRI because I don't see -- it says here I did evaluate him on 2-8-16 at which point it was seen on X-ray, MRI, and exam that he had tore his patellar tendon. So, I think I did have an MRI, but it was brought with the patient.

Q. So, I can represent to you that he had an MRI in January of 2016.

A. Okay. Does it say if it was on a disk or hard copy? Because I don't see a disk or anything. Let me see if I have the report or anything in here because that I do not remember on what --

Q. I'm not sure if we do.

A. Here's radiology. Here we go.

Q. Do you have it?

A. Let's see here. It says comparison MRI of the left knee, so they had it somewhere. Here we go, MRI of the left knee. I do have the copy. 1-18-16, yes.

Q. So, you would have reviewed that --

A. Yes.

Q. -- at the time you met with Mr. Jones?
A. Yes.
Q. And that is what you base your diagnosis of a --
A. So, a combination -- yes. So, I think the diagnosis was made based on his history, his physical exam, and his imaging, all three.
Q. Your recommendation was for him to then have the surgery that you performed as soon as possible, correct?
A. Yes.
Q. And, again, you said that the timeframe between February 8 and February 16 was not concerning to you in any way in terms of the timeframe?
A. Eight days, no, is not concerning considering it was three months since when I saw him. So, an extra eight days does not change anything. I think you want to get to ruptures within -- the literature says less than four weeks. So, it was eight days from when I saw him, three months had already past, and I did know I was going to have to perform a reconstruction. So, no, the eight days was not concerning.

Q. Earlier you stated that when the patellar tendon ruptures, you can't walk. So, if a general practice physician saw a patient that was complaining of some knee pain and that person could still walk, it would not automatically be something that the doctor, general practice physician, should think is a ruptured patellar tendon, correct?
A. So, again, I don't know if he was braced. If he was braced, if he was placed in a knee -- when something -- you can ambulate with a brace. So, if he was put in a knee immobilizer and was able to bear some weight, that is possible because it's keeping your knee straight; you don't have to rely on your knee being straight. And the biggest thing he probably couldn't do, and I don't think he could do when I saw him, which I would be shocked if he could, is actually extend his knee against resistance. That's probably the most classic hallmark of a patellar tendon rupture is inability to extend his knee which it says -- yes, he could not hold his knee extended I think is when I did it. He couldn't -- the patient could not actively extend the knee and he couldn't hold it extended, so that's the biggest thing.

Q. But when you saw him, do you remember if he had a brace on his knee?
A. Let me see here. I do not know that. I'm not sure. I don't know if I indicated what he came in with, if he had come in with a knee immobilizer or not. I don't have any evidence either way. Let me see here. Yes. No, I don't think so because I put on there as a treatment option nonoperative management would include placing him in an immobilizer in extension and just trying to gradually activate the quadriceps. He would not really be able to extend his knee with his options. I can give him the option of that. So, as far as I know, I don't think he was in it at the time.
Q. So, as far as you know, he was not in a knee brace at the time?
A. As far as I know, yes, but I can't confer -- I have no evidence to say 100 percent that he was.
Q. So, February 16 you do the surgery?
A. Yes.
Q. You said that you knew that you did a graft I think is what you said?
A. Yes.

Q. Tell me about the surgery.
A. So, the surgery involved a midline incision. Let me pull up the op report so I'm on the same page. Okay. So, the surgery -- yes, the surgery involved a midline incision, usually a few centimeters above the kneecap going down to the front of the knee. You know, with a longer-standing rupture of the patellar tendon, typically the biggest -- I think the hardest thing about it is trying to get the kneecap back down because it chronically scars and it stays scarred more proximally because it's sitting more proximally. So, I think a lot of the time that we spent doing the surgery was releasing scar. I think I ended up getting -- I did get some X-rays of the other side just to get a sense of how far down we needed to pull the kneecap down. Let's see here. Yes. So, in order to immobilize the area, we released the area, extra synovial. We did remove an area around a centimeter of scar tissue from the tendon after we had kind of released all the scar so that we could get a good fresh edge. There was a lot of scar down to the femur, and so we used -- I remember we used a big Cob elevator

which is a device that could elevate the tissue. I remember we had to run it up the femur in order to release that kneecap and that quadriceps tendon from it being scarred down to the bone. Once that was done, we were able to get it to mobilize. We did kind of have to hold it down, I remember that. We had to hold it down with a device, a rake, in order to pull the kneecap down, but we were able to get it down which was good after we had done, again, multiple releases. At that point, we basically wove a semi-tendinosis graft which is a hamstring graft from a cadaver. This cadaver graft was thawed, placed on the stitches basically through that tendon. And the reason we use that tendon is to weave it through the patient's native patellar tendon in order to, again, reconstruct his patellar tendon. Because by the time we were able to get the kneecap down and freshen up the patella tendon, what he had left, it just wasn't as good quality due to the scar tissue around it. So, once we did that, we actually -- I think we ended up -- yes. We put two anchors in front of the kneecap, and then, we basically grafted that tendon through his own patellar tendon. Let's see here. Yes. We

due to the metal concerns.

Q. Okay.

A. And so I think initially the information that I had received from the guards at that time were that they recommended the cast because they were concerned about not being able to put him in a brace. It doesn't change management really that much because the first two weeks before we take out the staples, we leave him in -- straight anyway, we leave him in extension, so it doesn't change management.

Q. So, the decision between a cast and a brace doesn't affect the long-term results of the surgery?

A. It does not.

Q. Even if it did, you got that information from the IDOC guards, not from Dr. James or from Wexford, correct?

A. Yes.

Q. The process that you just described with the grafting and all of that, how common is that when you do these types of surgeries?

A. So, reconstructions are not that common. I probably would say less than ten percent of the

actually passed around 20 millimeters of the actual tendon into the kneecap itself, so we actually drilled a hole into the kneecap and pulled it down, and then, passed the tendon through -- kind of back and forth through the native patellar tendon, and then, we anchored it down with two anchors. So, we took the tendon, anchored it back down into two anchors, which are basically screws that have stitches in them, and we did that about 30 degrees of flexion. And once we did that, we were able to get about 70 degrees actually at the end of it. We were able to get about 70 degrees of flexion without really pulling a lot of tension in the repair, so we were happy with our repair. We then put him into -- we ended up closing the two side -- the retinaculum, and then, we had to put him in a cast at that time due to the concern with the knee brace so we ended up putting him in a cast. And that was it.

Q. When you say the concern with the brace, what do you mean by that?

A. Well, that's always a different conversation that I have with the guards at the time on what brace we can put him in after surgery

time, maybe -- yeah, less than ten percent. Typically, you can repair tendon-to-tendon in most circumstances acutely.

Q. The reason for having to do the reconstruction in this case was because of the scar tissue?

A. Timeframe and scar tissue. So, timeframe from onset of injury and surgical procedure; with that, becomes more scar tissue which makes it less likely for a side-to-side approximation of the tendon because of how much tissue we have to kind of remove from that area in order to mobilize the patella.

Q. Is there a way to tell specifically what caused the scar tissue?

A. Time. I mean there's no -- I mean that's -- scar I mean is a very normal progression of how things heal. And, you know, at certain timeframes you're going to get a certain amount of scar tissue, and I would say scarring or -- you know, inflammation or scarring is how you heal. So, as the time proceeds on, you're more likely to get that scar tissue there.

Q. So, could that scar tissue have been the

result of another injury?
A. Not in that area, no, because the only other injury he had was the femur fracture, and the femur fracture was more proximal to that area so it's unlikely that that were to occur.
Q. But you can't rule it out?
A. Yes, I couldn't -- I would never rule it in, but, yeah, anything is possible, but there's no precedent for that to form scar in the knee without directly injuring the knee. Now, on that note, if he broke his femur and he didn't really move his knee for -- since '91 and there's definitely a possibility -- not directly from the injury, but from him not moving the knee from the initial injury after the initial injury, then he could get scar tissue from that. But the scarring wasn't really in his knee as it was more the scar was because of the fact that the patella was superiorly migrated for three months because of the patellar tendon rupture.
Q. I guess my question is how do you know that for sure as opposed to something else? And assume that his injury that resulted in him having the rod in his leg was a gunshot wound.

A. The reason I would say that I know that is the rod doesn't cause the patella to be superiorly migrated, and that's the problem. The scarring is not -- we don't care about the scar within the knee as much we care about the patella being superiorly migrated and us not being able to bring the patella down without releasing that scar and releasing the scar tissue around the tendon that had already formed. And so that's the scar that forms. That scar wouldn't form from a femur fracture. The scar -- there could be scar in the knee, like he could have stiffness within the joint, but scar of the patella being superiorly migrated or scar from the end of the patella tendon would not occur in a femur fracture because there's no precedent for it to occur, there's no reason for that to happen. Him having a stiff knee after a femur fracture and having, quote-unquote, scar tissue in the knee joint is definitely a possibility after a femur fracture. But having a patella that's superiorly migrated and having scar tissue around the patellar tendon does not typically occur after a femur fracture. I've never seen that occur, I've never seen it reported to occur.

Q. And you said that you were happy with the repair that you did, correct?
A. Yes.
Q. You considered it to be a successful surgery?
A. Yes. And my judge of success was that clinically there appeared -- we were able to mobilize the patella distally. Again, it was high before we were able to bring it down, and it had good tension in the repair. Again, we were able to flex him around -- almost I think 90 degrees once we had closed the retinaculum without it looking like there was significant tension. So, almost 90 degrees acutely without any healing so far, obviously, because we just fixed it. And so, you know, with that, I did feel like it was successful.
Q. And 90 degrees acutely is a good outcome?
A. It is.
Q. That's on someone whether that person comes in with an acute injury or with a chronic injury?
A. Yes.
Q. The follow-up after the surgery --
A. Yes.

Q. -- did Mr. Jones follow-up as requested by you? I think your initial request was that he come back in 10 to 14 days?
A. Yes. He followed up on the 29th which was 13 days after surgery.
Q. At that time you examined him again, correct?
A. I did.
Q. You thought that he was progressing as you would expect?
A. I did.
Q. There was nothing about that examination on the 29th that was concerning or alarming to you, correct?
A. Yes.
Q. That was a bad question from me.
There was nothing that was concerning or alarming?
MR. FLAXMAN: Was there anything?
MS. BYRD: Yes.
THE WITNESS: There was not anything alarming when I saw him at two weeks. His staples were removed. His wound was well-healed. He had a little bit of swelling. I did remove his staples,

and I did have him see the physical therapist that day to show him some exercises.

BY MS. BYRD:

Q. And that happened, he saw the physical therapist, there was a recommendation of him doing exercises, correct?

A. Yes.

Q. Those were shown to him; he was shown what to do by the physical therapist?

A. Yes.

Q. And then at that time you asked, I think, for him to come back in four weeks?

A. Yes.

Q. And that happened as well, correct?

A. Yes.

Q. At the time, I think, that date was April 4 maybe?

A. So, I guess in hindsight, yes, so I was trying to do my math here. So, it would have been the end -- no. I guess that was right. It just said -- yes, 2-16, it would have been 2 -- yes, that's right. That makes sense, yes, because it was 2 and then 6, okay. Yes.

Q. When you saw him on April 4, he was still

doing well, is that correct?

A. Yes. His range of motion was -- so, he's six to seven weeks, so his range of motion was about 50 degrees which is, you know, a little bit on the tight side, you know, but he did have an intact extensor mechanism at that point so he was able to straighten his knee against resistance even. But he was very tight, and that unfortunately is a little bit part of the protocol or part of the -- not protocol, but part of the problem sometimes with extensor reconstructions. We're a little slower with rehab and they can get tighter. He also was doing therapy on his own. The difference unfortunately with, you know, some patients in the jail system versus a patient that is not in the jail system is access to therapy, and he did not have -- generally, the patients in these protocols will have therapy two times a week at least and they will be doing it on their own the other four to five days. He didn't have that access. He was doing only therapy on his own, so that also makes him more likely to be tight.

Q. Other than that, there was nothing unusual at that April 4 visit that you noted?

A. No, just stiffness.

Q. So, he was progressing as you would expect him to progress at that point?

A. Yes.

Q. And then, I think, you recommended he come back four to six weeks after that, correct?

A. Yes.

Q. And that was May 9?

A. Yes.

Q. When you saw him on May 9, he was continuing to progress?

A. He was. He had gained, I think, around 30 or 40 -- he gained around 40 degrees of range of motion. He could extend against resistance again. I think at that point he was also -- both times he saw the therapist while he was here in order to work on different exercises.

Q. There was nothing unusual at that May 9 visit?

A. There was not.

Q. When you say he had gained 40 degrees, is that from the date of the surgery or from the last time you had seen him in April?

A. From the last time I had seen him in

April.

Q. So, if I understand you correctly, he had 50 degrees range of motion when you saw him in April, and then, by May it would have been 90 degrees?

A. Yes.

Q. After May 9, you did not see him again, correct?

A. That is correct.

Q. You don't have any reason to know about the care that he received after May 9, correct?

A. The only thing that I did see is that I think he wanted to transfer care because, as far as I know -- and this, again -- I'm assuming that he was released from prison because I did get a correspondence from my assistant in July, it looks like July 5, 2016, that he wanted to -- yes, he said reason for calling, Johnny Jones refer ortho in Chicago. So, I had recommended Rush downtown, and my assistant had written a note from 7-7 spoke to patient, referred to Rush, patient is happy and understands this plan. And then it says here instructed to call Rush to schedule transfer of care. Patient states he will call back if there's

any issues. So, that's the last correspondence that I have.

Q. That was nearly two months after the last time you saw him, correct?

A. Yes.

Q. Your recommendation on April 9 is that you see him in four to six weeks, correct?

MR. FLAXMAN: April 9 or May 9?

THE WITNESS: May 9, yes.

MS. BYRD: Every time I say April 9, we'll assume I mean May 9.

THE WITNESS: Yes.

BY MS. BYRD:

Q. You did not see him in that four- to six-week period, correct?

A. I did not.

Q. Other than he called for a referral, you don't know anything about his care after May 9, 2016, correct?

A. I do not.

Q. When you last saw Mr. Jones on May 9, 2016, was there any expectation on your part that he would need to have further surgery?

A. There was no expectation, no.

Q. Did you have any indication that he would need further surgery?

A. I didn't have any expectation that he would need further surgery. In these circumstances when patients are very tight after surgery or still -- there's a tightness, especially with flexion, there is always a risk of needing an additional surgery which would include a manipulation under anesthesia and occasionally a lysis of scar tissue or lysis of adhesions arthroscopically. I have had one instance of a quadriceps repair where I had to do that where the patient was very tight even six or nine months after surgery and we did perform that. So, that's the -- when I talk about risks of surgery with the patient, stiffness is, of course, one of them, especially on a reconstruction. And that is a possible additional surgery that the patient may need if they're tight. The other possibility is if the patient re-ruptures and they need a repeat surgery. Those are the two possible surgeries afterwards, but that's variable depending on how the patient does afterwards.

Q. There was nothing that you observed at

that time that made you think that he was going to fall into that camp?

A. I mean at that point at three months in my opinion, it's too early to do that. I would not recommend any sort of manipulation or lysis of adhesions at three months. That was the last time I saw him.

Q. Okay.

A. So, you know, I've -- again, in my experience, I've had multiple patients be maybe not -- you know, I've had patients that tight at three months, and in four months and five months they get full motion. So, I would still recommend at that stage to not perform a repeat surgery -- or not a repeat, an additional surgery until more time had past.

Q. When you see people who are that tight at three months and by five months they have full range of motion, what steps do those patients take in that timeframe to reach that?

A. So, typically I'll put patients on either some sort of antiinflammatory, so a steroid, oral steroids, I'll put patients on NSAIDs, and then, they will be in very vigorous, dedicated physical

therapy. So, they are getting therapy a few days a week with a therapist, and then, multiple days a week by themselves gradually every day trying to get a little bit more range of motion and breaking up scar tissue.

Q. If someone is not doing physical therapy in that timeframe, would you expect there to be any improvement in their tightness?

A. So, I think that it depends on how motivated patients are doing therapy by themselves, but if they are not doing therapy by themselves -- even if they are, I still think it's difficult to gain more motion without an individual getting any sort of assistance with that in terms of getting the knee bent back farther and farther with assistance.

Q. Have you operated on other patients where it's been three months between the injury and the surgery?

A. The longest, I think, would be a month. The longest would be a month for what I've seen. Yes, I would say a month is the longest. Never -- I have not seen a three-month -- he would probably be my only patient with three months in-between

time from injury to time to surgery.

Q. The one time, that was a month?

A. Yes.

Q. What did you observe in that patient?

A. That patient, it was a quad rupture so it was a little bit different, it wasn't a patellar tendon rupture, it was a quad rupture, but it was the same mechanistically thing. And the patient really couldn't walk for almost three weeks but felt that he may have just strained his quad and was essentially hobbling during that timeframe before he came in and saw me. So, you know, the repair itself -- he was actually the one patient that I did end up having to perform a manipulation under and a lysis of adhesions. So, he was the one that got tighter because I think, in my opinion, the longer he had not been mobilizing his knee, the rehab was a little bit slower with him, and he was more likely to get tight after surgery. And so I did have to manipulate -- and he had really good therapy, but I did have to manipulate him. And I did, and I think at nine months I had to perform a manipulation and an arthroscopic lysis of adhesions and he gained another 15 to 20 degrees. So, he had

knee. You may have some weakness in extension, so you may not have the same strength you have in your other knee, and then, you have stiffness with range of motion. Those are the biggest risks. That being said, I would say that 90 percent of patients gain full extension. And the majority of patients, I don't know the exact percentage on this, are close in terms of strength to their other side. If you do an isometric test, they're probably not quite there on their other side, but they're close. It's not as perceptible to the patient. You could lose though up to 10 to 15 degrees of flexion compared to your other side, but, again, that's a -- I don't know what the -- to be honest, I don't know the exact numbers on the most recent study on what the comparison are. And there's so many variables from time of surgery to type of repair to rehab type to tissue quality to otherwise mobility. So, there's just so many variables that I don't know if they have exact numbers on that.

MS. BYRD: Give me one minute. That might be all I have.

THE WITNESS: Okay.

good strength, but was tight.

Q. Would you agree that the therapy is a really important part of recovering from this kind of surgery?

A. It's crucial, yes.

Q. And that's whether you're doing it on your own or doing it with a professional?

A. Yes.

Q. How often would you say that someone needs to do physical therapy to successfully recover?

A. Their usual recommendation is two to three times a week. There's no literature or science to say what's the exact number, but typically that timeframe allows the patient to do exercises on their own but have a feedback in enough of a timely manner so that they can modify or adjust what therapy exercises they are doing and how aggressive they're doing it. It also allows the therapist to contact me if there's a problem.

Q. With regular therapy, do you see great success from these surgeries?

A. Yes. I would say that the biggest risk we tell every patient is that you'll have an extensor lag meaning you won't be able to fully extend your

BY MS BYRD:

Q. Is it accurate for me to say that you would have needed the MRI before you knew what specifically had happened with Mr. Jones' knee?

A. I think it's confirmatory. I don't -- and I do it for every quadriceps and patellar tendon patient because I think it allows me to see where the tear -- it's good for surgical planning. Is it ultimately crucial for diagnosis? I believe that the physical -- the history, physical exam, and X-rays are enough, but the MRI is a very important aid in surgical planning and it can be confirmatory for the diagnosis.

Q. When you say the physical exam, what would the appropriate physical exam be?

A. So, a palpable defect -- well, physical exam. No. 1, it would be weakness in extension, inability to extend the knee, especially against resistance, especially against gravity; a palpable defect at the inferior aspect of the patella; a patella that is superiorly migrated. Looking for other possible diagnoses to rule out, so a palpable quadriceps tendon so you could feel the quadriceps tendon, no instability in other ligaments so

varus-valgus, ACL is okay, PCL is okay. Those probably would be the biggest thing on physical exam. And then diagnostic imaging, being able to evaluate the height of the patella and a patella that is superiorly migrated on X-ray, especially with the -- I think I measured iso valve ratio, those are all helpful in diagnosing a patella tendon rupture.

Q. Would you expect swelling on a patella tendon rupture?

A. I would expect a large affusion, yes.

Q. What about pain, what would you expect?

A. I would expect an immediate pain right after the injury and continual pain. If the knee is placed in -- again, in extension and it's not stressed, then the pain may decrease. But, yes, immediate pain, immediate swelling. There's a large, bloody affusion. The patients will get a large -- basically an accumulation of blood when the tendon ruptures.

Q. If a patient presented with mild pain, no swelling, and the X-ray came back saying that the patella was slightly high-riding, would that automatically trigger to you that it's a patellar

tendon rupture?

A. If I was given that history, that would not be the expectation, no.

MS. BYRD: I think that's all I have.

EXAMINATION

BY MR. FLAXMAN:

Q. Could you explain to us what you meant by range of motion?

A. So, range of motion refers to the ability to -- for the patient to bend and straighten the knee. It's measured -- at least I measure it in three numbers; the first number is how much they can extend. So, typically if patients can extend to neutral, it's zero. If they can higher extend, you add whatever that degree of hyperextension is, so one, two, three. Typically, patients are anywhere from zero, so ability to fully extend which is zero degrees to upwards of five if they have hyperlaxity. The second number is typically zero. It's typically if they can extend to zero, if they can extend to zero or past zero, it's zero. And then the third number is the ability to flex the knee. So, you measure it from straight, we see how much they can flex. So, we talk about

50 degrees of flexion, the patient if you were to take a straight line from straight to where it bends is about 50 degrees. Typically, patients can -- or normal people, I guess, can flex anywhere from 130 degrees to 140 degrees. You always compare it -- well, typically I'll compare it to the other side as a baseline, but that's what we talk about when we talk about range of motion.

Q. Is the type of injury that you saw in Mr. Jones a career-ending injury for a basketball player?

A. It is -- it can be. There are guys that have been able to return to playing. There's a few guys even in the NBA who have returned to playing. There's -- I have seen it in the NFL. I took care of an NFL team, I've seen guys return to the NFL, but it is a bad injury. It can be a career-ending injury.

Q. In the beginning of the deposition when you were talking about that physical therapy seems to have gotten easier -- there's more access to it in the prison now than there was when you first started. Could you explain what you meant by that, if I heard it correctly?

A. Yes. At least there was -- recently I performed an ACL reconstruction on a patient, and I was told by that inmate and patient that there was access to a therapist on-site that was able to do more consistent therapy with the patient.

Q. As far as you know, was there a physical therapist available to Mr. Jones back in 2016?

A. No, not that I know of.

MR. FLAXMAN: I have nothing further.

MS. BYRD: I think just two quick questions.

FURTHER EXAMINATION

BY MS. BYRD:

Q. The patient that you just talked about who said they had physical therapy available on-site, what prison was that person in?

A. As far as I know, it was Stateville prison, yes.

Q. You talked about range of motion. In your notes, you also have strength, you measure strength in here?

A. Yes.

Q. And you say that Mr. Jones has strength of five of five with extensor hallucis longus?

A. Yes.

Q. Did I get that?
A. Yes.
Q. What does that mean?
A. So, that really refers to his neurovascular status. And typically with an extensor tendon repair, we don't necessarily -- the nerves are very unlikely to get injured, but there's always a chance of them getting injured. So, the extensor hallucis longus refers to the big toe basically, and what nerve that refers to is the peritoneal nerve. So, I check all of their distal or all of my patients' distal extremities to make sure that everything distally is okay. So, the big toe is the extensor hallucis longus or EHL, and that just means that he's neurovascularly intact. I think there was an area that I had written, also, that he had five out of five strength against resistance as well which would have been, I think, the last time I saw him. Let me see here. I did put that he had good extensor strength.
Q. Yes.
A. Yes. So, I think I wrote in his last note on May 9, I said patient can extend against resistance with five out five strength. So, I

think he had good strength against resistance.
Q. So, that means that you had to put his leg out and you pushed down on it or what does that mean?
A. Yes. So, that means that he was able to extend his leg against me pushing against it.
Q. When you say five out of five, that's as good as --
A. Yes. That would imply in my opinion -- it's a subjective measure, there's no objectivity to it. But as a subjective measure, he was able to extend against resistance which makes, again, from a physical exam finding that he has an intact extensor mechanism.
Q. Which is what you would expect after a successful surgery?
A. Yes.
MS. BYRD: I think that's all I have.
MR. FLAXMAN: Signature?
MS. BYRD: We can send you a copy of the transcript so you can review it and make sure that what you said is what was written down.
THE WITNESS: Sure.
MS. BYRD: You can't change your answers. Or

you can trust that it was written down correctly and waive your signature.
THE WITNESS: Where does it get sent to? It gets sent to me directly to my e-mail or where does it get sent to?
(Whereupon, the record was read as requested.)
THE WITNESS: I think it's fine. You can waive.
(Whereupon, the deposition concluded at 3:20 o'clock p.m.)

STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)
I, CHRISTINE M. PINA, do hereby certify that heretofore, to-wit, on July 12, 2019 personally appeared before me, at 1310 N. Main Street, Sandwich, Illinois, DR. ANKHUR BEHL, in a cause now pending and undetermined in the United States District Court, Northern District of Illinois, wherein JOHNNY JONES is the Plaintiff, and WEXFORD HEALTH SOURCES, INC. and DR. MARSHALL JAMES are the Defendants.
I further certify that the said DR. ANKHUR BEHL was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by said witness was reported stenographically by me in the presence of the said witness, and afterwards reduced to typewriting by Computer-Aided Transcription, and the foregoing is a true and correct transcript of the testimony so given by said witness as aforesaid.
I further certify that the signature to the foregoing deposition was waived by counsel for

the respective parties.

I further certify that the taking of this deposition was pursuant to subpoena and that there were present at the deposition the attorneys hereinbefore mentioned.

I further certify that I am not counsel for nor in any way related to the parties to this suit, nor am I in any way interested in the outcome thereof.

IN TESTIMONY WHEREOF: I have hereunto set my hand this 1st day of August, 2019.

Christine M. Dina

CERTIFIED SHORTHAND REPORTER

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49

1

1
40:17
1-18-16
16:22
10
6:16 28:3 39:12
100
19:18
13
28:5
130
43:5
14
28:3
140
43:5
15
6:16 37:24 39:12
16
15:11,15 17:13 19:20

2

2
29:21,23
2-16
29:21
2-8-16
16:6
20
22:1 37:24
2015
15:3
2016
15:5,6,10,12 16:11 32:17 33:19,22 44:7
25
6:17
29th
28:4,13

3

30
14:5 22:9 31:12

4

4
29:17,24 30:24
40
10:21 14:5 31:13,21
40-year
10:20

5

5
32:17
50
6:2 30:4 32:3 43:1,3

6

6
29:23

7

7-7
32:20
70
22:11,12

8

8
15:5,6,10,14 17:13

9

9
31:8,10,18 32:7,11 33:6,8,9,10,11,18,21 45:23
90
27:11,14,17 32:5 39:5
91
13:14,15 25:12

A

ability
9:19 42:9,17,22
access
7:6 30:16,21 43:21 44:4
accumulation
41:19
accurate
40:2
Achilles
11:8
ACL
41:1 44:2
activate
19:11
actively
18:22
activity
12:8,10
actual
22:1
acute
7:9 27:20
acutely
24:3 27:14,17
add
42:15
additional
34:8,18 35:15
adhesions
34:10 35:6 37:15,23
adjust
38:16
affect
12:16 23:13
Affiliated
5:12
affusion
41:11,18
age
10:22
aggressive
38:17
agree
38:2
aid
40:12
alarming
28:13,18,21
ambulate
8:23 18:10
amount
24:19
anchored
22:6,7
anchors
21:22 22:6,8
anesthesia
34:9
ANKHUR
5:2
ankle
6:7
answers
4:16 46:24
antegrade
12:22
antiinflammatory
35:22
appeared
15:3 27:7
approved
7:12
approximately
15:5
approximation
24:10
April
29:17,24 30:24 31:23 32:1,4 33:6,8,10
area
20:18,19,20 24:12 25:2,4 45:16
arthroscopic
37:23
arthroscopically
34:11
arthroscopies
5:24
aspect
40:20
assistance
36:14,16
assistant
32:16,20
assume
7:13 25:23 33:11
assuming
4:12 32:14
athletic
12:9,13
attaches
9:24
attorney
4:5
automatically
18:5 41:24

B

back
12:22 14:16 15:2 20:10 22:4,7 28:3 29:12 31:6 32:24 36:15 41:22 44:7
bad
28:16 43:17
base
17:3
based
11:10 17:6
baseline
43:7
basically
15:23 21:11,13,23 22:8 41:19 45:10
basing
8:1
basketball
12:12 43:10
bear
18:12
beginning
43:19
Behl
4:3 5:2
bend
42:10
bends
43:3
bent
11:18 36:15
big
20:24 45:9,13
biggest
14:21 18:14,24 20:9 38:22 39:4 41:2
bit
28:24 30:4,9 36:4 37:6,18
blood
41:19
bloody
41:18
Bloomington
5:18
bone
10:9 21:4
bottom
10:7
brace
9:4,10 18:10 19:2,16 22:18,20,24 23:7,13
braced
18:8,9
bread-butter
6:6
break
9:24
breaking
36:4
bring
26:6 27:9
broke
25:11
broken
12:18
brought
16:8
Byrd
4:3,5,8,12,15,19 5:6 28:20 29:3 33:10,13 39:21 40:1 42:4 44:10,12 46:18,20,24

C

cadaver
21:12
call
11:23 32:23,24
called
33:17
calling
32:18
camp
35:2
care
7:2,15 15:7 26:4,5 32:11,13,24 33:18 43:15
career-ending
43:10,17
case
6:8 9:2 24:5
Cassiday
4:5
cast
22:17,18 23:5,12
catered
5:23
cause
26:2
caused
24:15
centimeter
20:20
centimeters
20:6
cetera
7:22
chance
45:8
change
17:18 23:7,10 46:24
check
15:13 45:11
Chicago
32:19
chronic
27:20
chronically
20:11
circumstances
15:24 24:3 34:4
clarify
11:1
classic
18:18
clean
10:15
cleanly
10:13
clinical
14:8
clinically
27:7
close
39:8,10
closed
27:12
closing
22:15
Cob
20:24
combination
17:5
common
12:11 23:21,23
commonly
12:11
communication
13:3
compare
43:6
compared
39:13
comparison
16:19 39:16
complain
12:3
complaining
18:4
completely
11:5
component
9:20 12:9
concern
22:17,20
concerned
23:6
concerns
23:1
confer
19:18
confirmatory
40:5,12
considered
27:4
consistent
44:5
contact
38:19
continual
41:14
continuing
31:11
contracting
11:18
conversation
22:23
conversations
7:20
copy
16:13,21 46:20
correct
6:23 15:8,12 17:10 18:7 23:18 27:2 28:7,14 29:6,14 30:1 31:6 32:8,9,11 33:4,7,15,19
correctly
32:2 43:24
correlation
12:18,20 13:17
correspondence
32:16 33:1
crucial
9:20 38:5 40:9
cut
10:15

D

date
29:16 31:22
day
14:18 29:2 36:3
days
15:18 17:16,18,21,24 28:3,5 30:20 36:1,2
deal
6:11
dealing
7:21 8:4
decides
7:14
decision
23:12
decrease
41:16
dedicated
35:24
defect
40:16,20
degenerative
10:17,24
degree
42:15
degrees
22:9,11,12 27:11,14,17 30:4 31:13,21 32:3,5 37:24 39:12 42:18 43:1,3,5
depending
34:22
depends
36:9
deposition
4:13 43:19
detach
9:17
device
21:1,7
diagnoses
40:22
diagnosing
41:7
diagnosis
15:23 17:3,6 40:9,13
diagnostic
41:3
difference
13:1 30:14
difficult
36:12

direct
12:17,19,20 13:3,17
direction
11:13 13:7 14:1
directly
25:10,13
disease
11:2,3,7,21
diseased
10:19
disk
16:12,13
distal
45:11,12
distally
27:8 45:13
doctor
5:7 7:14 18:6
downtown
32:19
drilled
22:3
due
8:17 21:20 22:17
23:1
duly
4:2 5:3

E

Earlier
18:1
early
8:24 35:4
easier
43:21
eccentric
11:11,12
edge
20:22
education
5:7
EHL
45:14
elevate
21:1
elevator
20:24
end
10:15 15:22 22:11
26:14 29:20 37:14
ended
16:2 20:15 21:21
22:15,18
essentially
37:11
estimate
6:15
evaluate
16:5 41:4
evidence
19:6,18
exact
38:13 39:7,15,20
exam
16:7 17:7 40:10,14,
15,17 41:3 46:13
examination
5:5 28:12 42:5 44:11
examined
5:3 28:6
exercises
29:2,6 31:17 38:14,
17
expect
28:10 31:2 36:7
41:9,11,12,13 46:15
expectation
33:22,24 34:3 42:3
experience
7:17,21,23 35:10
experiences
7:5
explain
42:7 43:23
extend
8:22 9:6,8,9 10:3
11:16 18:17,20,23
19:12 31:14 38:24
40:18 42:13,14,17,
20,21 45:23 46:6,12
extended
18:21,23
extension
19:10 23:10 39:1,6
40:17 41:15
extensor
8:20 9:18 11:15
30:6,11 38:23 44:23
45:6,9,14,20 46:14
extra
17:18 20:19
extremities
45:12

F

facilities
6:18
fact
8:17 25:18
fall
35:2
familiar
7:1
farther
36:15
February
15:5,6,10,11,14,15
17:13 19:20
feedback
38:15
feel
27:16 40:23
fellowship
5:13
felt
37:10
femur
6:7 12:15,17 13:8,12
20:23 21:2 25:3,4,11
26:10,15,17,19,22
fewer
14:2
finding
46:13
finish
4:20,21
fixed
13:12 14:12 27:15
FLAXMAN
28:19 33:8 42:6 44:9
46:19
flex
27:11 42:22,24 43:4
flexion
22:10,12 34:7 39:12
43:1
follow-up
27:23 28:1
force
11:19
form
25:9 26:10
formed
26:9
forms
26:9
Fort
5:11,12
four-
33:14
fracture
10:1,2 13:8 25:3,4
26:10,15,17,20,23
fractures
6:5,7
frequent
11:10
fresh
20:22
freshen
21:18
front
20:7 21:22
full
35:13,18 39:6
fully
38:24 42:17
function
11:15

G

gain
36:13 39:6
gained
31:12,13,21 37:24
gait
9:21 10:4
general
5:23 6:4 7:14 18:2,6
generally
12:24 30:17
genetic
12:9
give
19:13 39:21
good
6:15 10:10 20:22
21:9,19 27:10,17
37:20 38:1 40:8
45:20 46:1,8
gradually
19:11 36:3
graft
14:13 19:23 21:11,
12
grafted
21:23
grafting
23:21
gravity
40:19
great
38:20
groups
10:22
guards
6:22 22:23 23:4,17
guess
8:15 11:1 25:21
29:18,20 43:4
gunshot
25:24
guys
43:12,14,16

H

hallmark
18:19
hallucis
44:23 45:9,14
hamstring
21:12
happen
11:7 12:10 26:16
happened
29:4,14 40:4
happy
22:14 27:1 32:21
hard
16:13
hardest
20:9
heal
24:18,21
healing
27:14
Health
4:8
heard
43:24
height
41:4
helpful
41:7
high
27:8
high-riding
41:23
higher
42:14
hindsight
29:18
hip
13:2,12,24
history
17:6 40:10 42:2
hobbling
37:11
hold
18:21,23 21:6,7
holding
9:21
hole
22:3
honest
14:17 39:14
Hospitals
5:12
hyperextension
42:15
hyperlaxity
42:19

I

IDOC
23:17
imagine
10:16
imaging
17:7 41:3
immobilize
20:18
immobilizer
18:11 19:5,10
imply
46:9
important
38:3 40:11
improvement
36:8
in-between
36:24
inability
18:19 40:18
incision
13:5 20:3,5
include
19:9 34:8
including
6:5
independent
14:6 15:7
Indiana
5:13
Indianapolis
5:19,20
indication
34:1
individual
36:13
inferior
40:20
inflammation
11:24 12:1 24:21
information
7:19 23:3,16
inherent
12:4
initial
25:14,15 28:2
initially
23:3
injured
45:7,8
injuries
6:1 7:9 8:16
injuring
25:10
injury
8:12 14:21 15:3,16
24:8 25:1,3,13,15,23
27:20,21 36:18 37:1
41:14 43:9,10,17,18
inmate
6:9 8:13 44:3
inmates
6:11,12,13,14,16,17,
21 7:20 8:2,8,9,11,
15 14:3
instability
40:24
instance
34:11
instructed
32:23
intact
9:7,12,13 30:6 45:15
46:13
intervention
7:11
intramedullary
13:10
intrasubstance
12:2
introduced
4:3
involved
10:18 20:2,5
involves
9:22
iso
41:6
isometric
39:9
issues
33:1
IU
5:17,18

J

jail
30:15,16
James
4:9 23:17
January
16:11
Johnny
32:18
joint
26:12,19
Jones
6:8 14:7 17:1 28:1
32:18 33:21 43:10
44:7,22
Jones'
40:4
judge
27:6
July
32:16,17

K

keeping
18:13
kind
6:2 14:18 20:21 21:6
22:4 24:11 38:3
knee
8:22 9:6,8,9,19 10:3
11:13 12:4 13:4,13,
20 16:20,21 18:4,9,
11,13,14,17,20,21,
23 19:2,5,12,16 20:7
22:17 25:9,10,12,14,
17 26:4,11,17,18
30:7 36:15 37:17
39:1,3 40:4,18 41:14
42:11,23
kneecap
9:22 20:6,10,17
21:3,8,18,22 22:2,3
knees
6:5
knew
15:23 19:22 40:3
knowledge
15:7

L

lag
38:24
large
41:11,18,19
leave
23:9,10
left
16:20,21 21:19
leg
11:16,17 12:18
25:24 46:2,6
level
12:8
ligaments
6:1 40:24
literature
17:20 38:12
load
11:6,12
long-term
23:13
longer
37:17
longer-standing
20:8
longest
36:20,21,22
longus
44:23 45:9,14
lose
39:12
lot
6:4,12 7:10 10:11
20:13,23 22:13
lysis
34:10 35:5 37:15,23

M

made 17:6 35:1
majority 39:6
make 13:4 45:12 46:21
makes 13:1 24:9 29:22 30:22 46:12
making 4:16
management 19:9 23:7,11
manipulate 37:20,21
manipulation 34:9 35:5 37:14,23
manner 38:16
math 29:19
matter 4:9
meaning 11:12 13:18 38:24
means 9:16 45:15 46:2,5
meant 42:7 43:23
measure 42:11,23 44:19 46:10,11
measured 41:6 42:11
mechanism 8:20 9:18,24 11:10, 15 30:6 46:14
mechanistically 37:8
medical 5:9 7:2
medicine 5:13,14,24
met 17:1
metal 23:1
middle 10:12
midline 13:5 20:2,5
midsubstance 10:8,11
migrated 25:19 26:3,6,13,21 40:21 41:5
mild 41:21
millimeters 22:1
minute 39:21
mobility 39:18
mobilize 21:5 24:12 27:8
mobilizing 37:17
modify 38:16
month 36:20,21,22 37:2
months 15:2,5 17:17,22 25:19 33:3 34:13 35:3,6,12,18 36:18, 24 37:22
mop 10:15
motion 30:2,3 31:14 32:3 35:13,19 36:4,13 39:4 42:8,9 43:8 44:18
motivated 36:10
move 25:11
moving 25:14
MRI 15:19,20,22,24 16:3, 4,6,8,11,19,21 40:3, 11
multiple 21:10 35:10 36:2

N

nailing 13:10
nails 13:16
native 21:15 22:5
NBA 43:14
necessarily 45:6
needed 20:17 40:3
needing 34:7
nerve 45:10,11
nerves 45:7
neurovascular 45:5
neurovascularly 45:15
neutral 42:14
NFL 43:15,16
nonoperative 19:8
normal 9:21 10:4 11:5 24:17 43:4
note 15:2 25:10 32:20 45:22
noted 30:24
notes 44:19
November 15:3,6
NSAIDS 35:23
number 38:13 42:12,19,22
numbers 39:15,20 42:12

O

objectivity 46:10
observe 37:4
observed 34:24
occasionally 15:24 34:9
occur 10:19,21,22 25:5 26:14,16,22,23,24
occurred 14:11 15:3
Oklahoma 5:9,10
on-site 7:7 44:4,14
onset 24:8
op 20:3
operated 6:15 14:11 36:17
opinion 8:1 35:4 37:16 46:9
opposed 10:20 25:22
opposite 11:13
option 19:8,13
options 19:12
oral 35:22
order 20:18 21:2,8,16 24:12 31:16
ortho 32:18
orthopaedics 5:21
orthopedic 5:11,22
outcome 27:17
outloud 4:16
overuse 12:10

P

pain 12:4 18:4 41:12,13, 14,16,17,21
palpable 40:16,19,22
part 30:9,10 33:22 38:3
partial 12:1
passed 22:1,4
past 17:22 35:16 42:21
patella 8:5 9:22,23 10:1,5,7 11:14,20 21:18 24:13 25:18 26:2,5, 6,13,14,20 27:8 40:20,21 41:4,7,9,23
patellar 8:18,19 9:3,6,7,11, 12,13,15 10:4 11:8 12:12,19 16:7 18:1, 7,19 20:8 21:16,17, 24 22:5 25:19 26:21 37:6 40:6 41:24
patient 15:16 16:9 18:3,22 30:15 32:21,24 34:13,16,18,20,23 36:24 37:4,5,8,13 38:14,23 39:11 40:7 41:21 42:10 43:1 44:2,3,5,13 45:23
patient's 21:15
patients 7:5,6,9,10 8:23 10:20 12:3,13 30:15, 17 34:5 35:10,11,19, 21,23 36:10,17 39:5, 6 41:18 42:13,16 43:3
patients' 45:12
PCL 41:1
people 35:17 43:4
percent 6:3 19:18 23:24 24:1 39:5
percentage 39:7
perceptible 39:11
perform 17:23 34:14 35:14 37:14,22
performed 17:9 44:2
period 33:15
peritoneal 45:11
person 18:4 27:19 44:15
physical 7:7 17:7 29:1,4,9 35:24 36:6 38:10 40:10,14,15,16 41:2 43:20 44:6,14 46:13
physician 18:3,6
picture 14:8
placing 19:9
plan 32:22
planning 40:8,12
player 43:11
players 12:12,13
playing 43:13,14
point 10:10 16:6 21:10 30:6 31:3,15 35:3
position 11:18
possibility 25:13 26:19 34:19
post 13:9
practice 5:15,21,23 6:4,22 7:14 18:3,6
precedent 25:9 26:15
preexisting 11:3
presented 41:21
primarily 14:14
primary 6:2
prison 7:1,2 32:15 43:22 44:15,17
problem 26:3 30:11 38:19
procedure 24:8
proceeds 24:22
process 7:8,11 8:24 23:20
professional 38:7
progress 31:3,11
progressing 28:9 31:2
progression 24:17
protocol 30:9,10
protocols 30:18
proximal 25:4
proximally 20:12,13
pull 20:3,17 21:8
pulled 22:3
pulling 22:13
pushed 46:3
pushing 46:6
put 18:11 19:8 21:22 22:15,16,24 23:6 35:21,23 45:20 46:2
putting 22:18

Q

quad 8:19 37:5,7,10
quadriceps 9:22 10:1,20 11:14 19:11 21:3 34:12 40:6,23
quality 16:1 21:20 39:18
question 4:20,22,23 15:20,21 25:21 28:16
questions 5:18 44:10
quick 44:10
quickly 8:12
quote-unquote 26:18

R

radiology 16:17
rake 21:7
range 30:2,3 31:13 32:3 35:19 36:4 39:3 42:8,9 43:8 44:18
ratio 41:6
re-ruptures 34:20
reach 35:20
reading 13:15
reason 13:1 21:14 24:4 26:1,16 32:10,18
recall 14:6
received 15:8 23:4 32:11
recent 39:15
recently 44:1
recommend 35:5,13
recommendation 17:8 29:5 33:6 38:11
recommended 23:5 31:5 32:19
reconstruct 21:16
reconstruction 14:13 17:23 24:5 34:17 44:2
reconstructions 23:23 30:11
record 4:4
recover 38:10
recovering 38:3
refer 10:5 32:18
referral 33:17
referrals 7:16
referred 32:21
refers 42:9 45:4,9,10
regular 38:20
rehab 14:18 30:12 37:18 39:18
relationship 13:22
release 21:3
released 20:19,21 32:15
releases 21:10
releasing 20:14 26:7
rely 18:14
remember 12:21 13:6,11 14:8, 9,10,12,14,15 15:1, 18 16:15 19:1 20:24 21:2,6
remove 20:20 24:12 28:24
removed 28:23
repair 14:14 22:14 24:2 27:2,10 34:12 37:13 39:17 45:6
repeat 34:20 35:14,15
report 16:14 20:3
reported 26:24
represent 4:8,9 16:10

request 28:2
requested 28:1
resistance 18:18 30:7 31:14 40:19 45:18,24 46:1, 12
result 25:1
resulted 25:23
results 23:13
retinaculum 22:16 27:12
retrograde 12:21 13:16,18
return 43:13,16
returned 43:14
review 14:16 46:21
reviewed 16:23
risk 34:7 38:22
risks 34:15 39:4
rod 12:15,17 13:2,3,7 25:24 26:2
rule 25:6,7 40:22
rules 4:15,24
run 21:2
rupture 8:5,18,19,21 10:2,4, 9,10,11,12 11:4,6 12:19 18:19 20:8 25:20 37:5,7 41:8,10 42:1
ruptured 9:2 18:7
ruptures 9:15 10:21 17:19 18:2 41:20
Rush 32:19,21,23

S

Sandy 4:5
scar 20:14,20,22,23 21:20 24:5,7,9,15, 17,20,23,24 25:9,16, 17 26:4,7,8,9,10,11, 12,13,18,21 34:10 36:5
scarred 20:11 21:4
scarring 24:20,21 25:16 26:3
scars 20:11
Schade 4:6
schedule 32:23
scheduled 7:22,24
school 5:9
science 38:12
screws 22:8
semi-tendinosis 21:11
send 7:9 46:20
sense 20:16 29:22
severely 10:13
Sheridan 6:9
shocked 18:16
show 29:2
shown 29:8
side 20:16 22:15 30:5 39:8,10,13 43:7
side-to-side 24:10
sides 10:13,15
Signature 46:19
significant 27:13
sitting 20:12
six-week 33:15
sixth 5:16
slightly 41:23
slower 30:12 37:18
sort 10:17 35:5,22 36:14
Sources 4:9
specifically 24:14 40:4
spent 20:14
split 13:21
spoke 32:20
sports 5:13,14,24 6:4
sports-related 6:1
stage 35:14
staples 23:9 28:22,24
start 4:22
started 43:23
stated 18:1
states 32:24
Stateville 6:14 44:16
status 13:9 45:5
stays 20:11
steps 35:19
steroid 35:22
steroids 35:23
stiff 26:17
stiffness 26:12 31:1 34:16 39:3
stitches 21:13 22:9
straight 18:13,14 23:9 42:23 43:2
straighten 9:19 11:16 30:7 42:10
strained 37:10
streamline 7:12
streamlined 7:18
strength 38:1 39:2,8 44:19,22 45:17,20,24 46:1
stressed 41:16
study 39:15
stuff 6:4
subjective 46:10,11
subspecialty 7:15
success 27:6 38:21
successful 27:4,16 46:16
successfully 38:10
superiorly 25:18 26:2,5,13,20 40:21 41:5
supposed 11:14
surgeries 7:21 8:7 14:3 23:22 34:21 38:21
surgery 5:11 7:12,23 8:4 14:10,11,20 15:11, 17 17:9 19:20 20:1, 2,4,5,14 22:24 23:14 27:5,23 28:5 31:22 33:23 34:2,4,5,8,14, 15,18,21 35:14,15 36:19 37:1,19 38:4 39:17 46:16
surgical 7:10 24:8 40:8,12
swelling 28:24 41:9,17,22
sworn 4:2 5:3
synovial 20:19
system 7:2,3 30:15,16

T

tailored 6:3
takes 11:6
talk 34:15 42:24 43:8
talked 44:13,18
talking 43:20
team 43:16
tear 10:1,16 40:8
tearing 10:5 12:2
tears 11:11
ten 23:24 24:1
tendinopathies 11:9
tendinopathy 10:18 11:24 12:12
tendon 8:18,19 9:3,6,8,11, 12,13,14,16,23 10:2, 4,5,20 11:3,4,5,12, 14,20,22 12:1,5,19 13:5,21 16:1,2,7 18:2,7,19 20:8,21 21:3,14,15,16,17,19, 23,24 22:2,4,5,7 24:11 25:20 26:8,14, 22 37:7 40:6,23,24 41:8,10,20 42:1 45:6
tendon-to-tendon 24:2
tendonitis 11:9
tendons 6:1
tension 22:13 27:10,13
terms 14:12 17:14 36:14 39:8
test 39:9
testified 5:4
thawed 21:13
theoretically 13:23
therapist 29:1,5,9 31:16 36:2 38:18 44:4,7
therapy 7:7 30:13,16,18,21 36:1,6,10,11 37:21 38:2,10,17,20 43:20 44:5,14
thing 18:15,24 20:9 32:12 37:8 41:2
things 7:18 10:9 24:18
thought 28:9
three-month 36:23
tibia 6:7 9:23 10:2
tight 30:5,8,22 34:5,13,19 35:11,17 37:19 38:1
tighter 30:13 37:16
tightness 34:6 36:8
time 7:8 8:23 14:16,19 15:11,16,19 17:1 19:14,16 20:13 21:17 22:17,24 23:4 24:1,16,22 28:6 29:11,16 31:23,24 33:4,10 35:1,6,15 37:1,2 39:17 45:19
timeframe 14:9,10,21,24 15:14, 15 17:12,15 24:7 35:20 36:7 37:11 38:14
timeframes 24:19
timely 38:15
times 10:11 14:17 30:18 31:15 38:12
tissue 20:20 21:1,20 24:6, 7,9,11,15,20,23,24 25:16 26:8,18,21 34:10 36:5 39:18
toe 45:10,14
told 8:2 44:3
top 10:6,7
tore 16:7
torn 10:6,8,12,13 16:2
total 6:5
trained 5:10,14
transcript 46:21
transfer 32:13,23
treat 6:21
treatment 19:8
trigger 41:24
tubercle 9:23
type 15:16 39:17,18 43:9
types 23:22
typical 15:15
typically 8:14,15 10:9,19 20:9 24:2 26:22 35:21 38:13 42:13,16,19, 20 43:3,6 45:5

U

ultimately 40:9
undergraduate 5:8
understand 4:24 32:2
understanding 14:23
understands 32:22
University 5:9,10,14
unstable 9:10
unusual 30:23 31:18
upfront 4:24
upwards 42:18
usual 38:11

V

valve 41:6
variable 12:7 34:22
variables 39:17,19
varus-valgus 41:1
versus 30:15
vigorous 35:24
visit 14:15 15:4 30:24 31:19
volleyball 12:13

W

wait 4:19,21
walk 8:21 9:1,3,4 18:2,5 37:9
walking 9:11,20
wanted 32:13,17
weaken 13:5,22,23
weakness 39:1 40:17
weave 21:15
week 30:18 36:2,3 38:12
weeks 8:17 17:20 23:8 28:22 29:12 30:3 31:6 33:7 37:9
weight 18:12
well-healed 28:23
Wexford 4:8 6:13 23:18
work 31:17
Worth 5:11,12
wound 25:24 28:23
wove 21:11
wrist-forearm 6:6
written 4:17 32:20 45:16 46:22
wrote 13:9,10 45:22

X

X-RAY 16:6 41:5,22
X-RAYS 20:15 40:11

Y

year 5:12,16
years 5:11 6:20

EXHIBIT E

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

JOHNNY JONES, Plaintiff, vs. WEXFORD HEALTH SOURCES, NC., and DR. MARSHALL JAMES, Defendants.) No. 17 CV 08218

The deposition of NIKHIL VERMA, 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 Tasha Olivo, Certified Shorthand Reporter of the State of Illinois, at 1611 West Harrison Street, Suite 300, Chicago, Illinois, on the 4th day of September, 2019, at the hour of 7:08 a.m.

Reported by: Tasha Olivo, CSR, RPR
License No. 084-004420

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I N D E X

WITNESS	EXAMINATION
NIKHIL VERMA, M.D.	
By Ms. Byrd	4
By Mr. Flaxman	45

E X H I B I T S

NUMBER	MARKED FOR ID

(NO EXHIBITS WERE MARKED)

(Witness sworn.)

NIKHIL VERMA, M.D.,
called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MS. BYRD:

Q. Dr. Verma, my name is Sandra Byrd, and I'm with the law firm of Cassiday Schade. This is the case of Johnny Jones versus Wexford Health Sources, Inc. It's 17 CV 8218 pending in the Northern District -- United States District Court for the Northern District of Illinois. I am the attorney for Wexford Health Sources and Dr. Marshall James.

Dr. Verma, I'm assuming that you have given depositions before?

A. I have.

Q. And that you understand the rules of depositions?

A. Correct.

Q. That you need to answer out loud. We'll try not to talk over each other. If you don't understand a question that I ask, I assume that you will ask me to clarify because if you answer the question I'm going to assume you understood it the

way that I intended it.
A. Okay.
Q. Fair?
A. Yes.
Q. Okay. Dr. Verma, can you just briefly tell me what your educational background is.
A. Sure. I did my medical school at the University of Pennsylvania, an orthopaedic residency at Rush University Medical Center, and a fellowship in sports medicine and shoulder at the Hospital for Special Surgery in New York.
Q. Okay. And did you review anything in preparation for your deposition today?
A. Just my office notes.
Q. Okay. And those are your office notes regarding Mr. Johnny Jones, correct?
A. Yes.
Q. You didn't meet with Mr. Flaxman or anyone from his office prior to today.
A. Correct.
Q. Okay. You're familiar with Johnny Jones?
A. I am.
Q. Okay. He was a patient of yours?
A. Correct.

Q. And how did he become your patient?
A. I don't know.
Q. You just know that he showed up one day?
A. Correct.
Q. Okay. What kind of surgery did you perform on Johnny Jones?
A. I did an arthroscopic release to remove scar tissue.
Q. Okay. And how much experience do you have with these kinds of operations?
A. I would say a fair amount.
Q. And can you define what a fair amount is for me.
A. In what terms?
Q. In your terms. It's your words, so I'm just trying to figure out how often you do these. Is it something you see often? Is it unusual?
A. I would say it's not the most common diagnosis that we see, but I take care of a fair amount of stiff knee problems.
Q. So if you had to tell me how many of these surgeries you do every year, how many of them would you say you do?
A. Maybe 20.

Q. Okay. And when you're making a determination on whether or not to perform this type of surgery, what kind of information do you want to know?
A. The history, the onsets of symptoms, the duration of stiffness, the degree of stiffness, the impairment that the patient has, the response to treatment to date, presence or absence of other ongoing pathology in the knee.
Q. And of those things, what did you know about Mr. Jones prior to determining that he should undergo surgery?
A. I saw him in July. He had had a surgery to repair a ruptured tendon in November. His knee was fairly stiff from about 90 degrees of flexion, and at that point we recommended the surgery.
Q. Were there any alternatives to surgery that could have been done at that point to resolve his issue?
A. Probably not at that point.
Q. And why is that?
A. Just based on the time frame that the condition existed.
Q. So from November -- having surgery in

November until you saw him in July, is that the time frame you're talking about?
A. Correct.
Q. And what is it about that time frame that you think indicated that he needed to have surgery?
A. Once you get to that point, the stiffness is generally not resolvable with physical therapy just because of maturity of the scar tissue in the knee.
Q. So how long does it take that scar tissue to develop and get to that point? Is that different in everyone or is that somewhat consistent across the board?
A. Usually by four to six months we find that the response to therapy is less successful.
Q. And that's four to six months post surgery?
A. Correct.
Q. Okay. And when a patient has surgery -- you said it was for a tendon issue, correct?
A. Correct.
Q. When a patient has surgery for a -- was it a ruptured tendon? What was the --
A. That was my understanding.

Q. Okay. So when a patient has surgery for a ruptured tendon, what would be the course of treatment that would -- that would hopefully result in them not having to come see you for a second surgery? What should that person do?

A. Well, first of all, this is the most common problem that we see after a patellar tendon ruptures. So some people end up here regardless.

Q. Okay.

A. But generally they have some sort of immobilization for between six to eight weeks. We start therapy anywhere between two to eight weeks depending on the type of tendon tear and the severity of the tendon tear. We try to get them to about 90 degrees by eight to ten weeks after surgery, and then just progress from there with ongoing physical therapy.

Q. Okay. What -- when you say progress to 90 degrees, what is the ultimate goal? What would be full motion?

A. It's different for every person, but average is around 130 degrees.

Q. Okay. So you want to get them from 90 to hopefully 130?

A. Correct.

Q. Okay. If they can't get to 130, is that when you recommend surgery?

A. Well, not necessarily. I mean, if they're 120, we may not see additional gains with surgery, but it depends on the extent of the loss and the impact on their function.

Q. And what was the loss of impact of function for Mr. Jones?

A. Well, he was only at about 90 degrees which would mean he couldn't do things like run, stair climbing would be difficult, and he was -- he expressed frustration with the degree of deficit that he had.

Q. And when you -- you said when you see someone at this point, that recommending physical therapy would not be helpful, correct?

A. In my opinion, no.

Q. Okay. So in July -- you first saw Mr. Jones in July 2016, correct?

A. Correct.

Q. And isn't it true that at that point you recommended physical therapy for him?

A. No. We recommended a left knee

arthroscopy capsular release with manipulation.

Q. So you did not recommend physical therapy?

A. We recommended therapy after surgery, but not in lieu of surgery.

Q. Doctor, I know that you have a copy of your records in front of you, but I'm going to show you the copy that I have so that we can refer to the same page.

At the bottom each of those is Bates labeled, and if you can go -- it says at the bottom Wexford 00263.

A. Okay.

Q. Do you see the Bates label at the bottom?

A. Yeah. Which one do you want? 63?

Q. 263. There's two sets of numbers there, so --

A. Oh, 263. Okay.

Q. There's one -- on this page it's Wexford 263 or the larger bold number says 20 if that's helpful.

A. Okay.

Q. Is that not an order for physical therapy from July 18th, 2016, for Mr. Jones for 3 times a week for 6 weeks for a total number of 18 visits?

A. It is, but it's to be used after surgery.

Q. So can you explain to me why in July of 2016 a therapy order would be entered?

A. Because we want the patient to start therapy the day after surgery, and so we try to plan in advance to make sure that that happens rather than struggling the day of surgery to make sure that it gets started.

Q. Okay. And it's true that Mr. Jones didn't have surgery in this case until October of 2016, correct?

A. He didn't.

Q. So you put an order for in for physical therapy four months in advance of his surgery?

A. Well, I -- look, I don't remember back in July, but that would be our typical practice is to order therapy in advance. Maybe there was a delay in the surgery. I don't know why. But we certainly wouldn't typically order it four months in advance, but we also wouldn't schedule a patient for surgery four months in advance.

Q. Okay. So it's your testimony that this July 18th, 2016, was not you ordering him to do physical therapy in advance of surgery to see if

that was helpful?
A. I don't have any direct recollection, but that wasn't the recommendation that I provided in my note on that visit.
Q. What is a chronic --
A. Well, in fact -- I'm sorry. But if you look it says, we will schedule him for 8/9/2016 on the first note. So there was obviously a surgery date scheduled far in advance of October that for some reason was canceled.
Q. So that's why this physical therapy order would have gone into place in July of 2016 is because you were expecting to do surgery in August?
A. According to this note, yes.
Q. Okay. All right. When you use the term chronic neglected patellar tendon disruption, what do you mean by that?
A. Can you show me where you're referring to.
Q. I can. On the same -- in the same records if you go to Page 250 and it's in the section labeled HPI --
A. To be honest with you, I don't know what that's referring to. I don't know the nature of his patellar tendon disruption or what was done

around the time, but he basically had a chronic arthrofibrosis condition status post a patellar tendon repair.
Q. And you can't -- so you don't know, as you look at this note, what you meant by chronic neglected patellar tendon disruption in that note?
A. Correct.
Q. And if you look at the note that's on Page 247 from October 2017, when you use the same language, do you know what it meant at that point?
A. No.
Q. Do you know what that term generally means, chronic neglected patellar tendon disruption?
A. It's not a medical term, but it would basically mean tendon rupture that was not treated initially.
Q. When you -- you initially testified that when you are diagnosing a patient you take a medical history, correct?
A. Correct.
Q. And what does that medical history typically entail?
A. History of any injury, the subsequent

treatment that they've had, and the current symptoms.
Q. And do you take that or do you have a nurse or PA or someone else take that?
A. Depends on who's in the room.
Q. How important is it that the person that you're taking the history from be honest about what their medical history is?
A. Very important.
Q. Okay. And do you rely on that in making your diagnosis?
A. It depends. I mean, in this case frankly I didn't because his diagnosis is related to what he was coming in for today, but in other cases it may be more important.
Q. Okay. So when you say it wasn't important in this case, explain to me why you think that is the case.
A. Well, I don't think it mattered when his tear -- well, it mattered when his tear was. I don't think the specifics of how he tore his knee, the time between the knee tear and the surgery -- at this point he had a stiff knee and that was with a healed patellar tendon. That was really the

relevant findings. And regardless of what had happened six or nine months ago, the treatment would have been the same.
Q. Okay. And when you do surgery on a patient do you give that patient discharge instructions?
A. Yes, we do.
Q. And how important is it that the patient follow the discharge instructions?
A. Important.
Q. And why is that important?
A. Because those instructions are provided to optimize their postoperative care.
Q. And if a patient doesn't follow your discharge instructions, would you expect their recovery from the surgery to be less successful?
A. They can.
Q. When you first met Mr. Jones, what was your knowledge of his history related to his knee?
A. That he had an injury in November, surgery in February, and had difficulty with flexion.
Q. And did he discuss with you why he had difficulty with flexion? Did you have any information about that?

A. I'm not sure I understand your question.
Q. Did he discuss with you why he had -- why he was having trouble bending his knee? Did he have an opinion on that?
A. He just reported that he had -- again, it's injury in November, surgery in February, he stated that there was no therapy done. He was incarcerated, was released from jail in June, and had difficulty flexing his knee. That's the extent of the history I obtained.
Q. Did you review any of his other medical records?
A. Did not.
Q. Okay. So you assumed that what he told you was accurate and true. You didn't verify that through other records?
A. Again, to me it's irrelevant whether that was accurate or true. The relevant portion is the fact that he had a tendon rupture apparently based on the fact that he had an incision there. He had some type of surgery on his knee. He now had an intact extensor mechanism which was functional but his knee was stiff.
Q. Okay.

A. So whether it was an ACL or a patellar tendon or --
Q. Okay. And when he told you that he injured his knee in November and had surgery in February was that significant to you, that timing?
A. No.
Q. And why was that not significant?
A. For the same reason I just indicated. At this point it was not relevant in the treatment that I was going to administer.
Q. Okay. And the same with him reporting to you that he did not have physical therapy. That was unimportant to you?
A. Correct.
Q. Okay. Did he also tell you that he had an intramedullary rod in his leg?
A. Did not.
Q. Would that have been important to you?
A. Not at this point. No.
Q. And why is that?
A. For the same reason I've already indicated.
Q. So that would not affect the surgery that you're going to do one way or the other?

A. Correct.
Q. Okay. And when you saw Mr. Jones in July 2016 and recommended surgery, you didn't recommend that the surgery be done emergently, correct?
A. It was not an emergency. No.
Q. And would you consider it to have been elective surgery or was it absolutely necessary surgery?
A. It was elective.
Q. Okay. And can you define for me what you mean by elective surgery.
A. I mean that there was an option for him to live with the knee in the current condition and not have a surgery.
Q. Okay. The surgery then occurred on October 11th, 2016, correct?
A. True.
Q. And did you consider that to be a successful surgery?
A. I did.
Q. And what would define a successful surgery in this case?
A. We were able to establish normal range of

motion.
Q. And what is normal range of motion? You said 130 roughly?
A. Average 130. In this case we were able to achieve 135.
Q. And when you say you were able to achieve 135, tell me what that means. How -- like, how are you able to determine that at the time of surgery?
A. How much we're able to bend the knee.
Q. Okay. And would you expect that same amount of bend to occur after surgery?
A. Not necessarily. Patients tend to lose a little bit of range of motion once they're awake and have swelling and difficulty with maintaining motion secondary to pain.
Q. How much would you expect a patient to lose post surgery?
A. It's not how much we expect them to lose, but typically these patients gain somewhere between 20 to 30 degrees from their pre-op to post-op.
Q. Okay. And is that what they gain when they are in the surgical room? Like Mr. Jones had a 135 following the surgery.
A. Yes.

Q. Would you have -- going in would you have expected him to only be at, you know, 110.
A. Well, he was at 90 when we examined him in the office. So the typical gain from the preop exam to the post-op exam is about 20 to 30 degrees. So we would expect him to end up somewhere around 110 to 120.
Q. Okay. So 135 was a very successful surgery?
A. Well, again, that was while he was asleep; but, when all was said and done, we would have expected him to end up around 110 to 120.
Q. You then saw Mr. Jones on October 20th, 2016, for his first post-op visit, correct?
A. True.
Q. And that's when you ordered the physical therapy?
A. Correct.
Q. Okay. And at that time you ordered physical therapy 5 times a week for 2 weeks and 3 times a week for 6 weeks for a total of 18 visits; is that correct?
A. True.
Q. And why did you order that course of

physical therapy?
A. To try to maximize his motion recovery.
Q. And what would be your expectation if you ordered that type of physical therapy for a patient and they didn't follow through on that recommendation?
A. They would not -- they would have a suboptimal result.
Q. You noted on October 20th, 2016, that Mr. Jones had significant swelling and edema in his knee. Is that something you would expect at that time or was that significant?
A. I'm sorry. You're referring to the November --
Q. No. October 20th, that first postop follow-up visit.
A. That would be fairly typical for a first postop visit.
Q. Okay. And you also noted that it was imperative that he continue to work on range of motion to get the swelling out of his knee. Why is that imperative?
A. Well, if he doesn't move it, it's just going to get stiff again and we'll end up back

where we started.
Q. And that was going to be accomplished through the physical therapy, correct?
A. True.
Q. And there's also a note that there's a CPM machine that he's using?
A. Correct.
Q. What is that?
A. It's basically a machine that moves the knee passively up to four to six hours a day.
Q. And this is something that he was doing at home?
A. He was instructed to. Yes.
Q. Okay. And you don't have any way of verifying whether he's actually doing that, correct?
A. I don't.
Q. On October 26, 2016, you filled out some Social Security Administration disability reports for Mr. Jones. Do you recall that?
A. I don't. They're generally filled out by my staff.
Q. Okay. Those -- I use the words filled out only because I think your signature is on them.

If you could look at 299 in the packet I gave you -- and they go through Page 306. On Page 306 is that your signature?
A. Yes.
Q. And is that your writing on that page as well?
A. It's not.
Q. Do you know who's writing it is?
A. It's one of my physician assistants.
Q. Okay. Do you know the purpose of these forms or why you were asked to fill them out or sign off on them?
A. It looks like we had recommended to be off work during the time of physical therapy over 12 weeks.
Q. And what kind of work was he doing at the time?
A. I don't know.
Q. Would that have been something he self-reported to you as well?
A. Typically, yes.
Q. Okay. And it's not something you would verify, correct?
A. It's not.

Q. Okay. But if he told you he needed to be off work, you would have -- there's another letter in there from you saying that he needs to be off work, but you don't know what it is he needed to be off work from?
A. Again, I didn't fill these out directly. I don't know what his work was. If he was at a seated position, he probably could have worked. If he was doing some type of physical labor, he would have been unable.
Q. So on Page 269 which is also from October 26, 2016, there's a letter authored by you saying that he needs to -- it said he may not return to work at this time, correct?
A. True.
Q. But that's based entirely on him saying to you that he can't work. You don't know what he was doing for work, correct?
A. I don't have it documented here, but we would have made that decision at the time based on his type of occupation.
Q. But you didn't make any verification that he was actually working at the time, correct?
A. Did not.

Q. And would that be something that you would expect to occur a month out from surgery?
A. Not uncommon.
Q. Okay. And what's the purpose of that?
A. To try to decrease inflammation to further enhance range of motion recovery.
Q. And at that time Mr. Jones was also being prescribed hydrocodone, correct?
A. True.
Q. And you advised him that he needed to start supplementing with other pain relief, correct?
A. True.
Q. Okay. And why is that?
A. We just don't use narcotics on a long-term basis.
Q. And what would you consider a long-term basis?
A. More than 12 weeks.
Q. Your next visit with Mr. Jones was on December 14th, 2016?
A. Correct.
Q. And you put in another order for physical therapy, correct, for 3 times a week for 6 weeks?

Q. Okay. And as you sit here today you don't say whether or not -- whether he was or was not even employed at the time, correct?
A. I don't know.
Q. Okay. You then next saw Mr. Jones on November 16th, 2016, correct?
A. Correct.
Q. And at that time there was another physical therapy order made for 3 times a week for 4 weeks for a total of 12 visits, correct?
A. True.
Q. And is that in addition to the 18 visits that was ordered in October?
A. It was.
Q. Okay. So that would have taken his total visits at this point up to 30, correct?
A. That sounds right. Yes.
Q. And, again, you ordered that because you wanted -- you thought that's what he needed to do to have an optimal recovery from the surgery?
A. Correct.
Q. Okay. You also gave him a cortisone injection on that day, correct?
A. We did.

A. True.
Q. So that would be an additional 18 visits?
A. Correct.
Q. Okay. So up to now we're up to 48, I think.
A. Correct.
Q. Okay. And was it your understanding at the time that Mr. Jones was doing all of the physical therapy you had previously ordered?
A. Don't know.
Q. Okay. Would it have been your expectation that he was doing the physical therapy you had ordered?
A. It would be.
Q. Okay. That, again, is for sub -- or for an optimal recovery, correct?
A. True.
Q. And if he is not doing all of that physical therapy, you would expect he would have a suboptimal recovery.
A. True.
Q. You also ordered him a hinged knee brace on December 14th, 2016, correct?
A. Correct.

Q. And why would that be ordered?
A. He was complaining of some giving way events that would typically be related to weakness, and it was just to help supplement stability in the knee.
Q. And what would your instructions have been in terms of wearing that knee brace?
A. He would wear it for standing, walking activities, would not need to wear it at night or for seated times.
Q. And for how long?
A. I guess the expectation would be 6 to 12 weeks.
Q. Would you have expected that on January 13th, 2017, he would report to a physical therapist that he had stopped wearing the knee brace three weeks ago?
A. For which date?
Q. On January 13th, 2017.
A. That would seem to be a short-term use.
Q. So you would not have ordered him to stop wearing it by December 23rd, 2016, correct, if you ordered it on December 13th, 2016?
A. Correct.

Q. You also advised Mr. Jones on December 14th that his home exercise program was important, correct?
A. Correct.
Q. And why is the home exercise program important?
A. Same reason as physical therapy. The more you're compliant with the exercises, whether it's done with a therapist or on your own, the better the outcome will be.
Q. During this time would you have been receiving reports from the physical therapy providers?
A. We typically get serial updates, yes.
Q. Okay. And were you receiving those updates on Mr. Jones?
A. I don't review them. My staff does. But looking at your packets, it appears that they're there. So that sounds like we were.
Q. Okay. And then, again, on January 9th, 2017, another physical therapy order was put in for 3 times a week for 6 weeks for another 18 visits. Do you know if that is in addition to the one that was ordered on December 14th?

A. Correct.
Q. Okay. And, again, each of these orders is for additional physical therapy. They're not redundant orders.
A. That's how they would typically be issued. Yes.
Q. Okay. And you then saw Mr. Jones again on January 18th, 2017, correct?
A. January --
Q. 18th.
A. Correct.
Q. And another physical therapy order was issued at that time for 3 times a week for 4 weeks, correct?
A. Correct.
Q. And, again, this is additional visits.
A. Correct.
Q. And you issued another letter excusing him from work on that day, correct?
A. We did.
Q. And, again, you didn't verify that he was actually working; you took his word for it, correct?
A. Did not verify it. No.

Q. Okay. And, as you sit here today, you have no way of knowing if he was actually working at that time, correct?
A. I do not.
Q. Okay. And on that date you noted that he had a normal gait, correct?
A. I did.
Q. And what does that signify to you?
A. Just a normal finding.
Q. Okay. So he was no longer walking with a limp, correct?
A. He did not have a limp. No.
Q. And his range of motion was up to 115; is that correct?
A. True.
Q. So at that point you would consider that to be a successful outcome, correct?
A. I would.
Q. Okay. You also noted on January 18th, 2017, that Mr. Jones had persistent pain and had instability due to inadequate rehabilitation.
A. Correct.
Q. What do you mean by inadequate rehabilitation?

A. Meaning he still had quadriceps weakness.
Q. Is that something you would have expected to have been addressed in physical therapy?
A. We would have. Yes.
Q. Okay. And if he had, I think, over 60 visits ordered by this time, if he had been doing that physical therapy as ordered, you would expect that quadriceps weakness would have resolved, correct?
A. We would have expected it to at least have been better than it was.
Q. Okay. And on that day you gave Mr. Jones an additional 30 narcotics pills, correct?
A. True.
Q. But you indicated that no more would be provided.
A. Correct.
Q. Did you consider that to be the last visit you would have with Mr. Jones regarding his surgery?
A. Not necessarily. No.
Q. And why would -- why would it not be?
A. We would typically follow these patients for a period of about six months.

Q. Do you see that you -- that there was a date or time or period of time that you told Mr. Jones to follow up with you following this January 18th visit?
A. I did. I saw him in April and June.
Q. And that was a bad question. I'm sorry.
In your notes from January 18th, do you see where it says when he should follow up with you?
A. It did not say it in the note. No.
Q. Okay. When you saw Mr. Jones in April 2017 you noted that his motion was coming along well, correct?
A. True.
Q. What does that mean?
A. Well, he had 120 degrees which was 30 degrees better than his preop status, and that was fairly consistent with a good outcome following this type of procedure.
Q. And he was still complaining of pain, correct?
A. Correct.
Q. Is that something that you would expect or --

A. No.
Q. No. And why would you not expect that at that point?
A. Well, I just didn't have necessarily an anatomic basis on which he would have this type of pain.
Q. He told you that he had terminated his physical therapy in February, correct?
A. True.
Q. And did he tell you that he was actually discharged from therapy for noncompliance?
A. He did not.
Q. And at that time his gait was still normal, correct?
A. True.
Q. And he indicated he was still using the brace, correct?
A. He did.
Q. And you recommended another course of physical therapy for another 12 visits, correct?
A. We did.
Q. And at that time you told Mr. Jones that there was no reason to follow up again.
A. Correct.

Q. And on Page 260 of the documents I gave you, on that April 26, 2017, date there's a workers' compensation note.
A. Correct.
Q. Is that a form from your office or is that a form that Mr. Jones presented you?
A. It's just the way our system prints out office notes.
Q. Okay.
A. Off work notes at times. It must have been entered under a workers' compensation -- what's the word I'm looking for?
MR. FLAXMAN: Claim?
THE WITNESS: No. There's just -- you know, if you pick an off work note that's labelled work comp in the system, it just prints it out that way.
BY MS. BYRD:
Q. Okay.
A. There's specific set forms that somebody has to click on.
Q. So whoever clicked on this note clicked on workers' compensation as opposed to the note that we looked at earlier?
A. Correct.

Q. Okay. So as you sit here, you don't have any way of knowing whether Mr. Jones made a workers' comp claim on this, correct?
A. I don't have any knowledge that he did.
Q. Okay. And you still don't have any knowledge of whether or not he was actually working, correct?
A. I don't.
Q. And why is it that you would -- that you determined on April 26, 2016, that there was no further follow up necessary?
A. Based on the time frame after surgery and his somewhat static course, at this point I didn't think there was much else I could do for him.
Q. And you still considered it to be a successful surgery, correct?
A. I did.
Q. But Mr. Jones did come back in June 2017, correct?
A. He did.
Q. And he was given a hinged knee brace at that time, correct?
A. Correct.
Q. And is that a different kind of brace than

A. Don't know.
Q. That's not something that you -- that's something someone else entered?
A. Right.
Q. Do you know who entered that information?
A. It looks like this was from our DME department which is on the first floor.
Q. And DME is durable medical equipment?
A. Correct.
Q. Okay. And on this date you noted that Mr. Jones had some deficiencies in flexion, correct?
A. We're back to which date now?
Q. Same.
A. June 12th?
Q. June 12th. Yeah.
A. He did.
Q. And what were those deficiencies in flexion?
A. He was at 115 degrees. Again, the normal is typically around 130.
Q. And, I'm sorry, 115 you said?
A. Correct.
Q. And do you know what would cause him to go

he had previously or was this a replacement brace?
A. It looks like it was a replacement.
Q. Okay. If you look on Page 250 --
A. Okay.
Q. -- at the bottom under assessment and plan --
A. Okay.
Q. -- it indicates spontaneous rupture of other tendons, comma, other. Does that indicate that he had another tendon rupture?
A. No. That's probably relating to the initial tendon rupture.
250, is that what you're referring to?
Q. Yes. Two five zero.
A. That's just the code that gets used for a history of a patellar tendon rupture.
Q. Okay. And on Page 249, the page before, under procedure documentation --
A. Okay.
Q. -- that last sentence, patient refused DME receipt, what does that mean?
A. Don't know.
Q. And do you know why that is significant, why that would be recorded?

backwards from I think you said previously he was at 120?
A. I think that's within a standard error just on measurement or day-to-day changes.
Q. You indicated that he had difficulty returning to occupational activities.
A. Correct.
Q. And what were those occupational activities that he was having difficulty returning to?
A. So if you look at history of present illness, he indicated he was a former laborer. That's all the information that I have.
Q. And, again, not something that you independently verified, correct?
A. True.
Q. And he was using marijuana for pain control at this point?
A. True.
Q. And is there any significance to that?
A. No. Not really.
Q. And the deficiencies in flexion and the atrophying of his quadriceps, is that something you would expect for someone who is not following

through on the physical therapy that you recommended?
A. Yes.
Q. What's a 1A Lachman, L-a-c-h-m-a-n?
A. That means he had a good endpoint to Lachman testing. So that would be considered fairly normal.
Q. And what is Lachman testing?
A. It's a test we use for the ACL.
Q. To do what?
A. To test whether the ACL is functional or not.
Q. Okay. So that would tell you that the ACL is functional?
A. Correct.
Q. Okay. And then Mr. Jones returned again in October of 2017, correct?
A. Correct.
Q. In fact, a year to the date after his surgery, correct?
A. True.
Q. Okay. And why did he come back at that time?
A. He was subjectively complaining of pain.

Q. Was he asking you to do another surgery?
A. He was not. We were referring him for pain management.
Q. And you told him on that day that there were no other surgical interventions that you could do, correct?
A. True.
Q. You told him that his knee -- functionally his knee was much improved for his range of motion in his quadriceps strength, correct?
A. Correct.
Q. And so at this time you still considered your surgery to be a successful surgery, correct?
A. I felt that it was.
Q. And is that the last time that you saw Mr. Jones?
A. It is.
Q. You did refer him for another course of physical therapy on October 11th, 2017, correct?
A. Correct.
Q. For another 12 visits, correct?
A. Correct.
Q. And do you have any knowledge as you sit here on whether or not Mr. Jones followed through

on that?
A. I don't.
Q. What would have been the purpose for referring him for more physical therapy at that point?
A. It looks like he requested that he wanted to try it again.
Q. So by my count you referred Mr. Jones for a total of close to 100 physical therapy sessions. Does that sound right?
A. Based on the numbers we just discussed, it sounds about right.
Q. And your expectation would have been that he would have done each of those sessions, correct?
A. True.
Q. So if you learned that he only completed approximately 25 of those sessions, what would your expectations be in terms of his recovery from the surgery?
A. Suboptimal.
Q. And if you learned that he was discharged from physical therapy in February 2017 for noncompliance, same, you would think that he would have had a suboptimal outcome?

A. Correct.
Q. So it was critical that he participate in physical therapy as ordered, correct?
A. It was.
Q. Do you have any opinions on Mr. Jones' treatment prior to him seeing you?
A. I do not.
Q. And do you have any opinions on any treatment he may have received after he stopped seeing you?
A. Do not.
Q. Okay. Do you have any opinions on the quality of the surgery that he received prior to seeing you?
A. Do not.
Q. So is it fair to say that in your opinion you performed a successful surgery on Mr. Jones, and it was incumbent upon Mr. Jones to follow through on your post-op recommendation for him to have?
MR. FLAXMAN: Objecting to compound question.
BY MS. BYRD:
Q. Okay. That it was incumbent upon Mr. Jones to follow through on your post-op

recommendations for him to have an optimal recovery?
A. I think that's a fair statement.
MS. BYRD: If you can give me just a minute, I think we could be done.
I don't have anything else.
THE WITNESS: Thanks.
MR. FLAXMAN: I have a few questions, very few.
EXAMINATION
BY MR. FLAXMAN:
Q. Could you explain how you measure range of motion.
A. We just move the knee.
Q. And --
A. Make an assessment.
Q. -- do you use a protractor to measure the degree?
A. Not generally in the office. No.
Q. How do you determine that it's 130 degrees or 135 degrees?
A. You get good at it. I mean, we don't -- you know, honestly whether it's 130 or 135 probably doesn't make a big difference. Whether it's 120 or 130 makes a big difference. Once you're used to

examining knees, you can get fairly close just by being comfortable with it.
Q. So when the knee is straight out, that's zero, and then you bend it back --
A. Correct.
Q. -- to get the -- okay.
Do all of your patients who've had surgical treatment comply with physical therapy recommendations?
A. I would say most of them do.
Q. Okay. And are there -- is Mr. Jones the only one who may not have complied with recommendations?
A. He's not the only one, but those who don't certainty are a suboptimal outcome.
MR. FLAXMAN: Okay. I have nothing further.
MS. BYRD: I have nothing.
THE WITNESS: That's it. Thanks, guys.
MR. FLAXMAN: Thank you.
MS. BYRD: Thank you.
Signature.
THE WITNESS: I'll waive.
(Deposition concluded at 7:59 a.m.)

STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)
I, TASHA OLIVO, an Officer of the Court, do hereby certify that heretofore, to-wit, on the 4th day of September, 2019, personally appeared before me, at 1611 West Harrison Street, Suite 300, Chicago, Illinois, NIKHIL VERMA, M.D., in a cause now pending and undetermined in the Circuit Court of Cook County, Illinois, wherein JOHNNY JONES is the Plaintiff, and WEXFORD HEALTH SOURCES, NC., and DR. MARSHALL JAMES is the Defendant.
I further certify that the said witness was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by said witness was reported stenographically by me in the presence of the said witness, and afterwards reduced to typewriting by Computer-Aided Transcription, and the foregoing is a true and correct transcript of the testimony so given by said witness as aforesaid.
I further certify that the signature to the foregoing deposition was waived by counsel for

the respective parties.
I further certify that the taking of this deposition was pursuant to Notice, and that there were present at the deposition the attorneys hereinbefore mentioned.
I further certify that I am not counsel for nor in any way related to the parties to this suit, nor am I in any way interested in the outcome thereof.
IN TESTIMONY WHEREOF: I have hereunto set my hand and affixed my notarial seal this 11th day of September, 2019.

Illinois Certified Shorthand Reporter

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00263
11:11

1

100
43:9
110
21:2,7,12
115
32:13 39:20,22
11th
19:17 42:19
12
24:15 26:10 27:19 29:13 35:20 42:21
120
10:5 21:7,12 34:16 40:2 45:23
12th
39:15,16
130
9:22,24 10:2 20:3,4 39:21 45:19,22,24
135
20:5,7,23 21:8 45:20,22
13th
29:15,19,23
14th
27:21 28:23 30:2,24
16th
26:6
17
4:10
18
11:24 21:21 26:12 28:2 30:22
18th
11:23 12:23 31:8,10 32:19 34:4,7
1A
41:4

2

2
21:20
20
6:24 11:19 20:20 21:5
2016
10:20 11:23 12:3,10, 23 13:12 19:3,17 21:14 22:9 23:18 25:12 26:6 27:21 28:23 29:22,23 37:10
2017
14:9 29:15,19 30:21 31:8 32:20 34:12 36:2 37:18 41:17 42:19 43:22
20th
21:13 22:9,15
23rd
29:22
247
14:9
249
38:17
25
43:17
250
13:20 38:3,13
26
23:18 25:12 36:2
37:10
260
36:1
263
11:15,17,19
269
25:11
299
24:1

3

3
11:23 21:20 26:9 27:24 30:22 31:13
30
20:20 21:5 26:16 33:13 34:17
306
24:2,3

4

4
26:10 31:13
48
28:4

5

5
21:20

6

6
11:24 21:21 27:24 29:12 30:22
60
33:5
63
11:14

7

7:59
46:24

8

8/9/2016
13:7
8218
4:10

9

90
7:15 9:15,19,23 10:10 21:3
9th
30:20

A

a.m.
46:24
absence
7:8
absolutely
19:8
accomplished
23:2
accurate
17:15,18
achieve
20:5,6
ACL
18:1 41:9,11,13
activities
29:9 40:6,9
addition
26:12 30:23
additional
10:5 28:2 31:3,16 33:13
addressed
33:3
administer
18:10
Administration
23:19
advance
12:6,14,17,20,21,24 13:9
advised
27:10 30:1
affect
18:23
alternatives
7:17
amount
6:11,12,20 20:11
anatomic
35:5
apparently
17:19
appears
30:18
approximately
43:17
April
34:5,12 36:2 37:10
arthrofibrosis
14:2
arthroscopic
6:7
arthroscopy
11:1
asleep
21:10
assessment
38:5 45:15
assistants
24:9
assume
4:22,24
assumed
17:14
assuming
4:14
atrophying
40:23
attorney
4:12
August
13:13
authored
25:12
average
9:22 20:4
awake
20:13

B

back
12:15 22:24 37:18 39:13 41:22 46:4
background
5:6
backwards
40:1
bad
34:6
based
7:22 17:19 25:16,20 37:12 43:11
basically
14:1,16 23:9
basis
27:16,18 35:5
Bates
11:10,13
bend
20:9,11 46:4
bending
17:3
big
45:23,24
bit
20:13
board
8:13
bold
11:19
bottom
11:9,11,13 38:5
brace
28:22 29:7,17 35:17 37:21,24 38:1
briefly
5:5
Byrd
4:6,7 36:17 44:22 45:4 46:17,20

C

called
4:3
canceled
13:10
capsular
11:1
care
6:19 16:13
case
4:9 12:10 15:12,17, 18 19:23 20:4
cases
15:14
Cassiday
4:8
cause
39:24
Center
5:9
certainty
46:15
chronic
13:5,16 14:1,5,13
claim
36:13 37:3
clarify
4:23
click
36:20
clicked
36:21
climbing
10:12
close
43:9 46:1
code
38:15
comfortable
46:2
comma
38:9
common
6:18 9:7
comp
36:15 37:3
compensation
36:3,11,22
complaining
29:2 34:20 41:24
completed
43:16
compliant
30:8
complied
46:12
comply
46:8
compound
44:21
concluded
46:23
condition
7:23 14:2 19:14
considered
37:15 41:6 42:12
consistent
8:13 34:18
continue
22:20
control
40:18
copy
11:5,7
correct
4:19 5:16,20,24 6:4 8:3,18,20,21 10:1, 17,20,21 12:11 14:7, 20,21 18:14 19:1,5, 17 21:14,18,22 23:3, 7,16 24:23 25:14,18, 23 26:3,6,7,10,16, 21,23 27:8,12,22,24 28:3,6,16,23,24 29:22,24 30:3,4 31:1,8,11,14,15,17, 19,23 32:3,6,11,14, 17,22 33:9,13,17 34:13,21,22 35:8,14, 17,20,24 36:4,24 37:3,7,16,19,22,23 39:9,12,23 40:7,15 41:15,17,18,20 42:6, 10,11,13,19,20,21, 22 43:14 44:1,3 46:5
cortisone
26:22
count
43:8
Court
4:11
CPM
23:5
critical
44:2
current
15:1 19:14
CV
4:10

D

date
7:8 13:9 29:18 32:5 34:2 36:2 39:10,13 41:19
day
6:3 12:5,7 23:10 26:23 31:19 33:12 42:4
day-to-day
40:4
December
27:21 28:23 29:22, 23 30:2,24
decision
25:20
decrease
27:5
deficiencies
39:11,18 40:22
deficit
10:13
define
6:12 19:11,22
degree
7:6 10:13 45:17
degrees
7:15 9:15,19,22 10:10 20:20 21:5 34:16,17 39:20 45:19,20
delay
12:17
department
39:7
depending
9:13
depends
10:6 15:5,12
deposition
5:13 46:23
depositions
4:15,18
determination
7:2
determine
20:8 45:19
determined
37:10
determining
7:11
develop
8:11
diagnosing
14:19
diagnosis
6:19 15:11,13
difference
45:23,24
difficult
10:12
difficulty
16:21,23 17:9 20:14 40:5,9
direct
13:2
directly
25:6
disability
23:19
discharge
16:5,9,15
discharged
35:11 43:21
discuss
16:22 17:2
discussed
43:11
disruption
13:16,24 14:6,14
District
4:11,12
DME
38:20 39:6,8
Doctor
11:5
documentation
38:18
documented
25:19
documents
36:1
due
32:21
duly
4:3
durable
39:8
duration
7:6

E

earlier 36:23
edema 22:10
educational 5:6
elective 19:8,10,12
emergency 19:6
emergently 19:4
employed 26:3
end 9:8 21:6,12 22:24
endpoint 41:5
enhance 27:6
entail 14:23
entered 12:3 36:11 39:3,5
equipment 39:8
error 40:3
establish 19:24
events 29:3
exam 21:5
EXAMINATION 4:5 45:9
examined 4:4 21:3
examining 46:1
excusing 31:18
exercise 30:2,5
exercises 30:8
existed 7:23
expect 16:15 20:10,16,18 21:6 22:11 27:2 28:19 33:7 34:23 35:2 40:24
expectation 22:3 28:11 29:12 43:13
expectations 43:18
expected 21:2,12 29:14 33:2, 10
expecting 13:13
experience 6:9
explain 12:2 15:17 45:11
expressed 10:13
extensor 17:22
extent 10:6 17:9

F

fact 13:6 17:19,20 41:19
fair 5:3 6:11,12,19 44:16 45:3
fairly 7:15 22:17 34:18 41:7 46:1
familiar 5:21
February 16:21 17:6 18:5 35:8 43:22
fellowship 5:10
felt 42:14
figure 6:16
fill 24:11 25:6
filled 23:18,21,23
find 8:14
finding 32:9
findings 16:1
firm 4:8
Flaxman 5:18 36:13 44:21 45:8,10 46:16,19
flexing 17:9
flexion 7:15 16:21,23 39:11, 19 40:22
floor 39:7
follow 16:9,14 22:5 33:23 34:3,8 35:23 37:11 44:18,24
follow-up 22:16
form 36:5,6
forms 24:11 36:19
frame 7:22 8:2,4 37:12
frankly 15:12
front 11:6
frustration 10:13
full 9:20
function 10:7,9
functional 17:22 41:11,14
functionally 42:8

G

gain 20:19,21 21:4
gains 10:5
gait 32:6 35:13
gave 24:2 26:22 33:12 36:1
generally 8:7 9:10 14:12 23:21 45:18
give 16:5 45:4
giving 29:2
goal 9:19
good 34:18 41:5 45:21
guess 29:12
guys 46:18

H

happened 16:2
healed 15:24
Health 4:9,13
helpful 10:17 11:20 13:1
hinged 28:22 37:21
history 7:5 14:20,22,24 15:7,8 16:19 17:10 38:16 40:11
home 23:12 30:2,5
honest 13:22 15:7
honestly 45:22
Hospital 5:11
hours 23:10
HPI 13:21
hydrocodone 27:8

I

Illinois 4:12
illness 40:12
immobilization 9:11
impact 10:7,8
impairment 7:7
imperative 22:20,22
important 15:6,9,15,16 16:8, 10,11 18:18 30:3,6
improved 42:9
inadequate 32:21,23
incarcerated 17:8
incision 17:20
incumbent 44:18,23
independently 40:15
inflammation 27:5
information 7:3 16:24 39:5 40:13
initial 38:12
initially 14:17,18
injection 26:23
injured 18:4
injury 14:24 16:20 17:6
instability 32:21
instructed 23:13
instructions 16:6,9,12,15 29:6
intact 17:22
intended 5:1
interventions 42:5
intramedullary 18:16
irrelevant 17:17
issue 7:19 8:20
issued 31:5,13,18

J

jail 17:8
James 4:13
January 29:15,19 30:20 31:8, 9 32:19 34:4,7
Johnny 4:9 5:16,21 6:6
Jones 4:9 5:16,21 6:6 7:11 10:9,20 11:23 12:9 16:18 19:2 20:22 21:13 22:10 23:20 26:5 27:7,20 28:8 30:1,16 31:7 32:20 33:12,19 34:3,11 35:22 36:6 37:2,18 39:11 41:16 42:16, 24 43:8 44:17,18,24 46:11
Jones' 44:5
July 7:13 8:1 10:19,20 11:23 12:2,16,23 13:12 19:3
June 17:8 34:5 37:18 39:15,16

K

kind 6:5 7:3 24:16 37:24
kinds 6:10
knee 6:20 7:9,14 8:9 10:24 15:21,22,23 16:19 17:3,9,21,23 18:4 19:14 20:9 22:11,21 23:10 28:22 29:5,7,16 37:21 42:8,9 45:13 46:3
knees 46:1
knowing 32:2 37:2
knowledge 16:19 37:4,6 42:23

L

L-A-C-H-M-A-N 41:4
label 11:13
labeled 11:10 13:21
labelled 36:15
labor 25:9
laborer 40:12
Lachman 41:4,6,8
language 14:10
larger 11:19
law 4:8
learned 43:16,21
left 10:24
leg 18:16
letter 25:2,12 31:18
lieu 11:4
limp 32:11,12
live 19:14
long 8:10 29:11
long-term 27:15,17
longer 32:10
looked 36:23
lose 20:12,17,18
loss 10:6,8
loud 4:20

M

M.D. 4:2
machine 23:6,9
made 25:20 26:9 37:2
maintaining 20:14
make 12:6,7 25:22 45:15, 23
makes 45:24
making 7:1 15:10
management 42:3
manipulation 11:1
marijuana 40:17
Marshall 4:13
mattered 15:19,20
maturity 8:8
maximize 22:2
Meaning 33:1
means 14:13 20:7 41:5
meant 14:5,10
measure 45:11,16
measurement 40:4
mechanism 17:22
medical 5:7,9 14:15,20,22 15:8 17:11 39:8
medicine 5:10
meet 5:18
met 16:18
minute 45:4
month 27:2
months 8:14,16 12:14,19,21 16:2 33:24
motion 9:20 20:1,2,13,15 22:2,21 27:6 32:13 34:12 42:9 45:12
move 22:23 45:13
moves 23:9

N

narcotics 27:15 33:13
nature 13:23
necessarily 10:4 20:12 33:21 35:4
needed 8:5 25:1,4 26:19 27:10
neglected 13:16 14:6,13
night 29:9
NIKHIL 4:2
noncompliance 35:11 43:23
normal 19:24 20:2 32:6,9 35:14 39:20 41:7
Northern 4:10,12
note 13:4,8,14 14:5,6,8 23:5 34:10 36:3,15, 21,22
noted 22:9,19 32:5,19

34:12 39:10
notes 5:14,15 34:7 36:8,10
November 7:14,24 8:1 16:20 17:6 18:4 22:14 26:6
number 11:19,24
numbers 11:15 43:11
nurse 15:4

O

Objecting 44:21
obtained 17:10
occupation 25:21
occupational 40:6,8
occur 20:11 27:2
occurred 19:16
October 12:10 13:9 14:9 19:17 21:13 22:9,15 23:18 25:12 26:13 41:17 42:19
office 5:14,15,19 21:4 36:5,8 45:18
ongoing 7:9 9:17
onsets 7:5
operations 6:10
opinion 10:18 17:4 44:16
opinions 44:5,8,12
opposed 36:22
optimal 26:20 28:16 45:1
optimize 16:13
option 19:13
order 11:22 12:3,13,17,19 13:11 21:24 26:9 27:23 30:21 31:12
ordered 21:16,19 22:4 26:13,18 28:9,13,22 29:1,21,23 30:24 33:6,7 44:3
ordering 12:23
orders 31:2,4
orthopaedic 5:8
outcome 30:10 32:17 34:18 43:24 46:15

P

PA 15:4
packet 24:1
packets 30:18
pain 20:15 27:11 32:20 34:20 35:6 40:17 41:24 42:3
participate 44:2
passively 23:10
patellar 9:7 13:16,24 14:2,6,13 15:24 18:1 38:16
pathology 7:9
patient 5:23 6:1 7:7 8:19,22 9:1 12:4,20 14:19 16:5,8,14 20:16 22:4 38:20
patients 20:12,19 33:23 46:7
pending 4:10
Pennsylvania 5:8
people 9:8
perform 6:6 7:2
performed 44:17
period 33:24 34:2
persistent 32:20
person 9:5,21 15:6
physical 8:7 9:17 10:16,23 11:2,22 12:13,24 13:11 18:12 21:16,20 22:1,4 23:3 24:14 25:9 26:9 27:23 28:9,12,19 29:15 30:7,12,21 31:3,12 33:3,7 35:8,20 41:1 42:19 43:4,9,22 44:3 46:8
physician 24:9
pick 36:15
pills 33:13
place 13:12
plan 12:6 38:6
point 7:16,18,20 8:6,11 10:16,22 14:10 15:23 18:9,19 26:16 32:16 35:3 37:13 40:18 43:5
portion 17:18
position 25:8
post 8:16 14:2 20:17
post-op 20:20 21:5,14 44:19,24
postop 22:15,18
postoperative 16:13
practice 12:16
pre-op 20:20
preop 21:4 34:17
preparation 5:13
prescribed 27:8
presence 7:8
present 40:11
presented 36:6
previously 28:9 38:1 40:1
prints 36:7,16
prior 5:19 7:11 44:6,13
problem 9:7
problems 6:20
procedure 34:19 38:18
program 30:2,5
progress 9:16,18
protractor 45:16
provided 13:3 16:12 33:16
providers 30:13
purpose 24:10 27:4 43:3
put 12:13 27:23 30:21

Q

quadriceps 33:1,8 40:23 42:10
quality 44:13
question 4:22,24 17:1 34:6 44:21
questions 45:8

R

range 19:24 20:2,13 22:20 27:6 32:13 42:9 45:11
reason 13:10 18:8,21 30:7 35:23
recall 23:20
receipt 38:21
received 44:9,13
receiving 30:12,15
recollection 13:2
recommend 10:3 11:2 19:4
recommendation 13:3 22:6 44:19
recommendations 45:1 46:9,13
recommended 7:16 10:23,24 11:3 19:3 24:13 35:19 41:2
recommending 10:16
recorded 38:24
records 11:6 13:19 17:12,16
recovery 16:16 22:2 26:20 27:6 28:16,20 43:18 45:2
redundant 31:4
refer 11:7 42:18
referred 43:8
referring 13:18,23 22:13 38:13 42:2 43:4
refused 38:20
rehabilitation 32:21,24
related 15:13 16:19 29:3
relating 38:11
release 6:7 11:1
released 17:8
relevant 16:1 17:18 18:9
relief 27:11
rely 15:10
remember 12:15
remove 6:7
repair 7:14 14:3
replacement 38:1,2
report 29:15
reported 17:5
reporting 18:11
reports 23:19 30:12
requested 43:6
residency 5:9
resolvable 8:7
resolve 7:18
resolved 33:8
response 7:7 8:15
result 9:3 22:8
return 25:14
returned 41:16
returning 40:6,9
review 5:12 17:11 30:17
rod 18:16
room 15:5 20:22
roughly 20:3
rules 4:17
run 10:11
rupture 14:16 17:19 38:8,10,12,16
ruptured 7:14 8:23 9:2
ruptures 9:8
Rush 5:9

S

Sandra 4:7
scar 6:8 8:8,10
Schade 4:8
schedule 12:20 13:7
scheduled 13:9
school 5:7
seated 25:8 29:10
secondary 20:15
section 13:20
Security 23:19
self-reported 24:20
sentence 38:20
serial 30:14
sessions 43:9,14,17
set 36:19
sets 11:15
severity 9:14
short-term 29:20
shoulder 5:10
show 11:6 13:18
showed 6:3
sign 24:12
signature 23:24 24:3 46:21
significance 40:20
significant 18:5,7 22:10,12 38:23
signify 32:8
sit 26:1 32:1 37:1 42:23
Social 23:19
sort 9:10
sound 43:10
sounds 26:17 30:19 43:12
Sources 4:9,13
Special 5:11
specific 36:19
specifics 15:21
spontaneous 38:8
sports 5:10
stability 29:4
staff 23:22 30:17
stair 10:12
standard 40:3
standing 29:8
start 9:12 12:4 27:11
started 12:8 23:1
stated 17:7
statement 45:3
States 4:11
static 37:13
status 14:2 34:17
stiff 6:20 7:15 15:23 17:23 22:24
stiffness 7:6 8:6
stop 29:21
stopped 29:16 44:9
straight 46:3
strength 42:10
struggling 12:7
subjectively 41:24
suboptimal 22:8 28:20 43:20,24 46:15
subsequent 14:24
successful 8:15 16:16 19:20,22 21:8 32:17 37:16 42:13 44:17
supplement 29:4
supplementing 27:11
surgeries 6:22
surgery 5:11 6:5 7:3,12,13,16,17,24 8:5,17,19,22 9:1,5,16 10:3,5 11:3,4 12:1,5,7,10,14,18,21,24 13:8,13 15:22 16:4,16,20 17:6,21 18:4,23 19:3,4,8,9,12,15,16,20,22 20:8,11,17,23

21:9 26:20 27:2 33:20 37:12,16 41:20 42:1,13 43:19 44:13,17
surgical 20:22 42:5 46:8
swelling 20:14 22:10,21
sworn 4:1,4
symptoms 7:5 15:2
system 36:7,16

T

taking 15:7
talk 4:21
talking 8:2
tear 9:13,14 15:20,22
ten 9:15
tend 20:12
tendon 7:14 8:20,23 9:2,7, 13,14 13:16,24 14:3, 6,13,16 15:24 17:19 18:2 38:10,12,16
tendons 38:9
term 13:15 14:12,15
terminated 35:7
terms 6:14,15 29:7 43:18
test 41:9,11
testified 4:4 14:18
testimony 12:22
testing 41:6,8
therapist 29:16 30:9
therapy 8:7,15 9:12,17 10:17,23 11:2,3,22 12:3,5,14,17,24 13:11 17:7 18:12 21:17,20 22:1,4 23:3 24:14 26:9 27:24 28:9,12,19 30:7,12, 21 31:3,12 33:3,7 35:8,11,20 41:1 42:19 43:4,9,22 44:3 46:8
things 7:10 10:11
thought 26:19
time 7:22 8:2,4 14:1 15:22 20:8 21:19 22:12 24:14,17 25:14,20,23 26:3,8 27:7 28:8 30:11 31:13 32:3 33:6 34:2 35:13,22 37:12,22 41:23 42:12,15
times 11:23 21:20,21 26:9 27:24 29:10 30:22 31:13 36:10
timing 18:5
tissue 6:8 8:8,10
today 5:13,19 15:14 26:1 32:1
told 17:14 18:3 25:1 34:2 35:7,22 42:4,8
tore 15:21
total 11:24 21:21 26:10, 15 43:9
treated 14:16
treatment 7:8 9:3 15:1 16:2 18:9 44:6,9 46:8
trouble 17:3
true 10:22 12:9 17:15,18 19:18 21:15,23 23:4 25:15 26:11 27:9,13 28:1,17,21 32:15 33:14 34:14 35:9,15 40:16,19 41:21 42:7 43:15
type 7:3 9:13 17:21 22:4 25:9,21 34:19 35:5
typical 12:16 21:4 22:17
typically 12:19 14:23 20:19 24:21 29:3 30:14 31:5 33:23 39:21

U

ultimate 9:19
unable 25:10
uncommon 27:3
undergo 7:12
understand 4:17,22 17:1
understanding 8:24 28:7
understood 4:24
unimportant 18:13
United 4:11
University 5:8,9
unusual 6:17
updates 30:14,16

V

verification 25:22
verified 40:15
verify 17:15 24:23 31:21, 24
verifying 23:15
Verma 4:2,7,14 5:5
versus 4:9
visit 13:4 21:14 22:16,18 27:20 33:18 34:4
visits 11:24 21:21 26:10, 12,16 28:2 30:22 31:16 33:6 35:20 42:21

W

waive 46:22
walking 29:8 32:10
wanted 26:19 43:6
weakness 29:3 33:1,8
wear 29:8,9
wearing 29:7,16,22
week 11:24 21:20,21 26:9 27:24 30:22 31:13
weeks 9:11,12,15 11:24 21:20,21 24:15 26:10 27:19,24 29:13,17 30:22 31:13
Wexford 4:9,13 11:11,18
who've 46:7
word 31:22 36:12
words 6:15 23:23
work 22:20 24:14,16 25:2, 4,5,7,14,17,18 31:19 36:10,15
worked 25:8
workers' 36:3,11,22 37:3
working 25:23 31:22 32:2 37:7
writing 24:5,8

Y

year 6:22 41:19
York 5:11

EXHIBIT F

November 12, 2019

Sandra L. Byrd
Cassiday Schade, LLP
222 W. Adams St., Suite 2900
Chicago, IL 60606

RE: Johnny Jones

Dear Ms. Byrd,

Below you will find my medical opinions regarding Mr. Johnny Jones. All of my opinions are rendered to a reasonable degree of medical certainty based on my review of the below-listed documents and my education, training and professional experience as a board-certified orthopedic surgeon. In forming these opinions, I have reviewed the following documents:

- Plaintiff's Complaint;
- Illinois Department of Corrections Medical Records;
- Wexford Health Sources, Inc.'s Utilization Management Notes;
- Medical Records from Midwest Orthopedic, Midwest Orthopedic at Rush, Rush Hospital, Valley West Hospital, Oak Park Hospital, Schwab Rehabilitation Center, Lawndale Christian Center and the Social Security Administration;
- Deposition testimony of Plaintiff;
- Deposition testimony of Dr. Marshall James;
- Deposition testimony of Dr. Neil Fisher;
- Deposition testimony of Dr. Ankhur Behl;
- Deposition testimony of Nikhil Verma;
- The report of Plaintiff's retained expert, Dr. Vincent Cannestra; and
- Deposition testimony of Plaintiff's retained expert, Dr. Vincent Cannestra.

Background

I have been a practicing orthopaedic surgeon for over thirty years. I obtained a Bachelor of Arts at Princeton University in 1975. In 1979, I obtained my Medical Doctorate at Johns Hopkins University Medical School and in 1980 I completed my surgical internship at the University of Chicago. I completed an orthopaedic residency at Rush Presbyterian St. Luke's Medical Center in 1984 and, in 1985 I completed an orthopaedic and sports medicine fellowship at Harvard Medical School/Massachusetts General Hospital.

I obtained my board-certification in orthopaedic surgery in 1987 and was recertified in 1997, 2007 and 2017. I served as an assistant professor at Rush University's Department of Orthopaedic Surgery for more than twenty five years and am currently the President of the Illinois Sportsmedicine and Orthopaedic Centers and Medical Director of the Illinois Orthopaedic Foundation. My *curriculum vitae* is attached hereto.

As a board-certified orthopaedic surgeon, I am familiar with the care and treatment of the orthopedic conditions involved in this matter.

Background

On November 14, 2015 Mr. Jones injured his left knee playing basketball. The same day he was examined by a nurse who noted that the patient characterized his pain as only a level of four on a scale of 1 to 10. The patient was also noted to have no tenderness swelling or bruising and was ambulatory under his own power.

The patient was then seen on November 16, 2015 by Dr. Marshall James. Dr. James considered the possibility of injury to his patellar tendon, ordered an x-ray to rule out a patellar tendon rupture and instructed Mr. Jones on home exercises. The x-ray showed a slightly upriding patella with a small knee joint effusion. Complete patellar tendon ruptures almost always have a large effusion. In general a complete rupture of the patellar tendon will also produce far more upriding than this. Based on the patient's presentation and the x-ray results, Dr. James appropriately told the patient to return on an as needed basis – *i.e.* if he were not doing well.

When the patient did return a few weeks later on December 8, 2015, Dr. James noted Mr. Jones had persistent left knee pain and swelling and that Mr. Jones' patella was notably displaced, in contradistinction to what he observed when the patient initially presented to him. Dr. James immediately ordered an MRI which is the standard of care for evaluation of knee injuries. The MRI was approved on December 15, 2015. Notably, on both December 26, 2015 and December 29, 2015, Mr. Jones refused medical care with the Sheridan Correctional Center medical staff.

Mr. Jones had an MRI on January 18, 2016. The radiologist did not urgently refer Mr. Jones for a surgical consult. Mr. Jones then saw the orthopedic surgeon on February 8, 2016. The surgeon discussed both operative and nonoperative options with Mr. Jones and Mr. Jones chose to undergo surgery. On February 16, 2016, Mr. Jones underwent successful surgery to repair his patellar tendon.

Following his surgery, Mr. Jones was housed in the prison infirmary until his release from prison in June 2016. Prior to his release from prison, Mr. Jones was seen for all recommended follow up appointments with his surgeon, and received physical therapy as recommended by the surgeon's office. Mr. Jones, however, admitted that he was not sufficiently self-motivated to diligently follow through with the recommended physical therapy on his own in the prison infirmary. As well, Mr. Jones was observed on occasion to not be wearing his brace as ordered by his surgeon.

Following his release from prison, Mr. Jones missed his follow-up appointment with his surgeon and in October 2016, Mr. Jones underwent elective surgery with a different surgeon, Dr. Verma, after complaining of moderate stiffness, which can occur after any primary repair or graft repair. Full flexion, that is full motion, was achieved during this surgery. Following the surgery, Dr. Verma referred Mr. Jones for an intensive course of physical therapy from which Mr. Jones was discharged for noncompliance. As well, Mr. Jones was noncompliant with Dr. Verma's recommendation to wear a brace on his knee.

In January 2017, Mr. Jones was noted to have a normal gait and walk without a limp and at his last appointment with Dr. Verma, Mr. Jones was noted to have 120° of knee flexion—a degree of knee flexion that would not produce restrictions on any activity—and Dr. Verma further noted that he could

not find any "anatomic reason" for Mr. Jones' subjective reports of pain. Mr. Jones' ultimate surgical result was good. At no time did Midwest Orthopaedics or Dr. Verma indicate that any delay in surgery affected the result.

Opinions

1. The medical care that Mr. Jones received from Dr. James was within the standard of care for a primary care doctor evaluating an acute knee injury.

Mr. Jones presented with little swelling, little pain, no bruising and an essentially normal x-ray. There was no reason for Dr. James or the nurse who initially triaged Mr. Jones to fear that a complete patellar tendon rupture had occurred. The clinical and radiologic presentations were quite atypical such that even an experienced orthopedic surgeon might not have diagnosed a complete patellar tendon rupture. Certainly I would not expect any non-orthopedic surgeon to come up with a diagnosis of complete patellar tendon rupture based on this patient's presentation.

Most injuries presenting in this fashion are acute and self-limited. They do not require a follow-up appointment be scheduled unless the patient is not doing well. For this reason Dr. James appropriately told the patient to return on an as needed basis if he were not doing well. When the patient did return a few weeks later Dr. James noted that the injury was presenting in a significantly different fashion than it had a few weeks earlier, and consistent with the standard of care, Dr. James ordered an MRI.

In a non-prison setting, insurance companies routinely refuse to approve MRIs for soft tissue injuries unless patients have first undergone a course of physical therapy or home exercise such as was prescribed by Dr. James. This is also true for companies that specialize in work-related injuries. The reasoning is that any non-fracture soft tissue injury will still be treatable after a delay of a few weeks and the great majority of these injuries will resolve during that timeframe, thus sparing the health system the unnecessary expense, and the patient the unnecessary discomfort, of unwarranted MRI scans. Thus Mr. Jones did not receive substandard care but rather exactly the care that is uniformly prescribed outside of the prison health system.

Additionally, complete tendon and ligament ruptures are frequently not diagnosed by the initial treating physician whether in the emergency room, in an urgent care clinic, a worker's compensation clinic or a primary care doctor's office. The initial treater is almost always a family practice doctor, internal medicine doctor or mid-level practitioner. They must be able to treat the full spectrum of medical problems and are not narrow subspecialists in the treatment of knee disorders. If an orthopedic surgeon performs the initial evaluation diagnostic accuracy is certainly higher. But in more than 30 years of practice as a knee specialist I have found that it is quite common for the initial diagnosis by the general practitioner to not be correct in this kind of case. It is the responsibility of the orthopedic surgeon to find the correct diagnosis in patients who are not progressing well as happened here. Surgery for ligament and tendon ruptures is quite commonly delayed for this reason.

Furthermore, a typical patellar tendon is roughly 50 mm long, however studies have shown significant variability in patellar tendon length. In fact, one study showed a difference of 7 mm in the average length of the tendon between patients with different probabilities of patellar dislocation. This longer patellar tendon is called patella alta and produces slight upriding but does not indicate injury. Dr.

Cannestra, Plaintiff's retained expert, indicated that a slight upriding patella would be considered to be roughly 2-6 mm. Thus slight upriding, as seen in Mr. Jones' x-ray, is not indicative of an abnormal state and not consistent with complete patellar tendon disruption. Dr. James was astute in even considering the possibility of some injury to the patellar tendon, especially since the patient had 5/5 strength. Dr. James' thorough examination did show some laxity of the affected patella, however when Dr. James compared it to Mr. Jones' other knee he noted the two knees were the same. By the time Mr. Jones did manifest a more typical patellar tendon presentation it was noted that he had 18 millimeters of upriding, vastly different than the slight upriding found by the radiologist and described by Dr. Cannestra.

As well, the fact that Mr. Jones was seen by a medical doctor as opposed to a mid-level practitioner, such as a physician's assistant, within 48 hours of his injury exceeds the standard of care in the community. It is typical for a patient presenting with symptoms consistent with those of Mr. Jones to first be seen by a mid-level practitioner, not a physician for weeks. Regardless, Mr. Jones' clinical and radiographic presentations were not typical for a complete patellar tendon rupture. It is unlikely that any primary care practitioner, including a primary care physician, would have recognized it as such given the normal x-ray and benign exam.

Finally, it is the standard of care to order an MRI only if the patient does not do well after several weeks of exercise. Insurance companies generally will not pay for MRI absent a course of physical therapy or prescribed exercise and patients do not pay for them out of pocket due to their expense. Thus, Dr. James' prescription for an MRI after Mr. Jones did not improve with rest and home exercise is exactly consistent with community norms and the standard of care.

2. Mr. Jones' tendon graft surgery was successful and restored function of his patellar tendon.

Mr. Jones underwent successful surgery to repair his patellar tendon in February 2016. Neither of Mr. Jones' surgeons has ever stated that any delay in surgery affected the outcome of the surgery. After Mr. Jones' surgery stability was restored, he developed moderate stiffness which can occur after any primary repair or graft surgery. Mr. Jones did achieve 90° of knee flexion which is quite consistent with painless walking and ascent of stairs but does require an altered gate for descent of stairs. The degree of stiffness Mr. Jones had would not produce pain or interfere with activities of daily living in the interval between his first and second surgery. Any stiffness experienced by Mr. Jones after his surgery was not due to any perceived delay in the surgery. Stiffness is seen following surgery performed both early and late and is actually more common in surgery performed earlier. It is more likely that any stiffness or failure to achieve full range of motion was the result of Mr. Jones's failure to successfully follow through on the ordered course of physical therapy. Restoration of satisfactory postoperative motion is the chief goal of this physical therapy. Failure to follow through on the recommended course of physical therapy most likely contributed to any sub-optimal outcome for Mr. Jones.

In fact, while Mr. Jones was awaiting his second surgery he had a full 90° of knee flexion which would allow him to perform all activities of daily living without pain. It should be noted that full flexion, that is full range of motion, was achieved during surgery. As well, following his second surgery Mr. Jones was able to maintain a very good range of motion, 120°, which would not restrict activities of any kind. There is no objective basis for Mr. Jones' continued subjective complaints of pain, which Dr. Verma confirmed when he stated that he could find no anatomic reason for Mr. Jones' continuing complaints of pain. As such, it is unlikely that Mr. Jones will require future medical treatment for his left knee.

Conclusion

Each of my opinions is rendered to a reasonable degree of medical certainty. I expressly reserve the right to supplement and/or revise my opinions should additional documentation develop. My current fee schedule and *curriculum vitae* are attached hereto.

Sincerely,

/s/ Chadwick Prodromos, M.D.

EXHIBIT G

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

JOHNNY JONES,)
Plaintiff,)
)
-vs-) No. 17 CV-08218
)
WEXFORD HEALTH SOURCES,)
INC., and DR. MARSHALL)
JAMES,)
Defendants.)

Deposition of DR. VINCENT CANNESTRA, taken before NANCY J. BLACKBURN CSR, and Notary Public, pursuant to the provisions of the Code of Civil Procedure of the State of Illinois and the Rules of the Supreme Court thereof, pertaining to the taking of depositions at 2350 Royal Boulevard, Elgin, Illinois, commencing at 2:10 p.m. on August 9th, 2019.

REPORTED BY: NANCY J. BLACKBURN, CSR
LICENSE NO. 084-001555

APPEARANCES:

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on behalf of the Defendants.

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I N D E X

WITNESS	EXAMINATION
DR. VINCENT CANNESTRA	
EXAMINATION	
By Ms. Byrd	Pg. 4, 98
By Mr. Flaxman	Pg. 96

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EXHIBITS

Exhibit No. 1	Pg. 5
Exhibit No. 2	Pg. 95

- - - - -

DR. VINCENT CANNESTRA,
called as a witness herein, having been first duly sworn, was examined upon oral interrogatories and testified as follows:

EXAMINATION

BY MS. BYRD:

Q This is the case of Johnny Jones versus Wexford Health Sources, Inc. and Dr. Marshall James. It's Case No. 17 CV 8218. It's pending in the United States District Court for the Northern District of Illinois.

This is the deposition of plaintiff's retained expert, Dr. Vincent P. Cannestra. It's taken pursuant to notice and pursuant to the Applicable Federal Rules.

Dr. Cannestra, you have been sworn in, correct?

A I have.

Q And I know we met briefly off the record but my name is Sandy Byrd. I'm an attorney from the law firm of Cassiday Schade and I represent both Wexford and Dr. James in this matter.

I'm assuming you have given depositions before?

A I have.

Q And you understand the basic rules of depositions? I'm going to ask you questions. You are going to answer those questions. Your answers need to be verbal so that the court reporter can take them down, and I'm going to do my best not to talk over you and ask that you do your best not to talk over me; and I'm sure we'll both fail at that but those are the rules. Understood?
A Understood.
Q Anything about that that you can't comply with?
A Nope.
Q Doctor, I am going to show you a copy of your CV that was provided to me. Can you just take a look through that and let me know if that is current and correct?
A It is.
Q I think I will mark it as Exhibit 1.
(Exhibit No. 1 marked)
BY MS. BYRD:
Q Doctor, have you ever had any disciplinary action against you involving your license to practice medicine?
A No.
Q What percentage of the work that you do is

expert work?
A It varies from year to year. I would say presently it can be anywhere from 30 to 40 percent.
Q And the rest of your work then is in your private practice?
A Right.
Q And what exactly is that private practice?
A Orthopedic surgery.
Q When you do work as an expert, how do you get retained? How do the cases come to you is probably a better way of asking that question?
A Either I'm contacted directly by the attorneys or I have another firm that I work with called INSPE Associates where I am an independent contractor and they refer me cases.
Q Do you advertise for your expert work?
A I do not.
Q How often have you worked with the plaintiff's law firm in this matter?
A How long have I worked?
Q How many times?
A This is the only time.
Q And in your expert work, what percentage of that work is representing plaintiffs?

A Anywhere from 10 to 15 percent.
Q And the rest is representing or working on behalf of doctors?
A Defendants.
Q When you say defendants, other than doctors, who do you work on behalf of?
A So, a fair portion of my consulting work has to do with personal injury. So, it may be for the insurance companies or a business but mostly for insurance companies for personal injuries.
Q How do you get retained by insurance companies? What are your contacts with them?
A Well, either they would contact me directly via the attorney or get me through INSPE.
Q And how many open expert cases do you have currently pending?
A Define open.
Q Anything that is -- that you have been contacted to provide an opinion that you are presently working on preparing an opinion, that you are presently preparing to do a deposition, that you are presently preparing to do a trial? Anything that you have not been contacted and say this case is resolved, you can close your file?

A Oh, I don't know. I mean, I have got some cases that have been going on for two or three years that I have had no recent work on just because it's going -- it's going through the legal process or they're still taking depositions or they're still trying to track down medical records.
So, as far as open cases presently across the board, I couldn't tell you. I could guess. Recently that come to mind, maybe ten.
Q And you're not sure that that encompasses all of your open cases? That's an accurate statement?
A Again, I don't know which ones are still open, because if they settle --
Q If your file --
A -- they may not necessarily let me know that they have settled.
Q So if your file is open, how many cases do you currently have open files on?
A Well, again, define open, okay?
Q If you have not closed your file?
A Okay. I close my file when my bills have been paid. That's when I close the file. Now, if they decide to send me more records to review or they ask me to write a report or they want me to do a deposition,

then I will submit another bill; but until that time, I don't know if the file is open or closed.

Q So this is not meant to be a difficult question. I am trying to determine how many cases you have that are currently open? Meaning, that the legal procedures to the best of your knowledge are not terminated?

A I don't know.

Q What percentage of your income is from expert work?

A I'm sorry, say that again please?

Q What percentage of your income is from expert work?

A 30 to 40 percent. Probably closer to 30 percent.

Q And what rates do you charge for your expert work?

A Typically for reviewing medical records and preparation of a report is $350 per hour. For depositions, roughly $900 an hour. Rates may be different for INSPE. INSPE may be $450 per hour.

Q What about trial work?

A Trial work, typically it will be $2,000 an hour portal to portal.

Q And what rates are you charging in this case?

A For what work?

Q For your work?

A Are you talking deposition or are you talking --

Q I'm talking for all of your work?

A Just as I stated, $350 for the review of materials and the preparation of report and $900 an hour for the deposition with a two-hour minimum.

Q What was the date that you were retained in this case?

A I would have to look at my bill to see when I first had contact. I don't know off the top of my head.

Q Is that something that you can determine easily?

A If I had my bill, yep.

Q I don't have your bills, so I can't provide you with that.

MR. FLAXMAN: I don't have your bill either.

BY MS. BYRD:

Q We're in your office, so I'm assuming that you have access to that?

A I don't because I have my bills at my house.

Q So, that is a date that I'm going to ask be provided to me after the deposition?

How did you get this case?

A I was contacted by Mr. Joel Flaxman, I believe, via email.

Q And how much time have you have spent so far on this case?

A I would have to look at my bill but I may have stated it in my report. It looks like 21 hours for the preparation of the report.

Q And you have done nothing since you prepared the report?

A Other than review it for this deposition, that is correct.

Q And how much time did you spend reviewing your report for this deposition?

A Roughly a half hour.

Q So, what have you been paid so far for this case?

A I would have to look at my bill. It's been, I believe, a few thousand dollars.

Q And again, I'll ask for that information?

MR. FLAXMAN: I'll give it to you right now. First contact was on March 14th and we have been billed -- we

paid $5,800.

MS. BYRD: And when you say March 14th, 2019 --

MR. FLAXMAN: That's correct.

MS. BYRD: Okay. Thank you.

BY MS. BYRD:

Q What all did you review in preparing your report?

A It's listed in the first paragraph of my report. You want me to --

Q So --

A -- read it all?

Q -- there is nothing other than what is listed in the first paragraph of your report that you reviewed?

A That is correct.

Q Can you tell me who Dr. Joseph Maides is, M-A-I-D-E-S?

A I believe he was one of the physicians employed by Wexford Health Services or Sources.

Q And who is Dr. Amy McCauley?

A I would have to go back and look at the medical records to see who she worked with.

Q How about Daniel Ozinga?

A I believe he was the physician's assistant at

Lawndale Christian Health Center.

Q Is there anything that you were not able to review for your report that you would have liked to have been able to review for your report?

A I think the only records that I did not have were the radiographs that were obtained on November 16th of 2015.

Q How many drafts of your report did you prepare?

A I believe there were three.

Q Do you still have all of those drafts?

A I would have to look at my records to see if I do.

Q To the extent that you have those, I would ask that those be produced?

MR. FLAXMAN: And to the extent that you want them produced, I refer you to Rule 26 which makes drafts of reports privileged.

BY MS. BYRD:

Q Who all had input into your report?

A Input meaning what?

Q Meaning any input whatsoever into the content of your report?

A I sent my initial report to Joel Flaxman and we discussed it. I know that subsequent x-rays were

provided that I requested. So, as part of one of my -- excuse me -- one of my revisions of my report was the inclusion of my findings of the x-rays.

Q Anybody else have input?

A No.

Q Who all helped write your report?

A I was the sole writer of the report.

Q No one other than you had input into your report or helped write your report?

A I reviewed it with Mr. Flaxman, Joel Flaxman. He at times wanted some clarification on wording in the report. Some of it I agreed with. Some of it I did not agree with.

Q Do you recall what writing you agreed with and what writing you didn't agree with?

MR. FLAXMAN: I'll object to that and instruct the witness not to answer because you are inquiring about drafts of reports.

BY MS. BYRD:

Q How many drafts did you exchange with Mr. Flaxman?

A Again, only three drafts.

Q So, your final report is essentially the fourth version of the report?

A I believe it's the third.

Q So, there were two drafts prior to the final version?

A Correct.

Q How do you communicate with Mr. Flaxman? Do you email?

A Email and phone.

Q While preparing your report or preparing for this deposition, did you take any notes?

A No. Well, I took notes for my report and then once I completed my report, those notes were destroyed because everything in my notes is in my report. As you can see, the report is very thorough and detailed.

Q Did you prepare an outline of your report?

A I did not.

Q Do you have a file for this case?

A Just my bill and the report.

Q So you didn't keep any of the records that you were provided?

A I have a record and CD.

Q And you don't consider that to be part of the file that you have for this case?

A It's not my own personal file but it's a CD of the medical records that I reviewed.

Q So, the entirety of the information that you have about this case is your bill, your report and then the documents that you reviewed that are listed in paragraph one of your report?

A That is correct. I would have to go back and look to see if there were any additional medical records that were sent to me via email. I don't recall.

Q Would you not have included those in paragraph one of your report if they were sent to you via email?

A I would have.

Q So, regardless of the form that they are kept in, the only records you have pertaining to this case are the records listed in paragraph one of your report and your bill?

A That is true.

Q How many times have you testified at a deposition as an expert?

A Too many to count.

Q Does that mean more than a hundred?

A Possibly. I have been doing expert work for, I think, since 2006.

Q So, it could be more than a hundred? Is it more than two hundred?

A I don't know. I mean you are talking about a 13-year period. Some years are busier than others. As far as how many depositions I have given, I couldn't tell you over that 13-year period. I think I provided a list of what I have done in the last five years.

Q I'm just trying to narrow it down as to how many times you have testified in depositions?

A I couldn't tell you whether it was 100 or more or less.

Q In your 13 years, there are 156 months. So, how many times a month roughly do you testify?

A Less than once a month.

Q So, it would be less than two hundred times?

A Yes.

Q So, somewhere between a hundred and a hundred and fifty depositions, is that a fair number?

A It could be less.

Q I'm not -- I don't know the answer.

A Neither do I.

Q I'm trying to narrow it down?

A Neither do I. That's why I said, I don't know.

Q It's certainly less than 156, is that fair? Since there are 156 months in 13 years?

A Again, I said less than once a month.

Q So, how many times have you testified at trial?

A Are you including arbitration with that or not?

Q Let's start with trial?

A Once.

Q How about arbitrations?

A Once.

Q Have you ever been barred from testifying as an expert?

A I have not.

Q Have you ever had your report barred?

A Not to my knowledge.

Q How many correctional health care cases have you been involved in?

A Probably ten or less.

Q I'm sorry, ten or less?

A Yes.

Q What kind of cases are those?

A One was a police shooting. One is -- several typically are due to inadequate medical treatment are the claims for various orthopedic conditions. Whether it's the low back pain or knee pain or shoulder pain. Slip and falls at the correctional facility. One is an opinion as to whether an inmate's previous orthopedic injuries caused sufficient disability that he could not

have perpetrated the crime, and that's all that I can recall off the top of my head.

Q In the inadequate medical treatment cases, are those all on behalf of inmates?

A Correct.

Q Have you ever testified on the behalf of a doctor in a correctional health care case?

A I have not. Let me think, I have not.

Q Have you ever practiced medicine inside a correctional facility?

A I have not.

Q What kind of prison policies have you reviewed in this case?

A None.

Q Any other case you reviewed prison policies?

A None.

Q What about correctional health care standards? Have you reviewed any of those?

A I have not.

Q Do you consider yourself to be an expert in correctional health care?

A Define correctional health care.

Q Health care that is provided within a correctional facility to inmates within that facility?

A Since I have never practiced such a position, I would say no.

Q What is a patellar tendon rupture?

A The rupture of the patella tendon which is a tendon that originates from the inferior or bottom portion of the kneecap and attaches to the shin bone.

Q How does one rupture their patellar tendon?

A Most commonly occurs with a high load impact activity on the legs such as running, coming down the stairs, a stumble but there is typically a high load delivered to the knee.

Q And what are the typical symptoms of a patellar tendon rupture?

A You could have pain, swelling, tenderness, inability to extend the knee, difficulty flexing the knee. You could have a palpable gap in the tendon. You can have a collection of fluid in the knee, what we call a hemarthrosis or a fusion. You can have a hypermobile patella. You can have a superiorly migrated patella or high-riding patella. You can have over the long term or longer term, you could have quadriceps tendon atrophy, pain or tenderness. You can have night pain. You can have inability to walk or inability to bear weight on the leg. You can have bruising or

ecchymosis. You could have redness and those are the majority of the symptoms or findings.

Q Is there a typical presentation of someone who has a ruptured patellar tendon?

A Typically, severe pain, inability to bear weight on the leg, an inability to extend the knee, a hypermobile patella, palpable gap, tenderness at the patellar tendon, difficulty flexing the knee. Potentially a high riding patella. Certainly, swelling and an effusion or a hemarthrosis in the knee.

Q And you said hypermobile?

A Hypermobile patella.

Q What is that?

A So, because the tendon attaches the kneecap to the shin bone, it essentially anchors the kneecap. When you rupture that tendon, that kneecap loses one of its points of fixation and as a result, that kneecap can be pushed or subluxed either medially or laterally or up and down, meaning inferior/superiorly.

So, a patellar tendon rupture allows that patella to shift or move much more easily.

Q How many of these injuries do you see in your practice? Is it a common injury?

A It is not a common injury.

Q On a typical month, how many would you see?

A Not even one a month.

Q How many in an average year?

A It can be anywhere from, in this practice, two to six maybe a year. Six probably would be on the high side in this area.

Q And when you say in this area, you mean in orthopedics?

A In this suburb.

Q In Elgin?

A In Elgin.

Q But your specialty is orthopedics, is that correct?

A That is correct.

Q And so is it fair to say that someone with this injury eventually makes it to an orthopedist in the typical case?

A Yes.

Q It's not something that a general practitioner would tend to treat, correct?

A It is not an injury that a general practitioner should treat.

Q So, a general practitioner should refer a patient to an orthopedic specialist if they suspect this type of injury?

A Yes.

Q And when a general practitioner refers a patient to a specialist for this type of injury, what is the typical amount of time that you see between the person seeing their general practitioner and coming to you?

A A week or less.

Q And as a general practitioner, what should a general practitioner be looking for to determine if a referral is necessary to an orthopedist?

A Well, certainly the number of symptoms and exam findings that I stated previously; but obviously if the patient can't extend their knee and they can't walk on their leg, if there is severe pain and a palpable gap in the tendon, these are clearly signs that a referral is absolutely necessary.

Q And how would a general practitioner determine if there is a palpable gap in the tendon?

A Examining the patient's knee.

Q And what is it that they should do to that knee to determine that?

A If there is a palpable gap?

Q Correct.

A Palpate the tendon.

Q What are the available treatment options for a patellar tendon rupture?

A I think the main treatment option is surgical repair.

Q Is that the only option?

A For your debilitated person or someone who is a non-ambulator, someone who is severely demented or elderly, potentially you could cast that person to treat the tendon rupture; but in all likelihood, they will not do well as far as being ever able to walk again or extend the knee.

Q How often do you perform this surgery?

A Not often.

Q You said you see somewhere between on average two to six cases a year. So, would it be fair to say that you do the surgery roughly two to six times a year?

A Typically, if I find a patient with this patellar tendon rupture, I will send them to my partner who does more of have them than I.

Q So, how many of these surgeries have you ever performed?

A Probably less than ten.

Q And when is the last time that you performed one?
A It's been years.
Q How many years?
A Probably over ten years.
Q How does a patellar tendon rupture differ from a patellar tendon tear?
A Well, you could have a partial tear of the patellar tendon. I have seen that recently, and depending upon the severity of the tear, they may be treated non-operatively without surgery. When you have a rupture, you have a 100 percent tear of the tendon. Most people when they talk about patellar tendon tears, they talk about a complete rupture. I would say a patellar tendon rupture is much more common than a partial tear of the patellar tendon. Those typically are much more rare than a complete rupture.
Q So, if I am understanding you correctly, both a patellar tendon rupture and a patellar tendon tear are the tendon tearing. The rupture is just a complete tear. Where if someone is referring to a patellar tendon tear, they are referring to an incomplete tear? Like there are portions of the tendon that are still intact?

MR. FLAXMAN: Let me object to the form of the question which was compound.
THE WITNESS: When typically people talk about a patellar tendon tear, they are talking about a complete rupture. Just because a partial tear is so rare.
BY MS. BYRD:
Q Would the symptoms of a tear versus a rupture be the same?
A Are you talking about a partial tear or what the lay person says is a patellar tendon tear?
Q I am talking about your definition that a rupture is a complete tear but that you can have an injury that is not a complete tear which is what you call a tear which is -- I should say, you could have an injury that is not a complete rupture which is what you are referring to as a tear?
A That's not what I am referring to as a tear. You asked me what the difference is between what people call a patellar tendon tear and a rupture.
Q No. I asked you what the difference between a tear and a rupture is and you told me what people call it. So I am asking you, are the symptoms of a tear the same as the symptoms as a rupture?
MR. FLAXMAN: Object to the form of the question.

He's really explained between a tear and a partial tear and it's confusing. Could you rephrase it?
BY MS. BYRD:
Q A rupture is a complete tear, is that an accurate statement?
A Yes.
Q And if someone does not completely tear their patellar tendon, there can be a partial tear, is that correct?
A Correct.
Q And that is not a rupture, correct?
A Correct.
Q So, can we agree to call that a tear?
MR. FLAXMAN: No, we can't agree. It's a partial tear.
THE WITNESS: You can have different severity of partial tears, okay?
BY MS. BYRD:
Q Okay.
A The greatest severity is a complete rupture, a complete tear.
Q How is that a partial tear then? Let's stop there?
A I didn't say partial tear, I said tear.

Q Okay. So, on the extreme of a fully intact patellar tendon to a complete rupture, let's say halfway in between those two on a continuum, what would you call that?
A That would be a 50 percent partial tear.
Q So, can we -- Are the symptoms of a partial tear the same as the symptoms of a complete rupture?
A It depends on the severity of the partial tear.
Q Okay.
A So, you can have a 10 percent portion of the tendon rupture and 90 percent intact. That is going to be much different than if you had 90 percent completely torn and only 10 percent intact.
Q So, let's say we have a 50 percent, in between those two. Are those symptoms going to be the same as the symptoms of a complete rupture?
A Some will be, yes.
Q You said that a partial tear is much more rare than a full rupture?
A In my experience, that is correct.
Q How often do you see partial tears in your practice?
A I think I have seen one in ten years.
Q And is surgery the only treatment for a partial

tear?
A Again, it depends on what portion of the tendon is completely torn.
Q Is it fair to say that someone who presents with a 10 percent partial tear is going to have symptoms that are less severe than someone who presents with a full rupture?
A Yes.
Q When you initially see a patient in your private practice, do you take a medical history from that person?
A I do.
Q And what does that history typically entail?
A Are we talking about specifically tendon injuries or are we talking about any injury?
Q Any orthopedic injury?
A Well, typically it's going to occur when the symptoms first began, what their symptoms are presently, what their symptoms have been in the past, how long has the condition been present, what things aggravate it, what things make it better, what treatment have they had for it, what evaluations have they had, whether their symptoms are improving with time or treatment, what impact does it have on their

ability to function, the location of their pain. Any other associated symptoms such as swelling or instability, loss of range of motion, areas of tenderness or the location of their pain, whether there is any crepitation. If they noted any bruising, any redness, any deformities. That's the basics.
Q And are you the person that takes that history or is that done by a nurse or a physician's assistant or --
A It's done by me.
Q How important in making your diagnosis is it that the patient be honest with you about the history of that injury?
A It's important.
Q It's something that you rely on in making your diagnosis?
A That is one portion, yes.
Q And I know you said it's been over ten years since you have done a patellar tendon rupture surgery but do you currently do other types of orthopedic surgeries?
A I do.
Q Is that a major part of your practice is doing surgery?

A Yes.
Q When you do surgery on patients, do you give them discharge instructions?
A Yes.
Q And what is the purpose of discharge instructions?
A Primarily educate the patient about what to expect and what things are recommended as far as postoperative care.
Q And the recommendations that you make regarding post-operative care, how important is it that the patients follow through on that?
A Well, it depends upon the surgery but obviously since we are giving them instructions, it's our suggestions.
Q And you wouldn't be suggesting things that aren't necessary, is that fair?
A They're recommendations, yes.
Q And it's your recommendation that they follow through on what you provide in your discharge instructions, correct?
A Correct.
Q And you recommend those things because it will make their recovery better, the outcome of their

surgery better, is that fair?
A Yes.
Q When you have a patient come into your private practice and your recommendation is that that patient has surgery, what is the process that the patient has to go through with his or her insurance company to get that surgery approved?
A It usually needs to be authorized by the insurance company.
Q Is that something that you're involved in?
A No. My office staff does that. Obviously if it's an emergency surgery, that doesn't require authorization and it's just that, it's an emergency.
Q But in non-emergent situations, you don't perform surgery until it's been approved by the insurance company, is that fair?
A Correct.
Q Do you know how long that process typically takes from the time you recommend surgery until an insurance company approves it?
A It all depends upon the insurance company.
Q And do you have -- Is there an average amount of time?
A Usually, we like to get the pre-authorization

in a weak or less. Obviously for the more urgent cases, we will get it within one or two days.

Q And when you say pre-authorization, how is that different than an authorization?

A I would say they're synonymous.

Q Have you ever done surgery on a patient for a ruptured patellar tendon without obtaining an MRI first?

A I don't believe so.

Q How about without obtaining an x-ray?

A No.

Q And is it fair to say that before you can obtain an MRI or -- certainly before you can obtain an MRI, that that also needs approval of an insurance company?

A Yes.

Q How about x-rays? Does that typically need approval of an insurance company?

A No.

Q And you said before, it depends on the insurance company how long it takes to get the authorization, correct?

A Correct.

Q Some are faster than others, correct?

A Correct.

Q How familiar are you with Sheridan Correctional Center?

A I only know it by name and the records that I reviewed.

Q How do inmates at Sheridan obtain their health care? What is the process they have to go through?

A I don't know.

Q What are the processes at Sheridan Correctional Center for an inmate to schedule surgical procedures?

A I assume you are talking about non-emergent surgeries?

Q Correct.

A So, on the few cases that I have done regarding correctional facilities, my understanding is that the health care is provided by a third party health system; and therefore, for patients or inmates who need surgical intervention or referrals or advanced imaging, that there has to be an authorization from the third party that manages the health care system.

Q And do you know if that is the case at Sheridan Correctional Center?

A It is based on the records that I reviewed.

Q And what do you -- Tell me everything that you

know about that process?

A So, the physician who is recommending surgery will submit a form for the surgery to be authorized.

Q To whom?

A To the third party administrator.

Q And then what is the process after that?

A And then the physician who ordered the procedure waits for the response.

Q How long does that process take?

A I guess it depends upon the third party administrator.

Q In your experience, how long does that process take?

A Typically, two weeks or less.

Q And once that process is complete or before, based on your experience, who schedules the appointment for the inmate to either have the consultation or the surgery?

A I'm sorry, the question again.

Q Who schedules the appointment for the inmate to have the consultation or the surgery? Does the inmate pick up the phone in the prison and call someone or does someone else take care of it?

A I believe it would be the managing physician

taking care of that inmate.

Q So, it's your belief that the managing physician picks up the phone and calls and schedules the appointment for the inmate to have whatever out -- whatever care outside the prison facility the inmate needs?

A My understanding is that there is a referral to a specialist or a request for surgery. That the ordering physician submits the request. If the request is granted, then the physician follows up with either arranging the specialist's consultation or making arrangements for the eventual surgical procedure; but typically if it's a specialist doing the procedure, it's going to be the orthopedic surgeon who will have to wait for the authorization from the third party administrator.

Q Do you believe that that prison physician has control over the, using your example, the orthopedic surgeon's schedule?

A I'm not sure what you are asking?

Q Is it the prison physician who is able to call the outside specialist and make an appointment when the prison doctor thinks that it should be made? Or is that prison doctor dependent upon the scheduling of the

outside consultant?
A I guess I'm still not sure what you are asking?
Q If the prison doctor called your office and said that he wanted one of his inmates to come see you today, August 9th, at 2:00 p.m. at the exact time that we had our deposition scheduled, would that prison doctor be able to put that patient on your schedule or would you say I'm sorry, I'm not available then?
A Well, I would say that we can see that person at the next available appointment.
Q So, the scheduling is dependent upon your availability, correct?
A Obviously.
Q Okay. So, even if the prison doctor wanted that patient to get in and see you at a time that you were not available, you would not be able to see that person then, correct?
A Yes and no. I mean, we have had physicians call us directly saying this is an urgent case. Can you get this person in? Can you squeeze him in today, and, you know, when we have that physician-to-physician communication and the urgency is communicated, yes, we get them in whether there is a conflict or not.
Q But just to get someone on your day-to-day

schedule, that doesn't happen, correct?
MR. FLAXMAN: Object to the form of the question.
THE WITNESS: Again, if we are contacted with an urgent matter, regardless of what day it is and regardless of how busy I am, I will see that person.
BY MS. BYRD:
Q What do you know about the security issues involved in taking prisoners out of the controlled prison setting for medical appointments?
A I do know they need to be accompanied by the prison staff.
Q What else do you know about that, about the security issues?
A They do need to be transported in a secure environment.
Q Anything else?
A No.
Q There is nothing else that you know? Or there is nothing else that you believe is an issue? It was probably a bad question on my part.
A That would be the extent of my knowledge of the security issues as far as transferring inmates.
Q In your report you use the word infirmary repeatedly. What is your definition of the prison

infirmary?
A Just that, an infirmary where patients can be seen and evaluated by the medical staff.
Q So, I'm just trying to get your understanding of the term. Would it be kind of the prison equivalent of your medical office?
A Well, I don't know. I haven't seen their infirmary, so --
Q You used the term. So that's why I'm just trying to clarify in your mind what you meant by that term?
A I used that term because that is the term in the medical records.
Q So, it was -- it's your belief that when Mr. Jones, the plaintiff in this case, saw Dr. James, that each time he saw Dr. James, he, Mr. Jones, and Dr. James were located within the prison infirmary?
A I do not know if Mr. Jones was seen by Dr. James in the infirmary on every occasion. Now, if there is a particular date that you have a question about, we can certainly go to the medical records and see if it records where Dr. James did his evaluation.
Q So, it's your testimony that if you used the word infirmary in your report, it's because you got

that word from the records?
A As best as I can recall, correct.
Q Tell me what you know about the prison grievance process?
A So, the inmate needs to fill out a form stating their grievance and it's returned to the appropriate personnel.
Q And who are the appropriate personnel?
A It depends on, my understanding, what the grievance is.
Q So, if an inmate had a grievance about their medical care, what would they do with that form?
A Again, they would hand it to the appropriate personnel.
Q And who are the appropriate personnel?
MR. FLAXMAN: Objection. It's beyond his personal knowledge.
MS. BYRD: That's kind of my question.
MR. FLAXMAN: Well, I mean you are asking him questions about things that he knows nothing about.
MS. BYRD: I said what is your knowledge? If he doesn't have any knowledge, then he should say I don't know. Not an objection.
MR. FLAXMAN: It is an objection when you ask

somebody to state something for which they have no personal knowledge about it, it's not going to be admissible. It's not competent testimony.
MS. BYRD: I'm allowed to figure out what he knows and doesn't know and my question is what does he know; and if he doesn't know, then his answer should be I don't know.
MR. FLAXMAN: He told you that he knows this stuff from reading it but it's not admissible evidence.
MS. BYRD: He didn't say that in response to this question. I said what do you know about the prison grievance process and he said that the inmate fills out a form and hands it to the appropriate personnel. So, I'm asking who the appropriate personnel is. I'm trying to determine the extent of his knowledge. That is the point of deposition.
MR. FLAXMAN: Not in an expert deposition. He doesn't have to have personal knowledge about anything other than the things about which he is providing opinions.
MS. BYRD: And it appears in his report, so I can ask questions about it.
MR. FLAXMAN: Well, I'm not interfering with asking questions but this is really not very productive.

BY MS. BYRD:
Q So who is the appropriate personnel?
A It looks like the grievance that he filed was received by Wexford Health Sources.
Q And on what do you base that statement?
A Based on the medical records.
Q So, it's your testimony that Mr. Jones filled out a grievance and it was received by Wexford and you deduced that from reviewing the medical records?
A Correct.
Q What do you know about the collegial review process?
A So, when the prison physician needs to discuss or obtain authorization for further medical care of an inmate, he has a review with a supervising physician.
Q And what about the utilization management process? What do you know about that?
A Nothing.
Q Do you have knowledge about any Illinois Department of Corrections directives or policies?
A No.
Q When Mr. Jones first presented to Dr. James in this matter, he presented and indicated that his left knee pain was a 4 of 10, correct?

A That is correct.
Q Dr. James noted that there was no swelling on Mr. Jones' knee, correct?
A Let me correct my previous answer. It wasn't Dr. James who documented that his knee pain was 4 out of 10. It was the nurse.
Q Thank you. You are correct on that. That nurse also noted that there was not any swelling, correct?
A Correct.
Q No tenderness?
A Correct.
Q And no bruising, correct?
A Correct.
Q She didn't observe any kinds of cut or open area on Mr. Jones' head, correct?
A No.
Q That was on, I think, the 14th -- November 14th of 2015, correct?
A That is correct.
Q And Dr. James then first saw Mr. Jones on November 16th, correct?
A Correct.
Q And is that an appropriate time frame within

which to see a patient who presented with left knee pain a 4 of 10, no swelling, no tenderness and no bruising?
A If in fact that was true, yes.
Q Do you have any reason to believe that that wasn't true?
A I do.
Q Why do you believe that that nurse's notes from November 14th, 2015 are untrue?
A Because he had a complete rupture of his patellar tendon which causes swelling and tenderness.
Q And what motivation would the nurse have to report inaccurate notes?
A I don't think she had any motivation to record inaccurate notes. I just don't think she closely examined Mr. Jones' left knee.
Q So, when Dr. James saw Mr. Jones on November 16th, 2015, Dr. James noted that -- I wish that they both didn't have J names -- Mr. Jones' left lower extremity had increased knee swelling and pain, correct?
A Yes.
Q What about -- Is there anything about that that tells you that the nurse incorrectly recorded her notes

on November 14th of 2015?
A Well again, with a known acute patellar tendon rupture, you would have immediate pain and tenderness.
Q And isn't it fair to say that the nurse on November 14th relied on what Mr. Jones told her in terms of recording his level of pain and his level of tenderness or any other injury that is not observable?
MR. FLAXMAN: Object. The witness doesn't know what the nurse relied upon back in November of 2014 -- 2015. Only the nurse knows what she relied on.
BY MS. BYRD:
Q You can answer.
A The question again please?
Q I said, isn't it fair to say that the nurse would have relied upon Mr. Jones' representations to her as to his level of pain and his level of tenderness?
A Well, those are symptoms. What she inaccurately recorded was his physical exam findings.
Q So, it's your testimony that she determined that his pain level was a 4 of 10?
A That's not a physical exam finding.
Q How would she have come up with that number of 4 of 10?

A That's a history. That's a symptom.
Q And the history is obtained from the patient, correct?
A That is correct.
Q So, if she wrote down that the level of pain was 4 of 10, it's because she obtained that during a history?
A That is correct.
Q And the history is given to her by the patient?
A I'm not disputing her history taking. I'm disputing her physical exam capabilities.
Q And when you say her physical exam, what are you referring to?
A Examination of his left knee.
Q When she recorded that there was no swelling, no tenderness and no bruising, is that physical exam or is that his --
A That's physical exam.
Q So you weren't present, correct, on November 14, 2015?
A That is correct.
Q So, you did not observe Mr. Jones on that date, correct?
A That is correct.

Q And you have never met the nurse that took that physical exam, correct?
A That is correct.
Q So, you don't have any way of noting or knowing for a fact if what she wrote down was exactly what she observed, correct?
A What I know is with an acute patellar tendon rupture, you will have tenderness and you will have swelling.
Q Absolutely every single time?
A Yes.
Q So, if she wrote down that there was no swelling, no tenderness and no bruising, is it unreasonable that Dr. James did not see Mr. Jones for two days? That's the information that he was presented with? Regardless of whether it's correct or incorrect, that's the information that he had?
A Well, I don't know what information he had on the night of November 14th of 2015.
Q I'm not asking you about the night of November 14th of 2015. I'm asking you about the date that Dr. James first saw Mr. Jones which was November 16th, 2015, correct?
A Well, I don't know what you are asking me? You

are asking about the information that Dr. James had from the nurse.
Q So, is it correct that the first time Dr. James saw Mr. Jones was on November 16th of 2015?
A That is correct.
Q And is it correct that the medical records reflect that the only thing that Dr. James knew at that time is that Mr. Jones' pain level was a 4 of 10, that he did not have any swelling, tenderness or bruising to his knee, is that correct?
MR. FLAXMAN: Let me object to the question because medical records don't show what somebody knew. They show what is written in the medical records, not what somebody knew.
MS. BYRD: And that's why my question is, do the medical records reflect it?
MR. FLAXMAN: Why don't you reask the question?
BY MS. BYRD:
Q Isn't it true that on November 16th of 2015, the first date that Dr. James saw Mr. Jones, that the medical records reflected that Mr. Jones' level of pain was a 4 of 10? That he did not have any swelling, tenderness or bruising to his knee, is that correct?
A Are you asking me if Dr. James reviewed the

medical records of November 14th?
Q I'm not asking you that, because you would have no way of knowing that. I'm asking you if that is what the medical records reflected?
A Well, the medical records of November 14th show that the nurse documented that he did not have any left knee swelling or tenderness.
Q Or bruising, correct?
A Correct.
Q And that his pain level was 4 of 10, correct?
A That is correct.
Q So as you sit here today, you don't have any knowledge that Dr. James had any information other than that when he saw Mr. Jones on November 16th of 2015, correct?
A That is correct.
Q Okay. So with that information, is it unreasonable that Dr. James did not see Mr. Jones immediately after his injury on November 14th, during the day on November 15th, and that he only saw him on November 16th? Is that unreasonable with that information?
A No.
Q When Dr. James examined Mr. Jones, he noted

that there was increased knee swelling and pain, correct?
A Correct.
Q And he ordered an x-ray of Mr. Jones' knee, correct?
A Correct.
Q And you previously testified that you have never done this surgery on a ruptured patellar tendon without first obtaining an x-ray, correct?
A Correct.
Q So, an x-ray is an important diagnostic tool for this injury, correct?
A Correct.
Q And it was not unreasonable for Dr. James to order an x-ray upon his initial examination of Mr. Jones, correct?
A Well, his initial examination of Mr. Jones lead him to believe that there was a possible patellar tendon rupture; and therefore, in addition to an x-ray, he should have ordered an MRI scan.
Q So, that was not my question. My question is, it was not unreasonable for Dr. James to order an x-ray of Mr. Jones' knee on November 16th of 2015, correct?
A Correct.

Q You have indicated in your report that Dr. James' examination was, I think it says, limited at best?
A Third paragraph.
Q His examination of the left knee was limited at best. Tell me what you mean by that?
A So, the only physical exam findings that he documented was swelling and pain. Now, if you are worried about a patellar tendon rupture, there is something more that would have led you to believe that there is a patellar tendon rupture, and he doesn't document that. He doesn't document any of the findings other than swelling and pain that I had previously outlined earlier in this deposition.
He either didn't examine Mr. Jones' left knee or he failed to document it; but certainly if he had a concern about a patellar tendon rupture and if he examined Mr. Jones' left knee in a detailed fashion and accurately, it would have been clear that there was a complete rupture of the patellar tendon.
Q So, what should he have done differently?
A I can list again all the clinical findings on exam of a patellar tendon rupture.

Q I didn't ask what the findings would be. I asked what should he have done differently?
A So, he should have documented that there was a palpable gap in the tendon. He should have documented that Mr. Jones had no ability to extend the knee. He should have documented that Mr. Jones could not walk normally on the leg. He should have documented that there was tenderness over the patellar tendon. He should have documented that there was an effusion or hemarthrosis in the knee. He should have documented that there was painful range of motion of the knee. He should have documented that the patella was hypermobile. He should have documented that there was possibly a high riding patella. I'm done.
Q And again, you weren't there for the examination, correct?
A I wasn't.
Q So, how do you know that each of those things that you just said he should have recorded were present? How do you know they were present on that date?
A Because they're present in every patient with an acute patellar tendon rupture.
Q Without fail?

A The only one that may not have been easily identifiable would be the high riding patella, but all the other ones most certainly were there.

Q After Dr. James -- during, before, Dr. James ordered that Mr. Jones not go to work, school, the yard, the gym, day room activities and group therapy, correct?

A Correct.

Q He ordered that Mr. Jones have meals in his room for four weeks, correct?

A Correct.

Q He ordered that Mr. Jones have a low bunk and a low gallery permit, correct?

A Correct.

Q Do you know what a low bunk and a low gallery permit is?

A I assume it means that you are the lower of the two bunks in the cell and that he's on the first floor.

Q And Dr. Jones ordered -- I'm sorry -- Dr. James ordered that Mr. Jones be able to have crutches, correct?

A Correct.

Q Do you have any issue with any of these orders?

A No.

Q When Dr. -- When the x-ray results were returned, they indicated that Mr. Jones had a slightly high riding patella, correct?

A Correct.

Q What is a slightly high riding patella?

A Well, it's a patella that is no longer in its normal position in the knee. Now again, these x-rays I don't have for review. I only have the radiologist's report, but even the radiologist saw that there was a abnormality of the patella consistent with the patellar tendon rupture.

Q The x-ray, the radiologist report says that it's slightly high riding. What does that mean?

A Well, without looking at the x-rays, I can't tell you how high riding the patella was. Slightly is a subjective term. One person may say 2 millimeters is slightly. Another person may say 6 millimeters is slightly. I can't tell you without looking at the x-rays myself whether I agree with that interpretation.

Q So, that was not my question. My question is what does it mean if someone writes slightly high riding?

A It means there is a high suspicion for a patellar tendon rupture.

Q And that's what that would mean to everyone who sees that term?

MR. FLAXMAN: Everyone who is a physician?

BY MS. BYRD:

Q Everyone that is a physician, sure?

A With a traumatic injury? Yes.

Q Define traumatic injury?

A An injury to the knee.

Q So, every injury to the knee is a traumatic injury?

A Yes.

Q So, if I bump into your table on my way out of door and get a bruise to my patella, that is a traumatic injury?

A Correct.

Q And if I fall down a flight of stairs and injure my knee that way, that's also a traumatic injury?

A Correct.

Q So, every single injury to the knee is a traumatic injury?

A Yes.

Q And that's your opinion? Or that is the generally accepted medical definition of traumatic

injury to the knee?

A Well, that's the whole definition of injury. You have a trauma to a certain body part. It's almost repetitious. You can't have an injury without trauma and you can't have trauma without an injury if it's truly traumatic.

Q What effect would the fact that there was an intermedullary rod in Mr. Jones' distal femur have on this particular injury?

A None.

Q Why?

A Because the intermedullary nail was used to fix a femur fracture from a gun shot wound to the thigh which is a fair distance away from where Mr. Jones ruptured his patellar tendon.

Q When Mr. Jones returned to the infirmary on December 3rd of 2015, you noted or the nurse noted that he complained of pain that was 5 of 10, correct?

A Correct.

Q Do you also believe that that is inaccurate?

MR. FLAXMAN: I object to the form of the question, also.

THE WITNESS: I never stated that the previous rating was inaccurate.

BY MS. BYRD:
Q Do you believe that this is an accurate recording, 5 of 10 pain?
A Yes.
Q And that, again, is something that would have come from Mr. Jones, correct?
A Correct.
Q It indicates that the nurse discovered that Mr. Jones' range of motion was limited, correct?
A Correct.
Q It doesn't say that he was unable to use his leg, correct?
A He was unable to use it normally.
Q How? Tell me what a range of motion being limited is?
A It means --
Q In this context means?
A It means that he doesn't have normal motion of his knee.
Q But it doesn't mean that he has no motion of his knee, correct?
A That is correct.
Q Then Dr. James saw Mr. Jones on December 8th of 2015, correct?

A Yes.
Q In that time frame, between November 16th of 2015 when Dr. James first saw Mr. Jones and December 8th of 2015, what information do you have about Mr. Jones' requests for medical treatment in those intervening days?
A I'm sorry, the question again?
Q What information do you have regarding Mr. Jones' requests for medical treatment between November 16th of 2015 and December 8th of 2015?
A Well, he returned back to the infirmary on December 3rd for persistent symptoms.
Q Do you have any knowledge that he attempted to obtain medical treatment between November 16th and December 3rd?
A I have no medical records to say one way or the other.
Q Do you have any knowledge that Mr. Jones sought and was denied treatment in those -- between November 16th and December 3rd?
A I have no documentation to support that.
Q Do you have any knowledge that between December 3rd and December 8th that Mr. Jones sought treatment and was denied treatment?

A I'm sorry, between which two dates?
Q December 3rd and December 8th?
A No.
Q What do you know about the process for an inmate inside Sheridan Correctional Center to obtain health care when they need or want health care?
A My understanding is there is an infirmary that they have access to for health care.
Q And that's an infirmary that they can present themselves to at any time? Or is there a process that they need to go through?
A I believe -- My understanding is they have to make a request.
Q And how does that request get processed?
A I believe the inmate has to fill out a form for the request.
Q Do you have any knowledge or information that Mr. Jones did that between November 16th and December 3rd?
A I don't have any knowledge of that.
Q Do you have any knowledge or information that Mr. Jones did that between December 3rd and December 8th?
A Well, he must have to get into the infirmary on

December 3rd and then he was scheduled to follow up five days later with Dr. James.
Q So my question was, between December 3rd and December 8th, do you have any knowledge that he filled out a form and asked to be seen sooner than December 8th?
A I don't have any information about that.
Q And on December 8th when Dr. James saw Mr. Jones, Dr. James noted that Mr. Jones' swelling had increased, correct?
A Dr. James documented that Mr. Jones had persistent left knee swelling. I don't know if it was documented that it was increased.
Q He also noted that there was persistent pain, correct?
A Correct.
Q Did not note that that pain had increased, correct?
A He made no mention of whether it was increased or decreased.
Q And he noted that the patella was notably displaced, correct?
A Correct.
Q And at that time, Dr. James then referred

Mr. Jones for an orthopedic intervention, correct?
A No. I believe he ordered the MRI scan.
Q I don't believe he ordered the orthopedic evaluation at that time.
Q In paragraph two of page three of your report, does it not state his plan was to refer Mr. Jones for orthopedic intervention?
A Sure, but that doesn't mean that he did order on that date an orthopedic evaluation.
Q You don't consider -- Well, would you require that a patient have -- You said you require a patient have an MRI before you would do a surgery on a ruptured patellar tendon, is that correct?
A That is correct.
Q So, is it fair to say that ordering an MRI is a precursor to seeing an orthopedist?
MR. FLAXMAN: I object to the use of the word precursor which I think it doesn't mean what you think it means.
THE WITNESS: I would disagree.
BY MS. BYRD:
Q Okay. So, if a patient came to see you and it was suspected that that patient had a ruptured patellar tendon, would you refer that patient get an MRI?

A Yes.
Q So that you could confirm what your suspicions were, correct?
A Yes.
Q So, it is medically sound to get that MRI prior to the patient seeing a doctor, correct? Seeing an orthopedist?
A No, it's not.
Q Why is it not?
A Because if your index of suspicion for a patellar tendon rupture is that high that you are going to get an MRI scan on the knee three weeks after the injury and rupture, you better send him to the orthopedic surgeon right away.
Q And why is that?
A Because now it's been a three-week delay since the injury and as a result, the results of any surgical intervention have been diminished; and the longer you wait, the greater likelihood that she's not going to have a successful result of the surgery to repair or reconstruct that tendon, if there is a delay in treatment.
The longer you wait to get him in to see the orthopedic specialist, the less

likely he's going to have a successful result of treatment by the orthopedic surgeon.
Q Would your answer to that question change at all if the referring physician is aware that the orthopedic surgeon requires an MRI when the patient is presented for an exam?
A No.
Q So, even if the referring physician knew that the orthopedic surgeon would require an MRI, the referring physician should not order one?
A I didn't say that.
Q So, how would your answer change if the orthopedic -- or if the general practitioner referring physician knew that information in advance?
A I still would have the person see an orthopedic surgeon; and if there is going to be a delay in seeing the orthopedic surgeon because that orthopedic surgeon wants an MRI first, knowing that it has already been a three-week delay in the process of ordering an MRI scan, then I would have him see someone else, from the orthopedic surgery standpoint. Time is of the essence at three weeks after an acute patellar tendon rupture.
Q On December 29th, you indicate in your report that Mr. Jones wrote a grievance, correct?

A I did.
Q And is it fair to say that Mr. Jones' concern in his grievance is that he makes sure that he has time to recover from his surgery before he gets released?
A Correct.
Q In fact, he knows the exact number of days until his release, correct?
A Correct.
Q And he indicates that he needs to be able to recover so he can work, correct?
A Correct.
Q Tell me what Mr. Jones' job is when he's out of prison?
A I don't know if he had any specific job that he was going to return to after his release. I know according to his grievance, that he was interested in returning back to some form of work.
Q And prior to his incarceration, when was the last time that Mr. Jones worked?
A That, I don't know.
Q And in Mr. Jones' grievance, he doesn't complain of any pain, correct?
A He does not mention it.
Q He doesn't complain of swelling, correct?

A He does not mention it.
Q He doesn't complain of limited range of motion correct,
A He does not mention it.
Q He doesn't complain of tenderness, correct?
A That is correct.
Q He doesn't complain of bruising, correct?
A That is correct.
Q He doesn't complain of any of the symptoms that you indicated would be present for a patellar tendon rupture, correct?
A Well, I don't think that was the point of his grievance, what his residual symptoms are. I think his grievance was that he wanted to get this ball rolling.
Q But my question was, he didn't complain of any of those symptoms, correct?
A That is correct.
Q And you testified earlier that this grievance was received by Wexford on December 29th, correct -- I'm sorry, on January 6th. Correct?
A 2016, correct.
Q And how do you know that it was received by Wexford on that day?
A Based on the medical records that I reviewed.

Q And if you learned that the grievance was not received by Wexford, would that change any of your opinions as it relates to Wexford in this case?
A No.
Q Why not?
A Because now it's six weeks after his acute patellar tendon rupture and he still hasn't gotten an MRI scan and he still hasn't seen the orthopedic surgeon. He still is struggling with extending his knee. He is still dysfunctional and again, there is further delay.
Q When Mr. James -- I'm sorry Mr. Jones had his MRI, it showed a clinical impression of a patellar tendon rupture, correct?
A Correct.
Q What does that mean? What does clinical impression mean?
A That's the diagnosis.
Q And it also said that there is a small tear in the posterior horn of the medial meniscus, correct?
A Correct.
Q And what does that mean?
A He had a small tear in his meniscus.
Q Is that something that requires surgery?

A If the patient is symptomatic and fails conservative measures, often people are treated for it, yes.
Q But it's not something that requires surgery?
A Not absolutely, no.
Q And is there any way to know if that tear happened at the same time as the rupture?
A There is not.
Q They can happen independently, correct?
A Yes.
Q What does it mean that there is no chondromalacia?
A No softening of the cartilage or arthritic changes. Although, the radiologist noted some low grade chondromalacia of the kneecap.
Q Can you explain? Because I noticed that. What are the -- How can there be none and low grade?
A I think the radiologist was talking about the medial compartment where the meniscal tear was, that there was no chondromalacia.
Q And then the low grade is?
A Underneath the knee.
Q Under the kneecap itself?
A Correct.

Q What is a 1.6 centimeter defect consistent with superiorly retracted patella? What does that mean?
A So, as a result of his complete patellar tendon tear or rupture, the quadriceps muscle, which no longer is being opposed, contracts; and as it contracts over the course of time, it pulls the kneecap towards the hip joint. So, that creates a wider and wider gap at the side of the patellar tendon rupture. So, that is what the radiologist saw.
Now at nearly three and a half months -- no, excuse me, do my math right -- seven weeks roughly since the tear, that there is a gap or defect where the patellar tendon originally lied. As a result of the contracture of the quadriceps muscle, the kneecap then becomes retracted superiorly or migrates superiorly towards the hip joint.
Q Is there a normal gap like someone whose patellar tendon is fully intact?
A Normal is no gap.
Q So, 1.6 is from 0 to 1.6 centimeters abnormal?
A Anything is abnormal.
Q Okay. So, there should be no gap at all?
A That is correct.
Q And what does it mean that the patella was high

riding and subluxed 4 millimeters laterally?

A So, as a result of the patellar tendon rupture, again, the patella has retracted superiorly or up the thigh and therefore, it was high riding. Meaning, it was riding high in the knee joint which is consistent with a complete tendon rupture; and as a result of the pull of the quadriceps muscle, it started to sublux or partially dislocate 4 millimeters to the outside of the knee joint.

Q So again, is that a 0 to 4 -- 0 would be normal?

A Correct.

Q Okay, and is there a way to know if this high riding patella is now higher -- closer to the thigh than the slightly high riding that showed up in the x-ray?

A I would have to look at those original films to tell you.

Q What does it mean when the radiologist says there is minimal edema in the inferior aspect of the patella?

A It means that the -- that because of the length of time since the original injury, that most of the swelling and edema, synonymous with swelling, was

really minimal at the area of the tendon rupture.

Q And then the radiologist uses the word torn patellar tendon. Is that kind of what we already discussed about tear versus rupture and some people using them interchangeably?

A Yes.

Q And it says, it appeared thickened which is compatible with retraction, mild changes and consistent with a contusion or chronic tendinopathy. What does that mean?

A So, the tendon completely ruptured and it became retracted and because -- think of the patellar tendon as a rubber band. So, normally it's pulled tight because that's the way you extend your knee and that's what holds you up on your leg when you are walking or standing or on a single leg stance on the affected leg. So when that tendon ruptures, that tension is completely released and that patellar tendon or rubber band accordions. It does this. So now because it's accordioned, it becomes thickened and now that it's been seven weeks, it becomes fibrosed and scarred.

Q You state in your report that Dr. James was aware of the results of the MRI on January 18th of

2016. That's the date that the MRI was performed, is that correct?

A That is correct.

Q On what do you base that opinion that Dr. James knew that day what the results of the MRI were?

A Because on January 18th, Dr. James filled out a Medical Special Services Referral and Report to the orthopedic surgeon at Midwest Orthopedic Institute and on referral he wrote a complete tear of the patellar tendon at its origin.

Q And what is the significance of that to you?

A He was aware of the complete tendon rupture as confirmed by the MRI scan on January 18th.

Q And why is that significant to you that he found out the results the same day in your opinion?

A Because he should have picked up the phone and gotten Mr. Jones in to see the orthopedic surgeon as soon as possible. He should have done that weeks prior.

Q Do you know if Dr. James has the ability to just pick up the phone and call an orthopedic surgeon and get Mr. Jones in?

A He should have. Whether it was to his superiors at Wexford or to his collegial physician that

he reviews things with. He should have done something much more expeditiously because it wasn't until February 8th that Mr. Jones actually got in to see the orthopedic surgeon which was almost three weeks after Dr. James knew the MRI scan findings confirmed a complete tendon rupture from two months earlier. I mean, that's just crazy.

Q And what knowledge do you have that Mr. Jones could have gotten in to see the orthopedic surgeon sooner than February 8th, 2016?

A This is where it becomes the responsibility of the treating physician to do everything possible to get that patient in to be seen and treated by the surgical specialist.

Q Okay. So my question was, what information or knowledge do you have that Dr. James could have gotten Mr. Jones in to see the orthopedic surgeon sooner than February 8th of 2016?

A He could have done a lot of things. He could have sent him to the hospital.

Q My question to you is, what information or knowledge do you have that Dr. James had the ability to get Mr. Jones in to see the orthopedic surgeon sooner than February 8th of 2016?

A My knowledge is he could have sent him to the hospital for immediate orthopedic consultation.
Q And that's your opinion as to what he should have done?
A If he could not have gotten him in to see an orthopedic specialist within five days, in my opinion, of noticing the MRI scan findings, he should have sent him to the hospital to get treated.
Q When Mr. Jones did see the orthopedic surgeon, that was Dr. Bell, correct?
A Correct.
Q And that was on February 8th, 2016, correct?
A That is correct.
Q And after Dr. Bell examined Mr. Jones, Dr. Bell did not immediately perform surgery on Mr. Jones, correct?
A He recommended surgery as soon as possible.
Q But my question is, he did not immediately perform surgery on Mr. Jones, correct? He did not do emergency surgery on February 8th of 2016, correct?
A He did not do emergency surgery because at this point it was no longer emergent. He's been almost three months now since his injury.
Q And he did not -- He didn't recommend emergency

surgery and have that denied by Dr. James, correct?
A He recommended surgery as soon as possible.
Q The surgery was done on February 16th, correct?
A Another eight days later.
Q So, when did it -- when was the time frame that it was no longer emergent to do surgery? What was the day that occurred?
A The longer you wait, the less likely you are going to have a successful outcome. So, these tendon ruptures should be repaired as soon as possible. Optimally, in three weeks or less. Optimally, in the first ten days. Once you get beyond three weeks, your outcome starts to diminish. Certainly at three months, they are greatly diminished.
Q The surgery that was performed by Dr. Bell, that was a successful surgery, correct?
A In what sense?
Q In that Dr. Bell was able to accomplish what it is he believed he could accomplish when he did the -- when he started the surgery or recommended the surgery?
A To me a successful surgery is one where the patient fully recovers his function and has no symptoms or pain. That wasn't Mr. Jones. Mr. Jones still had problems with his knee after Dr. Bell's surgery and he

had such symptoms that he required a second surgery by another orthopedic surgeon. Do I think his surgery was successful? By my definition, no.
Q What would you have done differently to make it a successful surgery?
A I think at three months, I don't think anything could have been done to make it a successful surgery. The delay was too long.
Q Would you at the time Mr. Jones had his initial surgery, would you have expected that he would need to undergo a second surgery?
A I would say I would not be surprised that he would require another surgery, particularly for stiffness of the knee given the chronicity of his patellar tendon rupture and the difficulty in reconstructing the tendon. The delay was such that Dr. Bell could not repair the tendon. He had to reconstruct the tendon by using cadaver tendon, and Dr. Bell clearly showed in his operative report how much scarring and fibrosis there was in the knee as a result in the delay of treatment.
Q Is there anything that would have prevented the second surgery from needing to occur?
A Yes. Operating on the patellar tendon rupture

in a timely fashion.
Q Which you are saying was anything short of three weeks?
A Shorter than three weeks, best case scenario less than ten days.
Q So, anything over three weeks would have resulted in the same scenario?
A Again, the longer you wait, the greater the likelihood of having these complications; and for Mr. Jones, it was chronic pain and stiffness.
Q Do you have personal knowledge on the follow through that Mr. Jones did after his first surgery in terms of following the discharge recommendations of Dr. Bell?
A To some degree, yes.
Q And what do you know?
A I believe he was referred to the orthopedic team at Rush Hospital.
Q Anything else?
A I know that he required physical therapy eventually for the knee.
Q And was that recommended as part of his discharge from Dr. Bell?
A I believe Dr. Bell recommended physical therapy

during the time frame that he was treating Mr. Jones.

Q And what do you know of Mr. Jones' follow through on that recommended physical therapy?

A Well, I know he had physical therapy at Midwest Orthopedic Institute.

Q Anything else?

A I would have to go back and look at the medical records to see if Dr. Bell recommended physical therapy at the prison and after his release from the prison.

Q Inside Sheridan Correctional Center, where do inmates go to get their meals?

A The meal haul.

Q And where is that located in relation to where Mr. Jones' cell was prior to his surgery?

A I do not know.

Q Do you know anything about the logistics inside the prison that are involved with an inmate receiving their meals in their cell as opposed to going to the meal haul?

A I do not.

Q Do you know how far it was that Mr. Jones had to travel to obtain his meals when he had to go to the meal hall to get his meals?

A I do not.

77

Q Once Mr. Jones got to the meal hall, what was the process for him getting his meal? What did he physically have to do to get his meal?

A I do not know.

Q What injuries did Mr. Jones suffer as a result of having to leave his cell to get his meals?

A So, it appears that Mr. Jones did have a fall and I believe he sustained an injury to his other knee.

Q And that was during the time that he was still receiving his meals in his room, correct?

A I don't believe so. I think Dr. James removed those allowances -- I would have to look at the date. I don't recall specifically the date. I know I have it somewhere in my report.

Q Page 4 of your report you indicate that on January 23rd, Mr. Jones had his Ibuprofen prescribed again. He was given 50 tablets and on January 25th, the nursing staff documented that Mr. Jones was using two crutches and his left knee had restricted range of motion due to a previous injury. He had a recent fall after his right knee buckled. He fell onto his buttocks and injured his right shoulder, correct?

A That is correct.

Q And then on February 2nd you indicate that Dr.

78

James denied the extension of Mr. Jones' special order to receive meals in his room, correct?

A That is correct.

Q So, the falling happened prior to that being denied or extended -- not extended, correct?

A That happened before. His fall where he injured his right shoulder and buttocks occurred before Dr. James rescinded his allowance to have meals in his cell.

Q So, what injuries did Mr. Jones suffer as a result of Dr. James not extending his permit to have his meals in his room?

A I don't believe he sustained any injuries after that date.

Q So, you don't believe he sustained any injuries as a result of Dr. James not extending that permit, correct?

A It's not documented in the medical record, correct.

Q There are none that you are aware of, correct?

A Correct.

Q On what do you base your opinion that Dr. James deviated from the standard of care in his evaluation and treatment of Mr. Jones' acute patellar tendon

79

rupture?

A Dr. James delayed treatment for Mr. Jones' acute patellar tendon rupture in regards to his untimely referral to the orthopedic specialist as well as ordering the MRI scan.

Q Anything else?

A He also deviated from the standard of care that he provided inadequate follow-up after his evaluation of Mr. Jones on November 16th, 2015 after he clearly had a suspicion for an acute patellar tendon rupture.

Q What was inadequate about his follow-up?

A He wanted to see him on an as-needed basis.

Q And what does an as-needed basis mean within the prison correctional setting?

MR. FLAXMAN: Object to the form of the question.

THE WITNESS: I think it's irrelevant what it means. What it means is if you have a person where you are suspicious about an acute patellar tendon rupture, you better provide some follow-up to make sure that this person doesn't have that tendon rupture because that tendon rupture requires surgery in an urgent fashion.

Clearly by November 30th, Dr. James had no inclination to see Mr. Jones in follow-up

80

after his initial injury after ordering the x-rays.

Q Anything else?

A No.

Q On what do you base your opinion that Dr. James performed an inadequate physical examination of the knee?

A Again, during his initial evaluation of Mr. Jones on November 16th, 2015, he missed the clear signs of an acute patellar tendon rupture. Had he made an accurate diagnosis based on hs physical exam, or at least had follow-up of Mr. Jones in a timely fashion to reexamine his left knee, then there wouldn't have been the delay in seeking appropriate surgical intervention for his traumatic injury.

Q And again, you weren't present for the physical exam, correct?

A I was not.

Q So, you don't know whether or not Dr. James actually examined for these symptoms that you said should be there, correct?

A Well, if he did, he should have put them in his medical documentation.

Q So, it's an issue with the documentation?

A I think it's an issue of his lack of concern

for potential patellar tendon rupture. Because clearly, he was suspicious for it and he had his follow-up on an as-needed basis; and something that requires surgery absolutely in a young active individual.

Q On what do you base your conclusion that Dr. James never bothered to follow up on the radiograph testing that he ordered on November 16th of 2015?

A So, Dr. James signed the nurse's injury report of November 14th 2015 on November 30th of 2015, more than two weeks later; and on that report he signed, he wanted to see the offender on an as-needed basis only. Clearly, if he saw the x-rays or the x-ray report, his suspicion for patellar tendon rupture would have been vastly increased.

Q And that's the only thing that you base that conclusion on, is that --

A That he did not see the x-rays?

Q Yes.

A Well, if he had seen the x-rays, it certainly would have been outside the standard of care not to see Mr. Jones back in an immediate fashion because the x-rays were consistent with a complete patellar tendon rupture.

Q And that x-ray report being the one that said

it was a slightly high riding patella, correct?

A That is correct.

Q Is that the same reason that you concluded that it's clear from the medical record that Dr. James never saw the radiologist's report of the x-rays until he saw Mr. Jones on December 8th of 2015?

A If he saw the x-ray or the x-ray report, then it was his absolute obligation to reevaluate Mr. Jones in an immediate fashion for further evaluation for patellar tendon rupture; but clearly by November 30th, he had no interest in seeing Mr. Jones for a scheduled appointment. He wanted to see him on an as-needed basis. So, either he saw the x-rays and understood the findings and ignored them or he never looked at the x-rays. Either one is outside the standard of care.

Q On what do you base your opinion that the shortcomings from the standard of care constituted no treatment at all?

A Because the treatment for an acute patellar tendon rupture in a young, active individual is surgical and surgical optimally within ten days.

Q And when you use the term young, tell me what that means to you? Because that clearly has different meanings to all of us.

A True. Certainly it becomes urgent when you have someone, depending upon their comorbidities and their health, to have this fixed when they are 70 or younger.

Q I knew I liked your definition of young.

On what do you base your conclusion that it is readily apparent that Dr. James was unaware that Mr. Jones was still ambulating with crutches, had limited range of motion of the left knee, had no ability to extend the left knee, had persistent pain and swelling in his left knee and was still on pain medication? It's at the bottom of Page 9 if that is helpful.

A So, these were the findings that were present as of December 3rd of 2015; and again, Dr. James did not provide any follow-up of Mr. Jones to assess whether he was recovering from his injury of November 14th of 2015. Dr. James was unaware of Mr. Jones' persistent symptoms even three weeks after his injury.

Q And you base that conclusion on what? Did Dr. James write that in his notes somewhere?

A So, the second time Dr. James evaluated Mr. Jones was on December 8th. Clearly based on the nursing notes of December 3rd of 2015, Mr. Jones was still having these issues with his knee. Dr. James

provided no follow-up after he ordered the MRI -- excuse me -- the x-rays of Mr. Jones' left knee and so because there was no follow-up, Dr. James was completely aware that Mr. Jones was still doing quite poorly with his left knee up until December 8th of 2015. When he saw him on December 8th of 2015, he found that he was doing poorly. That the x-rays showed findings that were consistent with the patellar tendon rupture and then he had a hypermobile patella and persistent left knee pain and swelling.

Q Are those the same facts on which you base your conclusion that Dr. James never scheduled Mr. Jones for reexamination or checked his progress after evaluating Mr. Jones on November 16th?

A Well, based on his signing of the nurse's note which he signed on November 30th where he asked to see him on an as-needed basis. Which in my mind is ridiculous when you have a suspicion for an acute patellar tendon rupture and you order a study to evaluate for that injury and you don't bother to follow up with the findings of the study you ordered.

Q And again, you don't know within the setting of Sheridan Correctional Center what Dr. James means when he says an as-needed basis, correct?

A Well, I think that is the same for all physicians. It's follow up as needed. I don't need to see you back but if you got a suspicion for an acute patellar tendon rupture and you order a study and that study is abnormal and it's consistent with your suspicion for an acute patellar tendon rupture, you better see that person back. At least, if anything, to go over the x-rays with the inmate.

Q And you don't know anything about the scheduling process within Sheridan Correctional Center, correct?

A Scheduling for what?

Q Medical scheduling?

A To see a physician?

Q Correct. For an inmate to see a physician or an inmate to see a nurse?

A I do not but I do know as a physician if I order a test, I am obligated to follow up on that test.

Q On what do you base your conclusion that Mr. Jones returned to the infirmary on his own accord on December 3rd of 2015?

A Because he was still having pain, swelling and limited motion and an inability to extend his knee and inability to ambulate normally.

Q But how do you reach the conclusion that he returned on his own accord as opposed to that being a scheduled appointment?

A I believe that's in the medical records. Clearly on November 30th, Dr. James said follow up PRN, as-needed, only.

Q And on what do you base your conclusion that without a doubt Mr. Jones was told that he had a patellar tendon rupture by Dr. James as documented in his December 29th of 2015 grievance?

A In his grievance, Mr. Jones says it's been two months since I ruptured my patellar tendon. I need to get my MRI scan. I need to get this fixed. So, clearly someone told him that he had a ruptured patellar tendon and I don't think it was the nurse. I'm pretty confident it was Dr. James because that's what Dr. James was suspicious for on multiple visits and evaluations of Mr. Jones.

Q So, you're basing your conclusion that Dr. James knew at least by December 29th of 2015 that Mr. Jones had a ruptured patellar tendon? You're basing that conclusion on the grievance that Mr. Jones wrote?

A Well, sure because I don't think Mr. Jones

self-diagnosed himself with a patellar tendon rupture that occurred two months ago; and clearly, Dr. James was suspicious from the day that he examined Mr. Jones, he had a suspicion for a patellar tendon rupture. When he came back to be seen, Mr. Jones came back to see Dr. James on November 8th. Again, not only did he have a high suspicion for patellar tendon rupture, but he had more clinical exam findings consistent with a patellar tendon rupture including a displaced patella.

Q On what do you base your conclusion that Dr. Verma, "Had to perform a second surgery on Mr. Jones' left knee."?

A Well, I don't think Dr. Verma had to do anything. Dr. Verma was there to evaluate Mr. Jones for his complications as a result of the treatment of his neglected left patellar tendon rupture. Dr. Verma's job was to tell him what his treatment options were and Mr. Jones elected to proceed with surgical intervention.

Q When you use the words Dr. Verma who had to perform a second surgery, you don't mean it was a required surgery? You mean it was one of the possible treatments that Mr. Jones could have received?

A Correct, and eventually he did in fact have a

second surgery to treat the complications of his first surgery.

Q That was an elective surgery by Mr. Jones, correct?

A Yes.

Q Tell me what you know about Wexford's policies?

A Nothing.

Q So, which of the policies -- which of Wexford's policies was Dr. James following in his treatment of Mr. Jones?

MR. FLAXMAN: Object to the question. The witness just said that he doesn't know anything about their policies. Now, you are asking him which ones were violated. That's not --

MS. BYRD: I didn't say violated. I asked what was he following.

MR. FLAXMAN: But he just said that he doesn't know anything about the policies. That's not a productive question.

MS. BYRD: So, in his report he says Wexford Health Sources whose policies Dr. James was following and Dr. James knew that Mr. Jones had a patellar tendon rupture.

BY MS. BYRD:

Q So I'm asking, which policies of Wexford Dr. James was following that you refer to in your report?

A So, Dr. James had to do a collegial review for further evaluation and treatment of Mr. Jones' traumatic injury to his left knee. He also had to follow Wexford's policies to obtain a specialist referral as well as authorization for surgical intervention.

Q How do those policies differ from what you have to follow when you have a patient that needs surgical intervention and you need approval from an insurance company?

A So, as far as a surgical procedure, there is not much difference; but again, on an urgent situation, usually that authorization is obtained within one to two days when it's urgent. I also don't need to get the blessing of another physician to pursue an MRI scan on a patient or offer surgical intervention or refer one of my patients to another specialist.

Q But you do need to get the blessing of the insurance company, correct?

A I don't have to.

Q How often do you have patients undergo MRIs without approval from their insurance company?

A Usually, it's the MRI facility that's responsible for obtaining the authorization for the MRI.

Q And how often is that MRI completed without approval of the insurance company?

A You would have to ask the MRI facilities.

Q How often have you seen an MRI be performed without approval of an insurance company?

A I don't know the billing of the MRI facilities on how they collect from the insurance companies when it's authorized or not authorized.

Q So, it's your testimony as you sit here today that patients get MRIs without approval of their insurance company?

A It has happened, yes. Does it happen often? No, it doesn't happen often but when you are describing an urgent situation where most likely surgery is going to be indicated and that surgery needs to be done in a timely fashion typically, and I'm just -- I'm not just talking patellar tendon ruptures but fractures for instance, you know, you explain to the person -- the patient that hey, you know, this needs surgery and we need to get this MRI scan and we'll try our best to get

the authorization; but, you know, this is something that you can't wait for.

So, it's rare but, you know, but on rare occasions patients will go ahead and get their MRI or their CT scan and, you know, and even have surgery without authorization from the insurance company.

Q How often do you perform non-emergent surgery on patients without approval from in insurance company?

A Well, because we pick up the phone and we call and we make an effort to get authorization within 48 hours. Usually, we can get that authorization within 48 hours, okay? So, you know again, this is one of my criticisms of Dr. James is that there was a huge time delay in obtaining this MRI scan, a huge time delay in actually getting a referral to the orthopedic specialist and an unreasonable length of -- period of time from the time of his initial injury to get authorization for surgical intervention.

Q So, my question was, how often do you perform surgery on your patients without approval of the insurance company, non-emergent surgery?

A Non-emergent surgery, very rare. Probably, less than once every two years but I will give you a

classic example. A pediatric fracture that's, you know, displaced and angulated, you know, is it emergent? No, but it certainly is urgent and I tell the patients, we are going to go to the operating room in two days or tomorrow and we'll try to do our best with the authorization from the insurance company but the longer you wait, the greater the risk of complications. So, you don't wait to get authorization when it puts the patient's health at increased risk.

Q What correctional health care standards did Dr. James violate?

A Are you talking about the deviations from the standard of care?

Q Of correctional medicine, yes?

A He inadequately examined Mr. Jones' left knee. He delayed the MRI scan order. There was a delay in referring him to the appropriate specialist to treat his injury and he failed to provide adequate follow up.

Q Adequate follow up to the initial injury or adequate follow up following surgery?

A To the initial injury.

Q How many times have you met Mr. Jones?

A Zero.

Q Prior to his injury, how often did Mr. Jones

play basketball?

A I don't know.

Q When Mr. Jones was not in incarcerated, how often was he playing basketball?

A I don't know.

Q What other kinds of recreational activities did Mr. Jones participate in prior to his incarceration?

A I don't know.

Q What recreational activities is he prohibited from participating in today by his injury?

A I'm sorry, the question again?

Q What recreational activities does his injury prohibit him from participating in today?

A From his treating orthopedic surgeons or what I would typically recommend to my patients with patellar tendon reconstructions?

Q Based on your opinion?

A No running or jumping, no high impact activities, no squatting, avoid kneeling if it's painful.

Q And that's forever?

A Correct.

Q And that's for anyone with a patellar tendon rupture?

A Correct.

Q Do you have any opinions about Dr. James' treatment of Mr. Jones that we have not already discussed today?

A No.

Q And is there anything else that you want to add to your report as we sit here today?

A No.

Q And if the trial was today, you would testify consistently with your report?

A I would.

Q You wouldn't have anything else to add?

A That is correct. Again, realizing that I didn't see his initial x-rays done on November 16th.

Q If I could have just a minute?

(Exhibit No. 2 marked)

(Recess had)

BY MS. BYRD:

Q Doctor, I will just show you what we are marking as Exhibit No. 2. Do you need to see a copy? Can you look through that? It's my understanding that that is a copy -- a complete copy of your report that's dated May 8th of 2019?

A Correct.

Q And that's the report that you were referring to when I asked if you had any additions that you needed to make to your report, correct?

A That is correct.

Q And your answer to that was no, correct?

A That is correct.

Q Okay. Then I'll just introduce that in as Exhibit No. 2 and then I don't have any further questions for you.

EXAMINATION

BY MR. FLAXMAN:

Q I want to clarify a few things. There was a question way at the beginning of the deposition which I can't fully remember, but it was about the nurse seeing Mr. Jones at 8:15 p.m. on November 14th, and then I think there is a question was -- should she have scheduled him to see the doctor the next day. Do you remember a question about what she should have done the next day?

A Will, according to the medical records, Mr. Jones was scheduled to see Dr. James on November 17th but in fact he saw Dr. James on November 16th.

Q In the free world -- but if somebody has an injury like apparently happened to Mr. Jones and then

goes to get medical care promptly, what -- and the nurse's physical examination is consistent with a ruptured patellar tendon, what happens in the free world? Does the nurse send the patient to the emergency room?

A Well, most of these patients end up going to the emergency room before seeing any medical provider because they can't walk and they can't straighten their knee out. They can't extend it and they have quite severe pain and they have an injury, you know.

Patellar tendons are somewhat similar to quadriceps tendons. So, you know, you can't walk without the tendon attached. So, they end up in the emergency room and then the emergency room contacts the orthopedic surgeon and then a decision is made whether or not to admit the patient to the hospital for additional testing and surgery, or does the patient follow up with the orthopedic surgeon within the week.

Q Now, when you formed your opinions, did you consider that November 14th was a Friday?

A No.

Q Did you consider that there was no doctor on-site at Sheridan on November 14th at 8 p.m.?

A No.

Q I think it was a Saturday actually. Would your answer be the same if November 14th was a Saturday?

A No change in my opinion.

Q And if November 15th was a Sunday and there was no doctor at Sheridan, would any of your -- would that affect your opinions?

A No.

Q And you talked -- You were asked questions about Wexford's policies. Is it your inference from what you read that Wexford required that the patient or that a prisoner receive an MRI before Wexford would consider sending the patient to an orthopedic surgeon?

A That's not my understanding.

Q That's all have. Thank you for clarifying.

FURTHER EXAMINATION

BY MS. BYRD:

Q Do you have any knowledge of the staffing of physicians at Sheridan?

A As far as the number or the hours?

Q The hours or the days?

A I do not.

Q So, do you know if there are physicians on duty at Sheridan on Saturdays?

A I do not know.

Q Do you know if there are physicians on duty at Sheridan on Sundays?

A I do not.

Q Do you know if the medical staff at Sheridan has the ability to call a physician into the facility if needed?

A I do not know.

Q I have nothing further.

MR. FLAXMAN: Do you want to review this?

THE WITNESS: No, I'll waive.

FURTHER DEPONENT SAITH NAUGHT

- - - - -

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)

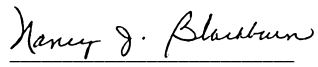
The within and foregoing deposition of the aforementioned witness was taken before NANCY J. BLACKBURN, C.S.R, and Notary Public, at the place, date and time aforementioned.

There were present during the taking of the deposition the previously named counsel.

The said witness was first duly sworn and was then examined upon oral interrogatories; the questions and answers were taken down in shorthand by the undersigned, acting as stenographer and Notary Public; and the within and foregoing is a true, accurate and complete record of all of the questions asked of and answers made by the aforementioned witness, at the time and place hereinabove referred.

The signature of the witness was waived. The undersigned is not interested in the within case, nor of kin or counsel to any of the parties.

Witness my official signature and seal as Notary Public in and for Cook County Illinois on August 23rd, 2019.



NANCY J. BLACKBURN, C.S.R.,
Notary Public

101

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May 8, 2019

Joel Flaxman
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Re: Johnny Jones vs. Wexford Health Sources, Inc. & Marshall James, M.D.
Court No.: 17 CV 8218
Date of Injury: November 14, 2015

Dear Mr. Flaxman:

What follows is my Medical Case Report regarding Mr. Johnny Jones. I had the opportunity to review the following medical records: those of Sheridan Correctional Center, Dr. Marshall James, Wexford Health Sources, Dr. Joseph Maides, Midwest Orthopaedic Institute, Dr. Ankur Behl, Midwest Orthopaedic Institute Physical Therapy, Midwest Orthopaedics at Rush, Dr. Nikhil Verma, Lawndale Christian Health Center, Daniel Ozinga, P.A., Dr. Amy McAuley, Schwab Rehabilitation Hospital, Valley West Community Hospital, Rush University Medical Center Physical Therapy, Oak Park Hospital, and the depositions of Mr. Jones and Dr. James. I also looked at the radiographs performed at Midwest Orthopaedic Institute and the MRI scan of the left knee.

Examination of the records demonstrates that Mr. Jones has a past medical history for gastroesophageal reflux disease, conjunctivitis, polysubstance abuse, a left Achilles tendon repair, a gunshot wound to the left femur with intramedullary nailing in 1991, right wrist and elbow pain and tendinitis, upper respiratory infections, headaches, vertigo, hypertension, chest pain, a right 5th finger injury, athlete's foot, pharyngitis, and folliculitis.

As you know, Mr. Jones is a 48-year-old gentleman who was incarcerated at Sheridan Correctional Center. He sustained an injury to his left knee while playing basketball on November 14, 2015. The earliest pertinent medical record was dated November 14, 2015. The Offender Injury Report noted that the time of injury was 8 p.m. in the gym and it was witnessed by the correctional staff. It occurred on the basketball court.

EXHIBIT # 2
Deposition
8-9-19
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Mr. Jones also had an injury report filled out by the infirmary nurse at 8:15 p.m. Mr. Jones described his left knee giving out while playing basketball and he fell on the floor hitting his head. At the time, he complained of left knee and head pain, which he rated 4/10. He was unsure if he lost consciousness. The nurse did not find any left knee swelling or tenderness. There was no bruising. There was no cut or open area on his head. There was a moderate knot and swelling at the base of his head. He was provided an ice pack, prescribed Motrin for five days, and given crutches for four days.

Dr. James was notified by the nurse, and Mr. Jones was scheduled for follow up on November 17, 2015. Mr. Jones was instructed by the nurse, Kristin Torres, to elevate and rest the knee. The report was reviewed and signed by Dr. James on November 30, 2015. Most interestingly on the report, Dr. James indicated that he would like to see Mr. Jones on an as needed basis.

The first time Dr. James examined Mr. Jones was on November 16, 2015. Dr. James noted that Mr. Jones complained of an injury to his head and left knee while playing basketball. On physical exam, Dr. James found that the left lower extremity had increased knee swelling and pain. His examination of the left knee was limited at best. His assessment was left knee derangement and rule out patellar tendon rupture. Dr. James ordered x-rays of the left knee to rule out a patellar tendon rupture. Dr. James ordered crutches for six weeks and a lay-in for four weeks. He prescribed Motrin 600 mg. twice a day for two weeks.

On November 16, 2015, Dr. James provided Special Orders for Mr. Jones for no work, school, yard, gym, or day room activities. He was not to do any group therapy interactions. Meals were to be in his room for four weeks. He was allowed a low bunk and gallery for two months. He was also given crutches for six weeks for a left knee derangement.

The radiographs were performed of the left knee on the same day that Dr. James examined Mr. Jones. The x-rays from November 16, 2015, of the left knee were done for pain after a fall. The radiologist saw an intramedullary rod in the distal femur consistent with Mr. Jones' previous internal fixation for his gunshot wound and fracture. There were mild tricompartmental osteoarthritic changes and a small joint effusion. The patella was described as slightly high riding. This report was dictated by the radiologist on November 18, 2015. I do not have these radiographs to review.

Mr. Jones returned to the infirmary 17 days later on December 3, 2015. He had limited range of motion of the left knee and swelling. He complained of 5/10 pain. The nurse discovered that his active range of motion of the left knee was limited. He was referred to Dr. James on December 8, 2015. Mr. Jones was instructed to use his pain medication, apply cold to his knee, and remain non-weight bearing on the left leg. The nurse's assessment was rule out skeletal injury.

The next time Dr. James examined Mr. Jones was on December 8, 2015. This was the

first time Dr. James saw Mr. Jones since November 16, 2015, despite his concern of a patellar tendon rupture and the radiographic findings of the left knee, which were reported on November 18, 2015. Dr. James found that Mr. Jones had persistent left knee pain and swelling. He had notable displacement of the patella. On physical exam, the left knee had a probable patellar tendon rupture.

Dr. James' assessment was rule out patellar tendon rupture. He found that the x-rays were consistent with a high riding patella. His plan was to refer Mr. Jones for orthopedic intervention. He ordered an MRI scan of the left knee and prescribed Motrin 600 mg. twice a day for another four weeks. At this point in time, it was over a month since Mr. Jones injured his knee.

A week later on December 15, 2015, Dr. James documented that there was approval by Collegial Review for an MRI scan of the left knee to rule out a patellar tendon rupture. The Utilization Management record from Wexford Health Sources dated December 16, 2015, authorized the MRI scan for a fall that occurred on November 14, 2015 with x-rays showing a slightly high-riding patella.

When Mr. Jones returned to the infirmary on December 26, 2015, he was instructed to continue his present management for his left knee injury. He came back to the infirmary on December 29, 2015. He was instructed to take Motrin 600 mg. as ordered by Dr. James.

On December 29, 2015, Mr. Jones filed an Offender's Grievance. He wrote that it had been almost two months since he ruptured his patellar tendon, and he knew that it took time to get things done. He was concerned that he was being released in 156 days, and he noted that he still had not gotten his MRI scan yet. At the time, he did not even know if the referral for the MRI scan had been approved. He stated that it took four to six months to recover from the major surgery for his injury. He claimed that he needed to be at least 75% recovered upon his release for his working purposes. He was interested in trying to speed up the process to get his knee fixed. This was received by Wexford Health Sources on January 6, 2016, more than a week later.

On December 30, 2015, Dr. James, again, provided Special Orders of no work, school, yard, gym, or day room activities, no group therapy interactions, and meals in his room for four weeks. Mr. Jones had an extension of his low bunk, low gallery, and crutches for another two months for left knee derangement with possible patellar tendon rupture. At this point in time, nearly six weeks after Mr. Jones' injury, he still had not received his MRI scan.

On January 6, 2016, Dr. James documented that the MRI scheduling form was completed for Mr. Jones. The MRI scan was finally performed on January 18, 2016, more than two months after Mr. Jones' injury. The MRI scan of the left knee noted that he had an injury in November with a clinical impression of a patellar tendon rupture.

The radiologist read a small tear in the posterior horn of the medial meniscus. There was no chondromalacia. There was a complete tear of the patellar tendon at its origin off the patella. A 1.6 cm. defect was observed consistent with a superiorly retracted patella. The patella was high riding and subluxed 4 mm. laterally. There was minimal edema seen in the inferior aspect of the patella. Low-grade chondromalacia of the patella was described along the medial facet.

The torn patellar tendon appeared thickened, compatible with retraction, and showed mild changes consistent with a contusion or chronic tendinopathy. There was questionable posttraumatic edema or tendinitis of the distal quadriceps tendon. It was felt that an intrasubstance tear was less likely involving the quadriceps tendon. A small joint effusion was observed as well as an 8 mm. Baker's cyst.

Dr. James saw Mr. Jones when he returned back from Valley West Community Hospital after his MRI scan. On exam, he found left lower extremity swelling and painful range of motion. Dr. James' assessment was rule out patellar derangement and rupture versus dislocation. His plan was possible follow up with orthopedics if the MRI scan was abnormal. Mr. Jones had a refill of his Motrin 600 mg. twice a day for two months.

Mr. Jones was instructed by Dr. James to return after his MRI scan results. On the same day, January 18, 2016, Dr. James filled out a Medical Special Services Referral and Report to Midwest Orthopaedic Institute for a left knee MRI scan which was consistent with a complete tear of the patellar tendon at its origin. It appears that Dr. James was aware of the MRI scan findings that day.

On January 23, 2016, Mr. Jones had his ibuprofen prescribed again 600 mg. twice a day. He was given 50 tablets. On January 25, 2016, the nursing staff documented that Mr. Jones was using two crutches and his left knee had restricted range of motion due to a previous injury. He had a recent fall after his right knee buckled. He fell onto his buttocks and injured his right shoulder.

On January 26, 2016, Dr. James was provided approval by Collegial Review for Mr. Jones' orthopedic consult. On January 27, 2016, Utilization Management of Wexford Health Sources approved a new outpatient office visit regarding the January 26th request for orthopedic consultation related to a patellar tendon disruption after an MRI scan showing the same. This was approved by Dr. Ritz in collegial conversation with Dr. James.

Mr. Jones returned to the infirmary on February 2, 2016. He was requesting an extension to his Special Orders for meals in his room. The nurse spoke to Dr. James and Dr. James denied the extension. Dr. James felt that Mr. Jones had two crutches and was able to use them for ambulation. It is unclear why Dr. James refused to extend Mr. Jones' Special Orders which he had done since November 16, 2015, and given the fact that Dr. James at the time was aware of the MRI scan findings showing a complete patellar tendon rupture. In light of Mr. Jones' recent fall with injury the

previous week, there appears to be no reasonable medical justification for Dr. James' actions.

On February 2nd a Specialty Appointment Document Request for a home exercise program was filled out by Dr. James. The Collegial approval was dated January 27, 2016. There was a notification of medical furlough to Midwest Orthopaedic Institute for February 8, 2016.

Mr. Jones was finally evaluated by Dr. Behl of Midwest Orthopaedic Institute on February 8, 2016. Mr. Jones had a chief complaint of a left patellar tendon rupture. The date of injury was listed as November of 2015. The injury occurred three months prior while playing basketball in prison. He went up for a shot, felt his knee pop, and ever since the injury Mr. Jones had excruciating pain, which was sharp in the quadriceps tendon. He rated his pain 10/10 and he was on ibuprofen for the pain. Mr. Jones had increased pain with walking, flexing, and use. He had inability to extend and bend his knee at his kneecap. Ever since the patellar injury he had atrophy and pain in the quadriceps region.

On physical exam, Mr. Jones could not actively extend his left knee. Passive range of motion was 0° to 90°, but he could not hold the left knee extended. He had diffuse, severe quadriceps atrophy. His kneecap was high riding. He was only able to flex to 90°. He had no resistance against "extension". In reality Dr. Behl meant to say "flexion", meaning that Mr. Jones could not extend his knee against it being bent or flexed. Radiographs were performed, which showed an intramedullary nail in the left femur with a bullet fragment in the posterior bone. Mr. Jones had a very high-riding patella with an Insall-Salvati ratio of 2.25. There was sclerosis seen of the tendon and inferior aspect of the patella. There was no arthritis.

I reviewed these x-rays from February 8, 2016 which included bilateral AP and PA standing views, a lateral radiograph of the left knee, and bilateral sunrise views. These clearly demonstrated that the left patella was high riding and had migrated superiorly as compared to the right patella. Furthermore, there was evidence of an avulsion fracture involving the inferior pole of the patella with the fracture fragment displaced roughly 2 inches inferior to the patella. The lateral x-ray showed patella alta (an abnormally high positioned patella). The knee did not exhibit any significant arthritic change. These findings are consistent with a complete rupture of the patellar tendon.

Dr. Behl's assessment was a left chronic patellar tendon rupture. He found that Mr. Jones had a very atrophic quadriceps muscle with inability to extend the knee and very limited range of motion. Dr. Behl opined that the outcome with this long of a delay, no matter if Mr. Jones underwent operative or non-operative management for his patellar tendon rupture, would be affected.

Dr. Behl noted that non-operative treatment would not allow Mr. Jones to extend the knee. Operative intervention would involve open tendon repair, and if not feasible due to the delay in treatment, possible reconstruction of the extensor mechanism and

patellar tendon. Dr. Behl recommended surgery and Mr. Jones indicated that he wanted to pursue the surgery. Dr. Behl stated he would have to wait for the approval from Wexford Health Sources.

When Mr. Jones returned back to Sheridan Correctional Center on February 8, Dr. James documented that he was evaluated at Midwest Orthopaedic Institute for a left knee patellar tendon rupture. Dr. Behl recommended surgery as soon as possible. Dr. Behl had written on the Medical Special Services Referral and Report that Mr. Jones had no ability to extend his knee. He had limited flexion and his assessment was a chronic left knee patellar tendon rupture. He recommended a repair or a possible reconstruction as soon as possible. Curiously, Dr. James on his physical exam found that the left lower extremity had a left knee deformity which is the first time he made this observation after the tendon rupture three months earlier. A referral for left knee surgery was submitted.

On February 10, 2016, Dr. James wrote that Mr. Jones' surgery was scheduled for February 16th. A record from Wexford Health Sources Utilization Management dated February 11, 2016, showed that his surgery was approved for the February 10th urgent request for patellar tendon repair by orthopedics due to a complete tear of the patellar tendon at its origin with 1.6 cm. separation between the inferior patella and the superior aspect of the torn tendon.

On February 16, 2016, Mr. Jones underwent surgery at Valley West Community Hospital. Dr. Behl's pre- and post-operative diagnosis was a left chronic patellar tendon rupture. Mr. Jones underwent reconstruction of the left chronic patellar tendon rupture using two swivel lock anchors and a semitendinosus tendon allograft. Dr. Behl was assisted by his partner, Dr. Steve Glasgow. Dr. Behl indicated that Mr. Jones injured his left knee three months prior, in November of 2015, while playing basketball in prison. Ever since the injury he had pain and inability to extend and bend the knee at the kneecap. Radiographs and the MRI scan were representative of a chronic patellar tendon rupture.

Intra-operatively, there was a large palpable gap of the patellar tendon which was easily felt. There was chondromalacia of the lateral femoral condyle and the lateral femoral trochlea. Dr. Behl excised one cm. of scar tissue from the patellar tendon and tried to mobilize the patella. However, there was a lot of scarring down of the patella to the femur. Dr. Behl had to cut out triangular areas of the retinaculum just in order to advance the retinaculum and free up the adhesions, so that he could mobilize the patella inferiorly enough to get a better closure of the extensor mechanism.

Eventually, Dr. Behl was able to mobilize the patella with a rake pulling down on it inferiorly, so that at 90° of flexion the patella and patellar tendon appeared to be re-approximated. Multiple releases were necessary, and at that point Dr. Behl felt that he could attach the semitendinosus tendon allograft and placed it mainly medially where the best fixation was available. The graft was passed through the middle of the patella.

An anchor was placed in front of the mid patella, and he placed fiber wire suture into the tibial tubercle with the knee flexed to 30°. The patella was anchored down. A second anchor was used in the tibial tubercle. He had to make multiple passes of the tendon graft through the remnant of the patellar tendon distally and then folding it over into the quadriceps area. Range of motion of the knee was 0° to 70° of flexion, without significant tension on the reconstruction.

Dr. Behl then closed the retinaculum and again excised a triangular portion of the retinaculum which was "all scar". After closure of the retinaculum, range of motion of the knee was 0° to 90°, without significant tension. The extensor mechanism was closed with the remnant of the patellar tendon closed to the remnant of the patellar tendon still attached to the patella. The graft was anchored to the patella.

Mr. Jones was placed into a cast and Dr. Behl elected to keep him non-weight bearing for 10 to 14 days. A femoral nerve block was performed, and he was instructed to follow up in 10 to 14 days for removal of the cast and the surgical staples. Dr. Behl's plan was to obtain x-rays at that time and see if he could get Mr. Jones' knee into a brace where he could gradually get some flexion (although initially he erroneously said extension). Dr. Behl also stated that he would like Mr. Jones to do physical therapy at that point in time as Mr. Jones was limited on when he could see Dr. Behl.

The deposition of Dr. James occurred on December 14, 2018. Dr. James testified that his initial knee exam of Mr. Jones showed that his left knee was slightly swollen and that there was a little laxity of the patella. (However, this was not documented anywhere in the medical record.) He examined the right knee, and he felt that it was similar in presentation. (However, again, this was not documented in any of his medical records.) Mr. Jones had 8/10 pain. He provided Mr. Jones some pain medication (which in actuality was ibuprofen). At the time, Dr. James felt conservative treatment was appropriate. (However, rarely, if ever, is conservative treatment appropriate for a patellar tendon rupture in an active individual with no known functional limitations.)

Dr. James stated at his deposition that he had elected to treat Mr. Jones with pain medications, complete rest, and non-weight bearing on the left knee unless he could present it to his superior at a collegial review. After the radiograph interpretation, Dr. James continued conservative treatment at the time with bedrest and physical therapy. (However, there was no evidence that Mr. Jones ever had physical therapy at Sheridan Correctional Center.) On December 8, 2015, Mr. Jones had persistent and significant pain and was not able to have any weight bearing on the knee after Dr. James had him rest for about four weeks.

Dr. James also specified at his deposition that he believed that Mr. Jones received surgery in a timely fashion, and he thought that Mr. Jones received surgery a lot quicker than those in the private health sector. Dr. James testified that Mr. Jones was not very cooperative with the recommendations at the time regarding physical therapy after surgery. Dr. James pointed out the rehabilitation recommendations which Mr.

Jones did not abide by "at all". (However, there was no evidence of this in the medical record and it was documented in the medical record by multiple people at Sheridan Correctional Center that Mr. Jones was doing his exercises on his own in the infirmary.)

Dr. James also indicated at his deposition that after the surgery, it was recommended that Mr. Jones keep his knee brace on throughout the day and on several occasions he had taken it off. (In fact, the only time it was documented in the medical record that Mr. Jones took his knee brace off was while he was in bed. It was clearly shown in the medical record that he used his brace while out of bed.) Dr. James claimed that it was reported by the nurses and all personnel that Mr. Jones hardly wore the knee brace as often as he should have.

Dr. James testified that using the brace would have decreased Mr. Jones' left knee postoperative stiffness. In reality using the brace all the time would have increased his stiffness as it would have been more restrictive and allowed less mobilization of the joint. Before Mr. Jones' surgery Dr. James made and printed out rehabilitation recommendations that, according to Dr. James, Mr. Jones did not abide. (However, it was clear that Mr. Jones could not have followed all the physical therapy or rehabilitation recommendations made by Dr. James as he had a complete rupture of his patellar tendon.)

Dr. James claimed at his deposition that he made recommendations about staying off the knee before Mr. Jones' surgery by which Mr. Jones did not abide. (However, this was not documented at all in the medical record. Certainly, Dr. James removing Mr. Jones' privilege of having meals in his room did not help Mr. Jones to keep off or help protect Mr. Jones' injured knee.)

It is my opinion that Dr. Marshall James deviated from the standard of care in his evaluation and treatment of Mr. Jones' acute patellar tendon rupture. The medical records show that Dr. James had an immediate concern about a left knee patellar tendon rupture from the first date that he examined Mr. Jones on November 16, 2015. This initial suspicion was despite Dr. James' inadequate examination of Mr. Jones' left knee after his traumatic injury, as seen in his documentation of November 16, 2015.

Dr. James did not document Mr. Jones' inability to extend his knee, his active range of motion of the injured knee, any tenderness to palpation in the knee, his inability to perform a straight leg raise, any defect in the patellar tendon, or the presence of an effusion or hemarthrosis. Dr. James simply noted that Mr. Jones had pain and swelling in his left knee. Dr. James, in my opinion, performed an inadequate physical exam of the knee, which lead him to believe that there was no severe or urgent injury to Mr. Jones' left knee. Had Dr. James performed an adequate physical exam of Mr. Jones' left knee on November 16, 2015, there would have been no doubt about the severity of his injury and the need for urgent surgical consultation.

Despite his inadequate examination, Dr. James did have a concern about an acute

patellar tendon rupture. If one loses the ability to actively extend the knee, can't weight bear on the leg because of severe weakness in the knee, and has severe pain at the patellar or quadriceps tendons in the knee after an injury, then this is an urgent medical condition and most likely requires prompt surgical intervention. Dr. James failed to meet the standard of care when he failed to order expeditious surgical treatment for Mr. Jones' acute patellar tendon rupture. This was imperative for an optimal recovery.

Dr. James also deviated from the standard of care by not ordering an MRI scan of Mr. Jones' left knee to evaluate for a patellar tendon rupture when this was obviously his primary concern. Radiographs, although supportive of a potential patellar tendon rupture, are not diagnostic or confirmatory for such an injury. The standard of care dictates that the appropriate test to evaluate for a suspicious patellar tendon rupture is an MRI scan.

It is my opinion that the urgent request for an MRI scan of the left knee should have been made by Dr. James on November 16, 2015. Furthermore, if Dr. James appropriately examined Mr. Jones' left knee and came to the conclusion of a patellar tendon rupture, then he should have sent Mr. Jones for an immediate orthopedic consultation. These acts or omissions deviated from the standard of care.

Just as egregious, after the radiographs were obtained on November 16, 2015, Dr. James never bothered to follow up on this testing that he ordered. It is clear from the medical record that Dr. James never sought the radiologist's report of the x-rays until he saw Mr. Jones again on December 8, 2015. This was a deviation from the standard of care. As a result, Dr. James did not order an MRI scan of the left knee until nearly 24 days after Mr. Jones sustained his patellar tendon rupture. This was another deviation from the standard of care. All of these shortcomings from the standard of care were so egregious that they constituted no treatment at all.

Further evidence that Dr. James ignored the obvious risks to Mr. Jones was seen by his signing of the nurse's injury report from November 14, 2015. Dr. James signed the report on November 30, 2015, stating that he would like to see the offender only on an as needed basis. It is plain that he had not even reviewed the radiographic findings by this date.

One would hope that, if Dr. James was concerned enough to order x-rays and initiate special orders for Mr. Jones up to two months for his knee derangement, he would have reexamined Mr. Jones more than on an as needed basis. It is also readily apparent that Dr. James was unaware that Mr. Jones still was ambulating with crutches, had limited range of motion of the left knee, had no ability to extend the left knee, had persistent pain and swelling in the left knee, and was still on pain medication.

Even in light of his concern regarding a patellar tendon rupture, Dr. James never scheduled Mr. Jones for re-examination or checked on his progress after he evaluated Mr. Jones on November 16, 2015. Dr. James failed to provide appropriate follow up

of Mr. Jones' left knee injury in the month of November 2015 and again deviated from the standard of care. Mr. Jones returned to the infirmary on his own accord on December 3, 2015, after he still had pain, limited motion, and swelling of his knee. All of the above shortcomings led to a delay in the ultimate diagnosis and appropriate treatment of Mr. Jones' left knee injury.

Without a doubt, Mr. Jones was told that he had a patellar tendon rupture by Dr. James as documented in his grievance of December 29, 2015. This was even before he obtained his MRI scan of the left knee confirming that he had a patellar tendon rupture. Dr. James, suspicious that Mr. Jones had a patellar tendon rupture, should have sent him for an immediate orthopedic consultation after his first evaluation of Mr. Jones on November 16, 2015. Dr. James' disregard of Mr. Jones' serious medical need is again seen in that Dr. James knew Mr. Jones had a patellar tendon rupture and did nothing to accelerate Mr. Jones' evaluation, treatment, or referral to the proper medical specialist.

Dr. James' wait and see approach for more than two months to obtain an MRI scan of the knee after having an initial clinical suspicion for patellar tendon rupture, after radiographs were consistent with a patellar tendon rupture, and after Mr. Jones had obvious clinical exam findings consistent with a patellar tendon rupture during this two month period was gross medical negligence and was so egregious that it constituted no treatment at all.

Wexford Health Sources, whose policies Dr. James was following, and Dr. James knew that Mr. Jones had a patellar tendon rupture, as seen by the indications for the MRI scan, and took an unreasonable amount of time to appropriately refer Mr. Jones to an orthopedic surgeon for his traumatic injury. As a result they ended up delaying his surgery to the point it negatively impacted his clinical outcome from his left knee surgery.

I would dispute Dr. James' claim that Mr. Jones had surgery in a timely fashion. No orthopedic surgeon would feel more comfortable treating a patellar tendon rupture greater than three weeks old. Most, if not all of these injuries, should be acutely diagnosed and treated with surgery urgently, preferably within three weeks of the date of injury, and optimally within 10 days. Surgical repair of a patellar tendon rupture should be done within three weeks, as there is an incremental decline in the clinical results and the success rate of such a repair beyond this time period.

The reasons for such urgency are several. The body starts to heal the injury with a large amount of scar tissue around the ruptured patellar tendon, quadriceps tendon, kneecap, distal femur, the torn retinacula (ligaments) on either side of the knee, and the overlying soft tissues. This contributes to severe stiffness, loss of motion, and chronic swelling, pain, and dysfunction. It also makes repair and/or reconstruction of the tendon that much more difficult as the knee structures are encased in scar and mobilization of the tissues very difficult.

In addition, the complete rupture of the tendon allows for the quadriceps muscle to contract unopposed, thereby causing significant shortening of the extensor mechanism with the kneecap and quadriceps tendon being pulled up the thigh. As a result, there is severe weakness of the quadriceps muscle. Eventually over time, this leads to significant contracture and atrophy of the muscle. This causes further difficulty in surgery to pull the kneecap and quadriceps tendon far enough down the leg so that they can be restored to their normal position in the knee. This will contribute to post-operative loss of motion, particularly flexion, potentially maltracking and/ or degenerative changes of the patellofemoral joint (arthritis), and chronic weakness, pain and dysfunction.

Certainly, it is a deviation from the standard of care to have this injury surgically treated three months after it was suspected. This was supported by Dr. Behl who diagnosed a chronic (not an acute or even subacute) left patellar tendon rupture. Dr. Behl could not do a primary repair of the torn tendon and had to do an extensor mechanism reconstruction with tendon allograft (cadaver) due to the delay in treatment causing significant scarring and contracture of the soft tissues. This is a longer, more complex, and less successful surgery than primary repair of the patellar tendon.

Furthermore, this was also supported by Mr. Jones' other treating orthopedic surgeon, Dr. Verma, who had to perform a second surgery on Mr. Jones' left knee because of the poor outcome as a result of the delay in the treatment for his patellar tendon rupture. Dr. Verma performed a second knee surgery in the hopes of improving Mr. Jones' pain, range of motion, function, and strength. This necessitated rather extensive physical therapy over the course of 4 months after Dr. Verma's surgery. Dr. Verma confirmed the deviation from the standard of care as seen in his record of October 11, 2017, when he described Mr. Jones' left knee condition as status-post patellar tendon reconstruction for a chronic, neglected patellar tendon disruption.

Because of the delay in surgery, Mr. Jones has developed severe stiffness, scarring, weakness, and quadriceps atrophy which in my opinion are irreversible. Clearly, the delay in treatment has caused Mr. Jones to have persistent and chronic pain, limited range of motion, dysfunction, and inability to use his left leg as he did prior to the injury. It is also highly unlikely that he will ever return back to the basketball court or participate in recreational activities as he did prior to his prison injury.

Should you have any further questions or concerns in regards to this Medical Case Report, please do not hesitate to contact me. My Curriculum Vitae and recent deposition and trial testimony list are attached. I am being paid for my work at a rate of $350 per hour. I have spent approximately 21 hours on this report. My fee for depositions is $1,800 for the first two hours, prorated thereafter in 15 minutes increments. For trial testimony the fee is $4,000 for the first two hours, prorated thereafter in 15 minute increments, portal to portal.

I do declare under penalty of perjury under the laws of the United States of America that the information contained within this report was prepared and is the work product of myself and is true and correct to the best of my knowledge and information. The opinions rendered in this report are made within a reasonable degree of medical and orthopedic surgical certainty.

Sincerely,

Vincent P. Cannestra, M.D.

EXHIBIT H

ILLINOIS DEPARTMENT OF CORRECTIONS

Complete and return to record office.

Offender Count Adjustment

Sheridan Correctional Center

Offender Name: Jones, Johnny ID#: B00208

Has been ordered on:			Has been released on:	
☐ Appeal Bond	☐ Critical Illness Furlough	☐ Transfer	☐ Discharge	☒ MSR
☐ Authorized Absence (juvenile)	☐ Funeral Furlough	☐ Work Release	☐ Parole	
☐ Compact Detainer	☐ Medical Furlough	☐ Writ	☐ Other (specify):	
☐ Other (specify):		☐ Writ Transfer Return		

Type of Transport: ☐ Authority Pickup ☐ Bus ☐ Personal Transport ☒ Staff Escort ☒ State Vehicle ☒ Train ☒ Other (specify): $15.50 TRAVEL ALLOWANCE

Outstanding Warrant: ☐ Yes ☒ No

Departure: Date: 6/06/2016 Time: 8:00 ☒ A.M. ☐ P.M.

Destination: AURORA TRAIN to CHICAGO - METRA TO CAROL STREAM

	Print Name	Signature
Field Services Representative	Field Services Representative	
Record Office Staff	Record Office Staff Renee Thompson	Renee Thompson
Approved:	David J. Gomez, Warden (Print Name of Chief Administrative Officer)	

Check Points ✓ where stop is required	Signature of staff processing offender in location	Check Points (specify) ✓ where stop is required	Signature of staff processing offender in location
☒ Bureau of Identification		☒ Personal Property	
☒ Clothing		☒ Trust Fund	Lisa A. Fellows 06/22/16
☐ Library		☐ Records Office	
☒ Medical Medications: ☒ Yes ☐ No ☐ HIV Test & Counseling Offered (Transfer to a transition center, MSR, Parole, or Discharge only)		☐	
		☐	
		☐	
		☐	

Departed facility through: ☐ Lobby ☐ Sally Port ☒ Gatehouse/Lobby ☐ Other (specify):

	Print Name	Signature
Releasing Officer:	LT Connor	

Date: 6-6-16 Time: 840 ☒ A.M. ☐ P.M.

Distribution: Master File

Printed on Recycled Paper

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EXHIBIT I

(FILED UNDER SEAL)

EXHIBIT J

(FILED UNDER SEAL)