Exhibit 26

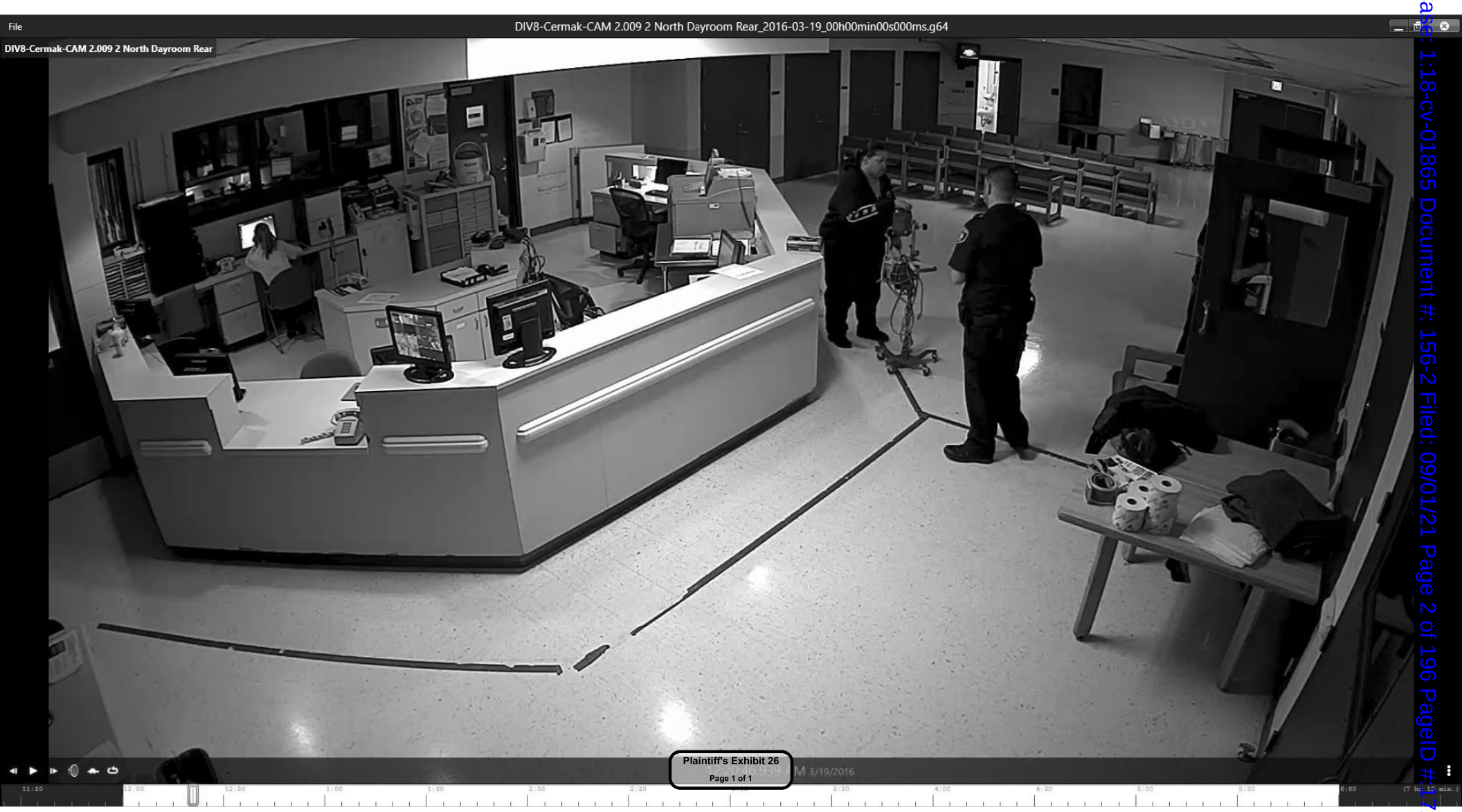

Exhibit 27

County 0201

Cook County Health and Hospitals System

1900 West Polk Street, Chicago, Illinois 60612

Patient Name: CRUZ, ANGEL
Patient Type: Visit CHS
Birth Date: [redacted]
Gender: Male

Admission Date: 3/15/2016
Discharge Date: 3/20/2016
FIN: 20160315122

MRN: 00741784z; 004705386c
CMRN: 1009171604

Nursing Note Inpt

Document Type:	Nursing Note Inpt
Service Date/Time:	3/19/2016 05:16 CDT
Result Status:	Modified
Perform Information:	CHATMAN RN,LORRAINE (3/19/2016 05:16 CDT)
Sign Information:	CHATMAN RN,LORRAINE (3/19/2016 05:54 CDT); CHATMAN RN,LORRAINE (3/19/2016 05:16 CDT)

Nursing Progress Note Entered On: 03/19/2016 05:27
Performed On: 03/19/2016 05:16 by CHATMAN RN, LORRAINE

Nursing Progress Note

Nursing Progress Note : S / O - Pt. right hand released to eat breakfast. Ate small amount. Pt. noted remaining drowsy from earlier given PRN. Took couple sips water. Pt. remains disorientated and making references about his mother. Pt. appears to be responding to internal stimuli. Attempted reality orientation. ROM done at this time. Sense pt. is calmer than earlier chest restraint removed. Pt. remains unpredictable and unable to contract for safety.
A / P - Alteration in sensory preception r/t responding to internal stimuli - Will continue in FLR's for protection of self/others w/q15 min checks per protocol.

CHATMAN RN, LORRAINE - 03/19/2016 05:54

~~{ [S / O - Pt. right hand released to eat breakfast. Ate small amount. Pt. noted remaining drowsy from earlier given PRN. Took couple sips water. Pt. remains disorientated and making references about his mother. Pt. appears to be responding to internal stimuli. Attempted reality orientation. ROM done at this time. Pt. remains unpredictable and unable to contract for safety. A / P - Alteration in sensory preception r/t responding to internal stimuli - Will continue in FLR's for protection of self/others w/q15 min checks per protocol.] - previously charted by CHATMAN RN, LORRAINE at 03/19/2016 05:16 };~~

Plaintiff's Exhibit 27
Page 1 of 1

Exhibit 28

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

LETICIA VARGAS, Administrator of the Estate of Angel Cruz,

Plaintiff,

-vs-

No. 18-CV-1865

SHERIFF OF COOK COUNTY, et al.,

Defendants.

Videotaped deposition of ELIZABETH PAIGE LASSEN sworn in telephonically by NADINE WATTS, RPR, CSR and Notary Public, and resworn in person, taken before CAROL CONNOLLY, CSR, CRR, and Notary Public, pursuant to the Federal Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, at 2650 South California, Suite 1100, Chicago, Illinois, commencing at 9:38 a.m. on the 27th day of September, A.D., 2019.

There were present at the taking of this deposition the following counsel:

KENNETH N. FLAXMAN, P.C. by
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appeared on behalf of the Plaintiff;

STATE'S ATTORNEY OF COOK COUNTY, ILLINOIS by
MR. WILLIAM RAGEN
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appeared on behalf of the Defendants Cook County, et al.,

STATE'S ATTORNEY OF COOK COUNTY, ILLINOIS by
MS. RAANA HAIDARI
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appeared on behalf of the Defendant Sheriff of Cook County Tom Dart.

ALSO PRESENT:
Mr. Jeremey Manga, Videographer
Mr. Andrew Segal, Kenneth Flaxman

I N D E X

DEPOSITION OF ELIZABETH PAIGE LASSEN, D.O.

TAKEN September 27, 2019

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EXHIBITS MARKED

THE VIDEOGRAPHER: We are now on the record. This marks the beginning of media number 1 in the deposition of Dr. Elizabeth Lassen. Today's date is September 27th, 2019, and the time is now 9:38 a.m. This is the matter of Vargas versus Sheriff of Cook County. This deposition is being held at 2650 South California Avenue, Chicago, Illinois.

Will attorneys please identify themselves.

MR. FLAXMAN: Joel Flaxman for the plaintiff. My paralegal Andrew Segal is also present.

MR. RAGEN: Bill Ragen for Dr. Lassen, Dr. Paschos, Jaruwan Supasanguan, Manuel Manalastas, Avis Calhoun, Lorraine Chatman, Cherri Krzyzowski, Helen Kanel, Augustus Alabi, and maybe that's it. And Cook County.

MS. HAIDARI: Assistant State's Attorney Raana Haidari on behalf of the Sheriff.

THE VIDEOGRAPHER: Will the court reporter please swear in the witness.

(Whereupon, the following proceedings were transcribed from the videotaped audio recording.)

MS. WATTS: Hi, this is Nadine Watts. I am a court reporter and notary public for the State of Illinois.

Doctor, would you raise your right hand please.

ELIZABETH PAIGE LASSEN,

called as a witness herein, having been first duly sworn, was examined upon oral interrogatories and testified as follows:

EXAMINATION

By Mr. Flaxman:

MR. RAGEN: Before we start this deposition I want to state for the record, the court reporter who Joel called for just had a family emergency. All the parties are agreeing to have Dr. Lassen provide testimony, you know, under oath, by the videographer, and that's going to be stenographed later.

MR. FLAXMAN: Right. And the other thing is we're going to do a second swear in when our court reporter arrives.

MR. RAGEN: Yes, I didn't put that on the record because who knows what's going to happen in the future, but that's the plan.

MR. FLAXMAN: I'm confident that we will have a new court reporter.

MR. RAGEN: All right.

MR. FLAXMAN: Q Can you state your name for the record, please.

A Elizabeth Paige Lassen.

Q And do you understand that you're under oath?
A Yes.
Q Okay. You don't have a problem with this procedure this morning was somewhat unorthodox, but you understand you're required to tell the truth?
A I do.
Q Have you ever given a deposition before?
A Yes.
Q When was that?
A There has been one for Cook County, and I currently work at a different hospital, so I have been deposed there two times.
Q Okay. When was the deposition that was related to Cook County?
A I can't recall. It's been over two years.
Q It was at least two years ago?
A At least two years.
Q Were you a defendant in that lawsuit?
A No. I don't believe so.
Q Do you remember what that lawsuit was about?
A I think it was about police use of force.
Q Police employed at the jail?
A Or correctional officer use of force.
Q Okay. Do you remember the name of the

plaintiff in the case?

A No.

Q And you said you have been deposed two times in relation to your current employment?

A Correct.

Q And were you the defendant in either one of those cases?

A In one every -- every provider, every physician that had -- had engagement with a particular patient was named, and I was one of those, yes.

Q Do you know the outcome of that lawsuit?

A That -- It was determined to be dropped.

Q Okay. Well, the -- All I want to tell you about the deposition is that I'll ask you to let me finish my questions, and I'll ask you to -- I'll ask you to let me finish talking before you speak, I'll do the same, I'll let you finish your answers before asking questions. Do you understand that?

A Yes.

Q As you have been doing, I'll ask you to give verbal answers, yes, no instead of shaking your head or mumbling or anything like that. Do you understand that?

A Yes.

Q And is there any reason that you wouldn't be

able to truthfully and accurately answer my questions today?

A No.

Q We referred to your current employment. What is your -- what is your current employment?

A I'm an outpatient psychiatrist at Hines VA, Veterans Hospital in Maywood.

Q How long have you been an outpatient psychiatrist at Hines VA?

A Since 2011, 8 years.

Q Okay. And was there a time that you were employed at Hines and employed at the Cook County Jail?

A The entire time, yes. Hines has been my full-time employment since 2011.

Q Okay.

A I worked for moonlighting and weekend coverage and evening coverage at the jail part-time.

Q Okay. Were you ever employed full time at the jail?

A No.

Q Did you ever seek full-time employment at the jail?

A No.

Q I'm going to hand you what I've marked at the

top as Plaintiff's Exhibit No. 1. It's a three-page document.

Is this a copy of your CV?

(Exhibit 1 marked as requested)

A Yes.

Q And does it accurately -- accurately list your four positions you've had at the Hines VA Hospital?

A Yes. I mean, one thing -- the primary care behavioral health psychiatrist was just a role, it wasn't like a full-time job. It was one of my many duties, so it's in there. I wasn't ever -- as solely held position. It was part of my other duties.

Q So the whole time you have been an outpatient psychiatrist, right?

A Correct.

Q But these are different job titles?

A Correct.

Q As of 2016 you've been the medical director of out patient mental health services?

A Correct.

Q What is Oak Lawn telepsychiatry?

A So Hines VA has six community based outpatient clinics, all of our -- Joliet, Elgin, Kankakee, LaSalle, Oak Lawn is also one, one of our larger community

clinics, and so I would be housed at Hines and provide telepsychiatry services to veterans in the Oak Lawn area. So it's -- we are like the second in the nation providing telepsychiatry services among VAs.

Q Okay. And does -- telepsychiatry services means treatment over a video connection?

A Correct.

Q And you also have been since 2011 an assistant professor at Loyola University?

A Yes.

Q What courses have you taught at Loyola?

A I am a clinical instructor so I supervise residents about half of their time during their training program. It's been over at Hines VA so I supervise them as they are seeing patients, seeing patients who have been -- help them get their outpatient services.

Q And what -- What degree are those students pursuing?

A They have completed medical school. They're in their psychiatry residency training program, which is a four-year program typically for general adult psychiatry.

Q And do you -- do you do any classroom teaching?

A On occasion I've given a lecture about -- a couple case conferences, a few lectures on anxiety

disorders. I really don't like that classroom, big presentation setting so I prefer the clinical work, so I have avoided that.

Q Okay. And the last work experience listed is correctional psychiatrist at Cook County Jail. What was -- when you were working -- I believe what you said was moonlighting in the evening, correct?

A Correct. So I took a moonlighting position. Initially it was 20 hours a week because they only offered a part-time position, that was a lot of hours in addition to a full-time job so -- later -- the latter years I worked fewer evenings, but a typical -- my typical week would be coming in to work in the intake receiving area of jail, and that would usually about be 5:00 p.m. to 10:00 p.m. and that's seeing people coming from the various lockups and coming in, evaluating those that need to started to be on meds, in they're in distress, kind of disposition. And then every other weekend I would work Saturday and Sunday, and that's covering our acute inpatient units, so male unit and a female unit, 2 north and 2 west, and we would see -- anywhere on the weekends we would see brand new patients, new intakes, do a full evaluation or anybody on close observation. So they might have behavioral issues

recently attempted suicide, been violent, unpredictable so she do short checks on close obs patients.

Q How many -- I think you said initially you worked 20 hours a week, right?

A Correct.

Q Was that reduced at some time?

A It seemed that it became more possible to work a little less in the evenings during the week.

Q Would you work every evening?

A No. I would do maybe Tuesday, Thursday, Friday, alternate the next week, Tuesday, Thursday, just whatever I could do to make that 20-hour mark, but with leadership changes, it seemed like they were more understanding later that I could maybe do 16 hours a week instead of 20.

Q I see. What was the leadership change that you mentioned?

A I was hired under Terry Marshall, and then she was no longer in that role.

Q What was her role when you were hired?

A I'm not sure.

Q Okay. Who replaced Terry Marshall?

A I'm not sure. I don't know if they did away with the position or -- I'm not sure what they did

structurally.

Q In 2016 when you stopped working at the jail, who was your supervisor who was in charge of determining how many hours you would work?

A Dr. Kelner was the chief of psychiatry.

Q What was -- okay. Do you know when Dr. Kelner became the chief of psychiatry?

A I don't recall.

Q And for the weekends that you would work, what hours -- what were your hours at the jail?

A It would depend, you know. They -- thankfully I think they were flexible with that, and since the patients were on inpatient units, you know, they were going to be there to be interviewed, so if I had other obligations, I would come in later, so -- and you work until you've seen all the new patients not the close obs, so there's no fit schedule.

Q Were you ever an oncall psychiatrist?

A No.

Q And would you -- Did you say that 2N and 2W were acute inpatient units?

A I think they are referred to as PSCU, psychiatric specialty care units, but, yes, those were -- functioned as inpatient psychiatric units, 2 north, 2

west.

Q Okay. Do you know what -- Is there a formal set of guidelines for what a PSCU is?

A I don't know the answer to that.

Q Same question, is there a federal regulation or some other sort of set of guidelines for what constitutes an inpatient psychiatric unit?

A I imagine there are, but I don't have -- access to those guidelines to answer that.

Q Okay. But is the -- Does the Hines VA have an inpatient psychiatric unit?

A Yes.

Q Do you ever work in the Hines VA's inpatient psychiatric unit?

A Only when I'm on call, which is about two times a year for a weekend each.

Q Why is it so rare?

A We have 45 psychiatrists.

Q Okay. And are there any ways that the inpatient psychiatric unit at Hines differs from the units 2N and 2W at the jail?

A I think operationally -- I mean, there's not a corrections presence at the Hines -- unless there's an emergency and they call the Hines police, and they come

if there's a conflict or somebody's --

Q Let's take a break.

THE VIDEOGRAPHER: Going off the record at 9:52 a.m.

(Off the record)

THE VIDEOGRAPHER: Going on the record. The time is 9:53 a.m.

MR. FLAXMAN: Q Dr. Lassen, you just told me the one difference between the Hines inpatient unit and units 2N and 2W at the jail is the correctional presence at the jail, right?

A Correct.

Q Are there any other differences?

A There probably are.

Q Okay.

A But I don't work on either inpatient unit regularly at this time. I would say we do -- a similarity is both at Hines and at Cook County you see the new patients and you see the close obs patients you don't round on every one.

Q Meaning that the psychiatrist assigned doesn't observe every single patient in the unit?

A Correct.

Q And do you know if the psychiatrist is present at the Hines inpatient unit 24/7?

A So we have a resident psychiatrist available and on call every -- every night, 24 hours, there's always coverage. So they cover, but the Loyola Hospital and an ER and Hines, so basically sometimes they will go over to Loyola if they get called to that ER, but they are covering those, and there is always an attending psychiatrist available by phone for any issues and questions with their staffing.

Q And when you were working weekends at the 2N and 2W, was there coverage of a psychiatrist in those places?

A There's always a psychiatrist available on call. I was not in that rotation as a part-time psychiatrist.

Q So when you were -- When you would be present doing your role on 2N and 2W would there also be a psychiatrist on call?

A Yes.

Q And would the medical staff who needed to speak to a psychiatrist contact the psychiatrist on call, or would they contact you?

A I think it could go either way. If I'm sitting on that unit and accessible, they might ask me, hey, you know, this patient is having some symptom, can you help

us out or put in this order, but if I was over on the other unit and not right easily available, they would call the oncall psychiatrist.

Q What is a doctorate of osteopathic medicine?

A I'm a D.O. rather than an M.D., so we -- slightly -- philosophical difference. I would say difference approach, slightly more holistic. We have all the same prerequisites as an allopathic medical program. Different set of tests, but you can take both and residencies can be -- like D.O.s can go to M.D. residencies, you know, they're accepted either way. We just -- in our training, we have additional training in osteopathic maneuvers. Kind of like chiropractic, we learn acupuncture, just a bit more holistic as far as the approach.

Q Is the -- on your CV, it's listed you're licensed physician and surgeon. That's available to either M.D. or D.O.?

A Correct.

Q Are you also -- Do you have any licensing as a psychiatrist?

A Board certification?

Q Yes.

A Yes, I'm board certified.

Q As a psychiatrist?
A Yes.
Q Okay. Is that -- that's where it says American Board of Psychiatry and Neurology on your licenses under board certification?
A That's correct.
Q It also says something here DEA available on request.
A That's my drug enforcement -- We all have to have a DEA number to prescribe certain controlled substances.
Q I see. And referring to your CV, you did a psychiatry residency at the University of Illinois at Chicago from 2007 to 2011?
A Yes.
Q And are the -- your employment at the Cook County Jail and at Hines the only employment you've had as a psychiatrist?
A There -- I did moonlight at North Shore Evanston Hospital during residency, so it was a long time ago. That's it.
Q Is the Evanston Hospital in association with University of Illinois?
A Not that I know of.

Q But there is a North Shore system where there's multiple hospitals?
A Yes.
Q UIC is not one of them?
A Correct. As far as I know.
Q It's probably not. It's the university. But I won't hold you to that.
When you were working as a psychiatrist at the jail, how were your shifts determined?
A I would sign up for shifts either in the intake center evenings or 5:00 o'clock to 10:00 was roughly the shift length, and I would sign up for every other weekend. It was just a standing pattern at that time.
Q Was there a sign-up sheet, physically --
A We would create -- we would print off a PDF of a calendar and write our names in, because on alternate names were other psychiatrists, so we just filled that out and give that Dr. Kelner. And if one -- if we were not available, he would find coverage.
Q And would you hand that to him physically?
A Yes.
Q It wouldn't have been done over e-mail or anything?
A Correct.

Q Would it be posted somewhere to show who was working?

A Taped to the door.

Q To whose door?

A Dr. Kelner's name.

Q Is there a name for that document?

A I don't think so.

Q But it looked like a calendar?

A Correct.

Q When you were doing intakes, was that in a different location of the jail than 2N and 2W?

A Yes.

Q Where were intakes done?

MR. RAGEN: Timeframe?

MR. FLAXMAN: Q How about when you did intakes.

A It was in more than one location. There was one building that I think was demolished that we were in for a while, and then we moved to a new building. I feel like it's Division 8, but I can't recall specifically. It was a different area then. Different building.

Q Okay. So when you stopped working at the jail in 2016, you were doing intakes in what you think was Division 8?

A I'll go with the newest, tallest building.

Q And that was a separate building from Cermak?
A Yes.
Q It connected with a tunnel or something?
A Probably.
Q Okay.
A I stayed above ground.
Q Okay. All right. You're aware that I'm going to be asking you some questions about a man who died in the jail named Angel Cruz, right?
A Yes.
Q Do you remember -- do you remember Mr. Cruz?
A Yes.
Q What do you remember about Mr. Cruz?
A I remember -- I did review my notes, which --
Q Okay.
A -- which assisted my memory. I remember a -- a brief encounter with a heavyset, young Hispanic gentleman.
Q And did you speak -- you spoke to him?
A Yes.
Q Okay. Was that in a cell in 2N?
A Yes.
Q Okay. When you said you reviewed your notes, do you mean the notes of the medical record?

A The medical record that's provided.

Q Did you review anything else before today's deposition?

A No, this was concentration on my own note.

Q It is a document at the top that's already marked Plaintiff's Exhibit 2.

(Exhibit 2 marked as requested)

Q This starts at County 35 and goes to County 37.

Is this a copy of the note you made about Mr. Cruz?

A Yes.

Q And what we're looking at on paper is not what it looked like to you when you were entering it into the computer, right?

A As far as --

Q I'll ask a better question.

This is a paper record of your note, correct?

A Correct.

Q And this is a note that you entered electronically, right?

A Yes.

Q And there's a lot of information on here. We'll go through it. But before we look at it, I just wanted to make sure I understand that some of it is

information you entered, some of it is information that was already in the system, right?

A Yes.

Q Okay. Before we do, let me just show you what is marked as Plaintiff's Exhibit 3.

(Exhibit 3 marked as requested)

Q Do you recognize this as the cell where Mr. Cruz was?

A I can't recall which cell. That is a Cook County -- yeah.

Q Okay. All right. Let's go back to Exhibit No. 2, which is the note. And you said you looked through -- it looks like in front of you you have a packet of all of Mr. Cruz's medical records, right?

A I don't know that it's all. It's all that I was provided. I think it -- I mean, it looks pretty comprehensive, but --

MR. FLAXMAN: She had the whole thing?

MR. RAGEN: I mean your --

MR. FLAXMAN: I don't want to demand to see it.

MR. RAGEN: That's fine. It's like page 1 through 226, yeah. That's it -- It's double-sided paper, so --

MR. FLAXMAN: Okay.

THE WITNESS: Feel free --

MR. FLAXMAN: Q I haven't -- I just want to make sure that I understand and we have on the record, you were able to review the records of Mr. Cruz that have been labeled in this litigation as County 1 through County 226?

A Yes.

Q And you reviewed your note which is in front of you marked as Exhibit No. 2, right?

A Yes.

Q Was there anything else in the records that you created?

A No.

Q Okay. Did you see your name anywhere else in the records?

A I believe one nursing note says patient seen by Dr. Lassen.

Q Okay. Is that a note about -- that was a nurse's note about the note that we're looking at Exhibit No. 2, right?

A Yes.

Q Let me finally get to asking you about Exhibit No. 2.

At the top it lists service date/time as 3-19-2016 at 1413. Is that the time that you saw

Mr. Cruz?

A That is the time that I probably started the note. Given that he was seen in his room -- I don't have a traveling computer, notebook. So I go in and see the patient, have the encounter, go find a computer and -- in an office that's on the Internet and then write my note. So I think to me that means that's probably when I started the note.

Q Okay. And underneath that there's a perform information and sign information. Is the time for sign information when you've finished making the note?

A Yes.

Q And you said you didn't have a portable computer, right?

A Correct.

Q Were there multiple places where you could sit at a computer and make a note of your encounter?

A While I worked there, there were three rooms that had -- they were patient interview rooms. So they had seating for the interviewer, the computer, and then the detainee.

Q And in this time in March of 2016, was it your practice to use a computer in one of those patient interview rooms to enter your notes of the encounter?

A I would -- that was the computer available to me to enter my notes, yes.

Q And is -- I've seen some pictures of 2N. There's something which I think is called a nurse's station?

A Yes.

Q Are those interview rooms behind the nurse's station?

A Yes. You go around and just beyond -- from the nurse's station, you could look into the interview rooms.

Q Are those interview rooms between 2W and 2N?

A No.

Q No. They're separate interview rooms on each unit?

A Yes.

Q So are there three on 2N that you could do this?

A At the time I was -- there were three, usually with the computer.

Q How many were there in 2W?

A Either three or four, also not functioning computers were an issue.

Q All right. And I believe what you told me is that you would have gone into the cell -- Am I right that

you went into the cell to have the encounter with Mr. Cruz and then went to the computer to type your notes?

A Yes.

Q And did you take any notes by hand when you were speaking to Mr. Cruz?

A I cannot recall.

Q You might have?

A I might have, but that didn't happen that often.

Q Okay. If you had taken notes by hand, would you have kept them anywhere?

A No.

Q And am I right that to go into Mr. Cruz's cell a correctional officer would have had to unlock the door for you?

A Yes.

Q Okay. Well, let me ask you about what is in this note. The first thing I wanted to ask you about is there's a line -- well, the first thing under sign-in information says close obs. Do you see that?

A Under sign -- oh, yes, close obs.

Q Does that mean close observation?

A Yes.

Q Do you know why Mr. Cruz was on close observation?

A He was having -- he was -- per the chart and the other notes by other providers, he was attempting to hurt himself, jumping off beds, I think trying to hit his head. So there was a threat to his own safety and probably the safety of others, physical safety of others.

Q Would you have -- Did you write that note that says close obs?

A I can't -- I can't say definitively. Probably, but I cannot say definitively.

Q Okay. And then going down there's one -- a line that says associated diagnoses. Do you see that?

A Oh, yes.

Q It says none?

A Yes. That's prepopulated. I don't know what that means.

Q That's not something you typed in?

A No.

Q Okay. And then underneath that box there's a basic information. Do you see that?

A Yes.

Q Then underneath that it says general communication. Do you see that?

A Yes.
Q And one thing on here is history limitation. It says clinical condition.
A Yes.
Q What was that?
A That means that the mental health -- that mental illnesses might be interfering with the ability for the person to provide a history.
Q Okay. Then the next line is documentation reviewed, and it says progress Cermak records.
A Yes.
Q Does that mean that you reviewed progress records of Mr. Cruz?
A Yes.
Q Would you have done that on a computer?
A I didn't.
Q Do you know which records you reviewed?
A I typically would review intake notes from medical and mental health and nursing, I would check.
Q Would you review any notes of medication given?
A Yes, the MAR.
Q That's -- MAR is medication administration record?
A Yes, that's right.

Q Okay. Would you have done that before or after you spoke to Mr. Cruz?

A It could be either. Preferably before, but I can't recall specifically on this.

Q The next section is subjective, and there's kind of a problem list. Do you know if those things listed are -- all problems were prepopulated?

A They were.

Q Okay. And then the next section is titled history of present illness, and it says general complaint. And then it says the patient presents with, and underneath that is what I believe is your note, is that right?

A Yes.

Q So starting with PT was seen today, this text is the note that you made about Mr. Cruz?

A Yes.

Q And am I right that that note meaning the text that you entered ends with on this page with housed 2N, period?

A On this page it ends with that. I did -- I see my typo impression and plan where I --

Q Which was your typo?

A Continue current medications, found currently

1R. That looks like me.

Q Okay. But you did intend to continue current medications?

A Yes.

Q And the -- Okay. So the vital signs that's listed on that second page wasn't entered by you?

A Correct.

Q Did you review Mr. Cruz's vital signs?

A Yes.

Q Why did you review them?

A It gives you a good sense of how the patient is functioning mental health-wise.

Q And based on reviewing them did you believe he was -- there was any issue with how he was functioning at that time?

A No. He looked like his vitals were within normal ranges for the most part, with the exception of slightly low diastolic blood pressure, but that had been hours before, and that wasn't an active issue.

Q Okay. And you didn't consider 97 beats per minute to be abnormal for a heart rate?

A That is in the -- the range is 80 to 100, heavier set gentlemen, and, you know, based on what I was reviewing, some of his behavior had been somewhat

agitated, so I think that it wouldn't be uncommon for the heart rate to fluctuate in the range.

Q Let me go back to patient presents with, which is on that first page. The first thing you wrote is PT, and that means patient?

A Yes.

Q So patient was seen today, meaning you spoke to Mr. Cruz, right?

A Yes.

Q And medical records reviewed I think we've already talked about, right?

A Yes.

Q And case discussed with staff. Do you remember who you discussed the case with?

A Not in particular. In general I would solicit input from whichever nurse was working that day and the officers that have been on that shift just to get the sense of how things have been going.

Q Okay. But you don't remember who those nurse or officers were?

A Not at that moment.

Q Okay. The next line says PT seen in his room, lying on bed facing the window. Do you see that?

A Yes.

Q And I know that in Exhibit No. 3 you weren't sure if that was Mr. Cruz's cell, so I'm not going to ask you was that his bed, but does the bed depicted in Exhibit No. 3 appear like the bed that you saw Mr. Cruz lying in?

A It looks like an inpatient psychiatric bed, a restraint bed in particular.

Q Okay. And how can you tell it's a restraint bed?

A It has areas where restraints can be tethered.

Q That's -- You're talking about what I guess looks like 1, 2, 3, 4, 5 horizontal openings in the bedframe?

A That's what it appears to me, yeah.

Q Okay. Do all of the rooms in 2N have restraint beds?

A I don't think I can answer that. I don't believe so, but it's -- I don't know.

Q During your time at the -- When you were working weekends at the Cook County Jail, did you ever order a detainee into restraints?

A Yes.

Q Why would you order a detainee into restraints?

A If a patient is, you know -- has moved beyond

verbal aggression into self-injury, if they're trying to insert things into their body or cut themselves, hit their heads, or if they have injured somebody else, they can't -- in verbal de-escalation, any other nonrestraint interventions have failed, as a very last resort for the patient's safety and the staff safety, we would use restraints.

Q And when you use restraints, was it always in a bed?

A Yes.

Q It's not shown in this picture, but you talked about restraints being tethered. That means it's some kind of a thing would be put in these holes that would then be strapped onto the detainee, right?

A We would order locked leather restraints, so they were like a strap, but the physicians aren't involved in the -- putting the patient in the restraints or taking them out.

Q Okay. Who is involved in that?

A Nursing and correctional officers, I believe.

Q And is it your understanding that when using restraints at the jail a physician should be monitoring somebody who is in restraints?

MR. RAGEN: Objection, vague.

You can answer.

THE WITNESS: A physician is contacted to put in the order and expected to evaluate the patient within a certain amount of time and -- but as far as monitoring, I think a lot of the, like, vital monitoring is done by nonpsychiatrists.

MR. FLAXMAN: Q Do you know what the certain amount of time is that the physician is expected to evaluate the patient?

A I believe it's within 2 hours, and then every 4 hours to renew -- if it needs to be renewed. It would be 4 hours maximum that a person -- an order could be for restraints.

Q And did you know that Mr. Cruz had been placed in restraints?

A Yes. He was no longer in restraints when I came into the unit.

Q So you didn't order him placed in restraints?

A I did not.

Q Okay. And you didn't -- did you ever order the restraints on Mr. Cruz to be renewed?

A No.

Q And how did you learn that -- did you learn he had been in restraints by reviewing the medical records?

A I did, plus talking with the staff, and I do think -- sometimes nursing staff would put an order under the psychiatrist's name. So now that I'm thinking of it, there is -- there may have been an order that might have my name on it though I think that was not put in by me. I don't think I was on the premises at that time, but that nurse -- nurses are allowed to put in an order if they need to under a psychiatrist's name.

Q Handing you what I marked as Plaintiff's Exhibit No. 4.

(Exhibit 4 marked as requested)

Q This is a three-page document that goes from County 118 to 120.

Do you recognize this as a list of orders from Mr. Cruz's chart?

A Yes.

Q And if you turn to the last page, there's two orders for psychiatric restraints. Do you see those?

A Yes.

Q The second one lists you as the ordering physician?

A That's what I was referencing, but I think the order was put in under my name.

Q And it was put in by a nurse named Manuel

Manalastas, is that right?

A Yes, who is trained in restraints.

Q Okay. How do you know that Nurse Manalastas is trained in restraints?

A Actually, that's a good question. I don't know that for sure. He works on an inpatient psychiatric unit and that's a modality available.

Q I'm sorry. The word you said was modality?

A Yeah. That's one of the interventions that inpatient psychiatric units have.

Q Okay. And I just wasn't familiar with the words. M-O-D-A-L-I-T-Y?

A Yes.

Q Okay. And did Nurse Manalastas speak to you before entering this order?

A I don't think so.

Q Do you know why Nurse Manalastas entered this order with you as the ordering physician?

A He probably knew that I was -- I can't -- I mean, I can't guess, but they have the -- they know who's coming every weekend so he knew he would see me that day I imagine, but I can't predict --

Q Okay. And so you were not present at 8:08 when this order is -- states that it's starts, right?

A I do not think so, no.
Q And I think you told me that you were never the oncall psychiatrist, right?
A Correct.
Q So do you know why Nurse Manalastas didn't contact the oncall psychiatrist?
A I don't know.
Q Okay. Did Nurse Manalastas talk to you about this order once you arrived at the jail on March 19th?
A I can't recall, but I mean he -- he was good with communication so I have no reason to think he did not.
Q Okay. And it's your understanding of the policy at the jail that it was appropriate for Nurse Manalastas to enter this order with you listed as the ordering physician?
A That's my understanding. And I do see it says pending complete so I don't know what that means. Under status -- order status.
Q I see. But you don't -- you're speculating about what that means, right?
A I'm just putting it out that it seems different than the one above, but I can't recall.
Q But as -- I mean in terms of your knowledge

about the system of entering orders, do you know what the phrase pending complete means?

A I do not know what that indicates as I look at it here today.

Q Let me go back to Exhibit No. 2. And we were looking at your narrative at the bottom of the first page. In the second sentence in that second paragraph you wrote PT denies any SI or HI.

A Yes.

Q Can you tell me -- What is SI?

A Suicidal ideation.

Q That is HI?

A Homicidal ideation.

Q And how did you determine that the patient denied those things?

A I asked him.

Q What question did you ask?

A Have you had any thoughts about hurting yourself? Are you having those thoughts now? Are you thinking about hurting anybody else at this time?

Q The next thing you wrote is was he able to sleep last night. Do you see that?

A Yes.

Q Is that something you learned by talking to

Mr. Cruz?

A Yes.

Q And did you know that he was in restraints while he was sleeping?

MR. RAGEN: Objection to foundation.

THE WITNESS: I can't -- I presume so, but I can't say for -- I think I would have reviewed the chart. So knowing he's coming out of restraints, that he was, but I wasn't there overnight.

MR. FLAXMAN: Q In your experience with ordering restraints and renewing restraint orders, should a detainee who is sleeping be kept in restraints?

A I think sometimes they end up sleeping. If they, you know, have had -- for instance, with what I read here, somebody -- more generally if someone is doing, you know -- very activated, aggressive, they go down -- sometimes medications are given around the time of physical restraint, there can also be chemical restraint using certain medications and those can make people pretty sleepy. So I think it happens that people that required physical restraint might end up sleeping, but we try to evaluate them frequently enough to get to the least restrictive setting as soon as possible.

Q When you evaluates somebody to determine

whether to continue a restraint order, what are you looking for?

A I would ask -- I mean, he was not in restraints when I interviewed Angel, so are you saying in general? You're asking in general what I would look for?

Q Yes.

A Okay. So if someone was still restrained, I need to find out where they're at as far as -- are they still thinking of hurting themselves, are they threatening to do so, are they threatening to, you know, start punching the walls or kill somebody else. So I'm asking about that try to get -- engage a conversation, how could you handle things differently if you start getting -- urge to hurt yourself again, you know.

If they can have that conversation with me, then I'll ask, like, if we take you out of restraints, do you think that you could stay safe for -- and so it's a conversation, plus clinical observation.

Q In your experience at the Cook County Jail, did you ever assess a patient in restraints to determine whether to continue a restraint order when the patient was sleeping?

A I would wake them up if they happened to be sleeping.

Q Okay.

A And then we could have a conversation unless they say something like no, I'm going to kill myself, like if you let me up I'm going to do X -- okay, then they've kind of put me in a position where I'm a little stuck with okay, you're not ready yet. But if they're calm enough to be sleeping and able to contract for safety, we can come up with another plan, then that would be a good opportunity to let them up.

Q And contract for safety is a phrase that I've heard, but I'm not sure I understand what it means. What do you mean when you say contract for safety?

A I mean, I think it is kind of -- we probably overuse it, but it's -- the patient and the provider can come up with a verbal agreement of either a plan, like a -- can you -- can you contract with me that you're not going to hurt yourself or what you're going -- those thoughts return, you're going to let me know. So it's like a negotiation in a way, and it requires some trust between provider and patient.

Q And did I understand you right that if a patient was sleeping, you would also -- you would not just take their sleeping as meaning they were calm, you would also want to have a conversation with the patient?

MR. RAGEN: Object to speculation, incomplete hypothetical.

You can answer.

THE WITNESS: Okay. I mean, I would prefer to have a conversation with them. I think there may be exceptions to that, but -- from what I recall, otherwise, I would want to talk with them before making any changes to that status.

MR. FLAXMAN: Q The next thing after -- I'm going back to Exhibit No. 2. We just talked to you about Mr. Cruz is able to sleep and also appetite is decreased, which PT attributes to being in here, and that he has a lot on his mind.

Was that also based on your conversation with Mr. Cruz?

A Yes.

Q And then you wrote denies AVH. What does AVH?

A Yes. He denied auditory and visual hallucinations.

Q Meaning you asked him if he was having hallucinations, and he said no?

A Correct.

Q The next line says compliant with medications. And how did you determine that he was compliant with

medications?

A Review of the MAR.

Q Were you ever responsible for giving medication to detainees?

A Actually handing it to them?

Q Yes.

A No.

Q Who was responsible for that?

A Nursing.

Q Okay. Were you ever responsible for prescribing medication to detainees?

A Yes.

Q And then next thing you wrote was no SE reported. What is SE?

A Side effects.

Q Meaning no side effects of the medication?

A Correct.

Q Again, that's from a question you asked Mr. Cruz, right?

A Yes.

Q Okay. The next thing that's written here is CPM. What does that mean?

A Continue present management.

Q And the next line says CONT. Does that mean

continue?

A Continue.

Q Close observation Q 15 minute checks for UPV.

A Unpredictable behavior.

Q What does the Q mean?

A Every -- it's Latin.

MR. FLAXMAN: Here's our court reporter. Let's take a break.

THE VIDEOGRAPHER: Going off the record, 10:32 a.m.

(Off the record)

(Whereupon, the court reporter arrives.)

THE VIDEOGRAPHER: Going on the record. This marks the beginning of media number 2, the time is 10:41 a.m.

(Whereupon, the remaining proceedings were taken down by court reporter Carol Connolly, CSR, CRR.)

(Witness resworn)

MR. FLAXMAN: Q The last thing I was asking you about is on Exhibit 2 at the bottom, and you wrote: A close observation Q 15 min checks. I think you told me what Q means, but please tell me again.

A It's -- Without a Latin dictionary, I can't recall. It's a Q meaning -- We use it prescribing like Q daily, or -- so that means every 15 minutes.

Q Okay. And who was responsible for doing the 15-minute checks?

MR. RAGEN: Objection, speculation.

THE WITNESS: The checks are done by nursing and corrections. I'm not sure about the frequency with mental health specialists, if they participate in that or not.

MR. FLAXMAN: Q Okay. Do you know if whoever is doing those 15-minute checks makes a record of their checks?

A I believe they do.

Q Is that something you've ever reviewed?

A If it was put into Cerner, into the computer electronic medical record system, probably so. If it's paper, I don't -- you know, I don't know.

Q Okay. The next line says CONT meaning continue, right?

A Yes.

Q Then it says safety smock and blanket.

A Yes.

Q What's a safety smock?

A It is a -- almost like a -- I mean, it's like a smock, a two-sided smock. If somebody is wearing a regular uniform, this can be shredded and people can tie

around their neck and really injure themselves, there's a safety smock that's impossible to tear into strips and a blanket that's not able to be tethered to anything.

Q And so when you assessed Mr. Cruz, he already had a safety smock and blanket?

A Yes.

Q And you meant it's a safety smock and the safety blanket?

A Correct.

Q The next line you wrote house 2N?

A That's his housing, continue that.

Q Did you have the authority to change a detainee's housing?

A Yes.

Q And when would you do that?

A If somebody was doing better and stable from a psychiatric standpoint, not a risk to themselves or others, stable with medication, I could discharge them off of an acute unit, also alternatively on the intake, that's when I would determine where they were housed.

Q And if they were discharged from the acute unit, somebody else within the jail system would then be responsible for giving them a housing assignment, right?

A Could you repeat that?

Q It's not that important.

You wouldn't pick where they would go next, right?

A Not specifically.

Q It was somebody else's job is what I mean.

A I would determine level of acuity with regard to psychiatric need.

Q Okay. That's -- Let me ask this a better way. What's a level of acuity?

A The acute unit is the highest level of acuity. It's an inpatient setting, and I believe at the time it was P4. So that's considered P4, and then -- I may be off on the numbers, so I'm going to stop with that. But then there's an intermediate level, and then an outpatient psychiatric level, and then no psychiatric needs could also be identified for a patient.

Q I understand you're not -- You said you don't know about all the -- P4, the other letters. What is P4?

A I don't know what they were using that as an abbreviation for. It's just a system to say if somebody needs to go to the acute unit, they are the highest level of psychiatric need.

Q And whose designation is that?

A Usually the psychiatrist.

Q Well, is that a designation that is within the Cook County Jail or is it something that's used widely within psychiatric services?

A Just local to this system as far as their numbering and how they are --

Q Okay. And the four different levels of acuity, were those also levels that you used when you were doing intakes?

A Yes.

Q You would have responsibility for assigning the level of acuity to a new detainee?

A With regard to psychiatry, yes.

Q With regard to psychiatry. Okay. And if there was a detainee who needed -- Is there a level of acuity that would need something higher than inpatient psychiatric care?

A No, that's the highest.

Q Was there ever -- if a detainee needed psychiatric care that wasn't available within the inpatient units at Cermak, could you send them to another facility?

A Can you tell me what you are thinking of?

Q Well, it's -- Were there psychiatric services that were not available in 2N or 2W?

A Yes. For instance, ECT, electric convulsive therapy, not available as far as I know, things could have changed, but I was working as a moonlighting psychiatrist, so I was not making those determinations.

Q If a detainee on 2N or 2W required some kind of care that wasn't available there, did you have the power to send that detainee to another facility?

MR. RAGEN: Objection, vague.

THE WITNESS: Are you talking about for psychiatric issues or --

MR. FLAXMAN: Q Well, sure.

A Personally as a moonlighting psychiatrist, I don't think I could have done that.

Q Okay.

A I think -- my example -- that might be what you're asking -- if somebody did cut themselves open and, you know -- but that's making sure they get the medical care they need. So there weren't a lot of -- I mean, we can handle most things in Cermak, and it can run like a fairly typical inpatient psychiatric, but a lot of inpatient psychiatric unites do not offer ECT, for example, so -- so I don't know what arrangements they make if they ever --

Q But that wouldn't be something -- ECT or

something like that wouldn't be something you were dealing with as a weekend person?

A Correct.

Q Let me go back to Exhibit No. 2. We got to the end of your note on the first page, and then the second page lists histories first. Would that section be prepopulated?

A Yes.

Q And then the next thing that was entered by you is all the way at the bottom of the third page under impression and plan, is that right?

A Yes.

Q You wrote disposition, patient psych, which we've already discussed, right?

A Yes.

Q Why did you -- why did you choose the disposition of inpatient psych?

A He had very recently been acting in an impulsive and dangerous in a disorganized way. It looked like while he was improving in the sense that he was no longer requiring restraints, I could interview him, he could communicate with me, so it did look like things were improving for him from a psychiatric standpoint, but, you know, given how recently he had been in such

distress and actually attempting to hurt himself, then he needed inpatient psychiatric care in my opinion.

Q Okay. The next line is medication recommendation, and you wrote continue current medications, correct?

A Yes.

Q Does your note list what those medications are?

A No, it did not prepopulate that.

Q But I believe you told me before that you would have looked at the medication administration -- administration record to see his medications, right?

A Yes.

Q Do you remember what his medications were?

A I could find it in here. I wouldn't want to misquote it.

Q Sure. Why don't you look at that and I may be able to direct you to it.

MR. RAGEN: Do you mind if I help her?

MR. FLAXMAN: No, not at all.

MR. RAGEN: I didn't pick a date. I took you to the MAR.

THE WITNESS: Okay. Do you want me to read it to you?

MR. FLAXMAN: Q Why don't you tell me what page

you're looking at.
A I'm looking at 112.
Q That's a portion of the medication administration record?
A Correct. I chose March 19th.
Q Okay. And based on looking at that, are you able to say which medication you ordered to be continued?
A I did not order medications. I just did not alter them, the orders were already in the system.
Q So what orders did you -- but you chose not to alter them, right?
A I chose not to alter them.
Q What medications are we talking about?
A The Risperidone, 2 milligrams.
Q What is Risperidone?
A That is a second generation antipsychotic.
Q 112 also lists diazepam.
MR. RAGEN: Are you pointing to --
MR. FLAXMAN: Q That's listed medication -- First one listed on page 112. D-I-A-Z-E-P-A-M.
A I don't know if that was a scheduled medication or a -- you know, as needed if he -- I don't know that. That is Valium, so antianxiety agitation medication.
Q The next section of this chart has orders and

there's orders medication. So if you look at page 122, does that -- at the bottom it list diazepam. Does that explain how it was prescribed?

A Order start time. Okay. It looks -- I would interpret this to be a scheduled medication then. So it was written for Valium 5 milligrams daily.

Q Why do you think it was daily?

A Because it says UD.

Q Okay. Risperidone also says UD on the next page?

A UD, yes.

Q Meaning daily?

A Daily.

Q One of the things I think you told me earlier was that your -- your duties when you were working weekends would be to make rounds on patients, is that right?

A Oh. The close obs we were not to make rounds every patient. We were to see the close observations and any new admissions.

Q Okay. And would some of the close obs patients -- close obs -- Let me start again.

A patient on close observations might be in restraints, right?

A Yes.
Q But a patient on close observations could also not be in restraints, right?
A Correct.
Q How did you choose which patients to -- what order to assess patients in?
A I would show up and start seeing patients. So -- new admissions took longer, close obs -- I would try to work with the staff to see if there was somebody that they would, you know -- this person might be -- needed their medication sooner, I would try to prioritize that, but really it's a list of patients, and you get in there and start seeing them.
Q How would you get that list?
A It was printed -- I don't know. It was physically there when I arrived. I think it's -- the patient list with name, DOC number, and room assignment.
Q Would that say who was on close observation?
A Depends on the mental health specialist or if they had the time to mark that, but if not, I would talk with staff and review records.
Q Okay. Was there a requirement for you to assess a patient in restraints within a certain amount of time from when a restraint order was entered or

continued?

MR. RAGEN: Can you have the question read back.

(Whereupon, the following was read back:

"Q Was there a requirement for you to assess a patient in restraints within a certain amount of time from when a restraint order was entered or continued?")

THE WITNESS: Yes.

MR. FLAXMAN: Q And what was the amount of time?

A I feel like -- I wish I had the JCAHO guidelines here. I think it's one hour. I would treat it like one hour if I'm on the premises.

Q What is JCAHO?

A Joint Commission accrediting body.

Q When you're saying that, you're saying J --

A JCAHO. Joint -- no. Joint --

Q I was going to say J dash C-O, but if you think it's a different way.

A I don't want to miss --

Q What is the Joint Commission?

A They come and evaluate hospitals to make sure that policies and procedures are being enacted.

Q And they publish a set of guidelines?

MR. RAGEN: Objection, speculation.

THE WITNESS: I can't speak to JCAHO's operations.

MR. FLAXMAN: Q Have you ever reviewed JCAHO guidelines?

A By guidelines, do you mean for the agency?

Q Well, you referred to something called JCAHO guidelines.

A I feel like that that is -- that -- I don't know that they produce standards. I think they hold hospitals to their standards. So I feel like -- again, I have not worked in an inpatient unit in 3 years, so I think that we see them within an hour.

Q Okay. Well, when you were employed at the Cook County Jail, were you aware of policies of Cermak?

A I am aware of policies.

Q Okay. Did you ever get training on Cermak policies?

A We would get annual training. I'd have to see it to recite it.

Q See what?

A Like the policies, you know, or detailed information.

Q Well -- I'm just asking generally. During your work at Cermak, would you rely on written policies of Cermak?

A What do you mean rely?

Q Well, did you ever review written policies of Cermak while you worked at Cermak?

A I think -- with part of the annual training was to, you know, review those, and these were mandatory trainings.

Q And who would lead the annual trainings?

A It was a variety of people in the online module.

Q So the training was done online?

A It was a combination from what I recall.

Q Were the online portions videos?

A I'm not sure if they were video clips or PowerPoints or -- I can't remember the content.

Q Okay. Do you remember receiving training about the use of restraints?

A Yes.

Q What do you remember about that training?

A That involved -- I think we would talk about when it's appropriate to use, what things we could do instead of restraints, interventions that, you know, could, you know -- moving a person to a quiet room, lower stimulus, anything to avoid the restraints, and then also for the staff that would put people in restraints, how to

do that, and I'm sure the timing part was in that, too.

Q Do you recall if the trainings you received about restraints were in-person trainings?

A Yes.

Q Yes, they were?

A I remember parts of that because they were showing the restraint usage so I remember parts -- portions of it are, but, again, it was 3 years ago.

Q Right. Do you recall who was leading the training?

A I don't.

Q Did you know that there was a written policy about the use of restraints at Cermak?

A I mean, all the hospitals I think that have inpatient units have these policies in place.

Q Did you ever review the written policy about restraints at Cermak?

A I have. I'm sure, but -- I mean --

Q I understand you can't tell me every word that's in it.

A Right.

Q Did you review it as part of your training?

A I think that would be part of my training, yes.

Q Do you recall the length of time that a

restraint order was supposed to be for?

MR. RAGEN: Objection, vague.

THE WITNESS: Like one order?

MR. FLAXMAN: Q I want to -- yes. My question is about when you would determine that it was necessary to order a detainee into restraints. Do you understand that I'm asking about that?

A Yes.

Q And was there a standard for how long that order would last?

A The order was for 4 -- up to 4 hours.

Q And would you always order it to last for 4 hours?

A I did, yes.

Q And after 4 hours, you or another professional would determine whether to continue the order, is that right?

A Yes.

Q Could you or could another medical professional end the restraint order before the 4 hours ran out?

A Yes.

Q And why would you do that?

A I think if someone's situation had changed and they were no longer a threat to themselves and other

people, somehow that was -- you know, they had calmed down, it was a possibility.

Q Do you remember ever doing that?

A I mean -- I really -- I can't recall. Probably, but --

Q And how would you learn if the detainee in restraints situation had changed?

A In talking with staff typically or if I -- they were on close obs and interviewing them.

Q And when you say talking with staff, I think we've talked about nurses and mental health workers. Those are two different types of professionals, right?

A Yes.

Q Which one -- would you hear from either one of them about whether a detainee needed to be in restraints?

A I would get input from everyone. It's a team.

Q Okay. Do you know if it was nurse or a mental health worker who's responsible for the 15-minute checks?

MR. RAGEN: I'm sorry. Can you repeat the question?

(Whereupon, the following was read back:

"Q Do you know if it was nurse or a mental health worker who's responsible for the 15-minute checks?")

THE WITNESS: Without looking at the policy, nursing

is involved in that.

MR. FLAXMAN: Q Okay. Would you also get information from correctional officers?

A Yes.

Q I wanted to go back to Exhibit No. 4, which was the orders. On the last page of that exhibit we talked before about the order that Nurse Manalastas made to continue Mr. Cruz in restraints. Do you remember that?

A Yes.

Q And you don't as we sit here today remember whether you talked to Nurse Manalastas at any time about this order, right?

A I cannot recall specifically, no.

Q When you were on site and performed an assessment and determined that a restraint order should be continued, would you enter that order into the computer?

A Yes.

Q And so would the order say that you were the one who entered it?

A If I was continuing a restraint order, it requires a new order, yes, so it would say I would enter that.

Q Okay. Did you -- Before you spoke to Mr. Cruz,

did you know that he had been in restraints earlier?

A I can't remember exactly, but in my typical review process, I would know that, yes.

Q And did you know why he was taken out of restraints?

A Typically people are taken out of restraints when they've demonstrated they can be calm, they're no threatening to hurt themselves or others, so I -- he was out of restraints when I was on the unit so I'm not sure at what time that happened.

Q How would you -- I mean, if you wanted to know that, how would you have found out?

A If I wanted to know -- Could you ask that again?

Q If you wanted to know why Mr. Cruz was taken out of restraints, how would you have found out that information?

A When I talk with staff, they would inform me.

Q Okay.

A So-and-so calmed down, they're doing okay, we're --

Q Do you know what range of motion exercises are?

A Broadly, yes.

Q And did you -- should a patient in restraints

be given range of motion exercises?

A Yes.

Q How often should a patient in restraints be given range of motion exercises?

A I would -- that's not under the psychiatry role so I'm not sure. There are probably exceptions when a patient is particularly violent or, you know, they're -- you can't always do them, that's my understanding. But I don't know the specifics.

Q What's your understanding of why range of motion exercises should be done?

A It's my understanding that with the restraints you want to make sure their circulation of the extremities.

Q Why do you want to make sure there's circulation of the extremities?

A You just don't want to cut off blood supply to any of the extremities with the restraints.

Q I just didn't hear the words -- You don't want to cut off blood supply --

A Blood supply to the extremities using the restraints.

Q So it was -- When you were employed in Cermak, it was not your responsibility to give range of motion

exercises, right?

A Correct.

Q Do you know whose responsibility that was?

A Offhand, I do not.

Q When you reviewed Mr. Cruz's chart, did you look to see if he had been given range of motion exercises?

A In preparation for this today or --

Q In preparation for assessing Mr. Cruz, did you review whether the chart showed that he had been given range of motion exercises?

A I can't recall. I mean, I reviewed the records available.

Q Okay. Is the risk from a lack of circulation that a patient might develop a blood clot?

A I think there are a couple health risks, but, again, that's not my area of expertise as far as the -- I'm there for the psychiatric aspects. I think any sort of restraint can block blood flow that can cause a gangrenous issue -- issues and blood return issues, and probably a lot of other things, including circulation problems.

Q When a patient comes out of restraints, are there any medical conditions that they are at a higher

risk of developing?

A I'm trying to think. I don't know, but -- I haven't seen the recent literature about that. Are you asking specific -- are you asking me to list them or --

Q The ones that you're aware of, yes.

A Okay. I mean, I think any sedentary position you've -- I'm sure there are medical repercussions -- I have to think about it. About -- Can you repeat the question?

Q Do you mind reading it back?

A I'm sorry.

(Whereupon, the following was read back:

"Q When a patient comes out of restraints, are there any medical conditions that they are at a higher risk of developing? The one's that you're aware of.)

A The ones that I'm aware of. I think edema, perhaps DVT, perhaps dislocation of, you know, joints. That's probably all I can come up at this time.

Q Okay. Are you aware that second generation antipsychotics can pose an increased risk of DVT?

A There is a warning for increased risk of stroke with second generation antipsychotics.

Q But you've never heard of increased risk of DVT

from second generation antipsychotics?

A I'm not aware of that specific risk factor.

Q In 2016, were you aware that obesity was a risk factor for DVT?

A I think that's one of many risk factors, yes.

Q Okay. You knew Mr. Cruz was obese, right?

A Yes.

Q Is there any testing that a doctor could order to determine if a patient is experiencing or going to experience a DVT?

A That's not my area of expertise. If I had -- you know, I think you can order a medical consult if there was something stressing, but he was telling me he was not in distress.

Q Did you order any medical consults or any other medical assessment of Mr. Cruz?

A No.

Q I use the word assessment. I'm just going to ask it. Did you order any other medical tests for Mr. Cruz?

A No.

Q And that was because having spoken to him you were not concerned about his health?

A I mean, I saw that he was able to communicate

with me, he was psychiatrically improving, and denied any side effects, discomforts, so I took him at his word.

MR. RAGEN: He's looking over his notes. He's going through them.

MR. FLAXMAN: Q This is a document I already marked as Plaintiff's Exhibit 6. These are some forms. They have the Bates label County 141 to 145. Do you recognize these forms?

(Exhibit 6 marked as requested)

A Yes.

Q What are they?

A These are the close obs forms.

Q Do you know who completed these forms?

A It appears to be nursing, I think.

Q Okay. Do you recognize any of the signatures though?

A I mean, I can't really decipher that.

Q And --

A I can look at the other ones.

Q Will you please look at all five pages to make sure that you don't recognize any of those signatures?

A Wow. No.

Q Okay. Why did you say that you believe these were done by nursing?

A It says circulation safety and these would be by the nurse when I would come on for shift or for -- come into work. This is how I would find out who is on close obs.

Q Would every detainee on close observation have one of these forms?

A Yes.

Q And where was it kept?

A Where I checked. So there may be more than one location, a folder by the nurse. So I would just make sure that I got everybody because I didn't want to rely on the other list.

Q So -- You would actually see a piece of paper like the one that's in front of you for this form, right?

A Yes, there were a lot.

Q Multiple pieces of paper for each detainee?

A That's my understanding, yes.

Q Does the -- at the bottom of the page there's the signatures that we can't read. Under the box that says star/title, can you read that is CNI?

A That looks like CNI.

Q Does that acronym mean anything to you within the Cook County Jail?

A So many acronyms. That, no. I don't want to

guess.

Q Are you familiar with a restraint logbook that was kept in 2N?

A No. In that -- I mean, it must exist, but -- I don't know that it must exist, but I don't look at that. I'm not sure about it.

Q Okay. So it was -- When you ordered or renewed an order for restraints, it was not your responsibility to write down information about that in a logbook kept in 2N?

A No.

Q Okay. Do you know whose responsibility it was to make those?

A I do not.

Q Did you learn at some time that Mr. Cruz died?

A Pardon me?

Q Did you learn at some time that Mr. Cruz died at Cook County Jail?

A Yes.

Q How did you learn that?

A I came to work on Sunday, and by the time I was there, I think the staff told me.

Q What did they tell you?

A That he passed away and -- but people were

pretty I think upset by it, so I didn't go looking for details. It's upsetting. It was very upsetting.

Q Did you ever learn what the cause of death was?

A I did.

Q How did you learn that?

A You know, word on the street I think when it comes out, plus there's autopsy results, but I heard that it was a PE.

Q And for the record, what is PE?

A Pulmonary embolism.

Q Did you say you reviewed the autopsy results?

A I did. I looked at them.

Q When did you look at them?

A It was part of the packet.

Q Did you review them -- So you looked at the autopsy results to prepare for today's deposition, is that right?

A I just looked through what I -- yeah, I looked through that as part of just review of documents.

MR. RAGEN: They're in the chart.

MR. FLAXMAN: Q Okay. In 2016 did you take a look at the autopsy results?

A No.

Q Did anyone from the jail ever speak to you

about Mr. Cruz's death?

A I think that -- I stopped working there shortly thereafter so I -- I didn't have much in the way of conversations about it.

Q When did you stop working at the jail?

A I think I stopped in June of 2016. It might have been July of 2016.

Q Okay.

A I can check --

Q If it's on your CV, sure.

A July, 2016.

Q Did you ever talk to Dr. Kelner about Mr. Cruz's death?

A I mean, he's my supervisor there, so -- I mean I -- afterward I think I would check in with him, but I can't remember a specific conversations, other than -- no, I can't even remember specifics, but it wouldn't be uncommon for me to go and talk with him, but nothing in depth or -- it was just -- I don't know. It's still upsetting to think about, you know.

Q Why is it upsetting?

A Because it's just unfortunate, and I think that we tried to provide the best care that we could for this gentleman and -- and this is -- like all of this is just

upsetting.

Q Do you believe there's something else that you or somebody at the jail could have done to help Mr. Cruz?

A No. I feel like we did the care that we could have given how sick he was.

Q What do you mean when you say given how sick he was?

A He sounded very psychiatrically ill and suffering a great deal.

Q Did you diagnose Mr. Cruz as schizophrenic?

A No.

Q Do you know who did?

MR. RAGEN: Objection, speculation.

THE WITNESS: Are you asking at Cook County or in the community? I don't know in the community. I think he was initially seen in intake, so the intake psychiatrist probably -- or someone in intake usually would enter a diagnosis.

MR. FLAXMAN: Q Okay. And when you say it's a tragic case given how sick he was, you're referring to his schizophrenia?

A Yes.

Q Did you know about any other medical conditions that Mr. Cruz was suffering from?

A I think listed in his medical evaluation was poly substance and asthma and obesity.

Q But those were also diagnoses made by somebody else at the jail, not you?

A Correct.

Q Going back to those conversations that I was asking about. Would you say that all your conversation with other employees at the jail about Mr. Cruz were informal conversations?

A Yes, informal.

Q I mean, nobody sat you down and did an interview about Mr. Cruz, right?

A No.

Q Did you know that Dr. Kelner wrote a report looking into Mr. Cruz's death?

A I did not -- I mean, I'm not -- not involved with that process at Cook County.

Q Did you know how long Mr. Cruz had been suffering from schizophrenia?

A Can I refer to other -- I can look at other people's notes and tell you, but I don't know -- I think he was 21 in the notes. So maybe 2 years, but that's me --

Q As you sit here today, you don't remember?

A Right.
Q You would have relied on other notes within the record?
A Yes.
Q Okay. The picture that's still floating around, Exhibit 3, I understand you don't -- you can't say for sure whether this was Mr. Cruz's cell, right?
A Correct.
Q But it does look like the cell where Mr. Cruz would have been, right?
A Yes.
Q And looking straight into the cell, you can see a window on the far wall, right?
A Yes.
Q In your note when you said Mr. Cruz was facing the window. Did you mean he was facing a window on the far wall of the cell?
A Yes.
Q Was there also a window on the door?
A There is technically.
Q But that's not the window you were referring to?
A Correct.
Q Okay. And besides this one encounter with

Mr. Cruz that I've asked you lot of questions about, did you ever have any other encounters with Mr. Cruz?

A Never.

Q Do you recall how busy you were on your shift on March 19th, 2016?

A I do not.

Q Were you always busy in that time period?

A It fluctuated, but it's a pretty busy unit, especially since state hospitals have closed down. It's a large psychiatric unit.

Q Dr. Lassen, have you ever been sued in relation to your work at the Cook County Jail?

A I don't believe so.

Q This is an exhibit I marked as plaintiff's Exhibit 7A. It's a complaint in a case called Brown versus Howard, et al. case number 15 CV 2906. Do you see at the top under Defendant's Answer To Plaintiff's First Amended Complaint, it says: Now come the defendants Dr. Howard and Dr. Lassen?

A Yes.

Q If you go to the second page, paragraph 5 it says: Upon information and belief defendant Lassen is a doctor of osteopathic medicine employed by CCDOC, and/or Cermak Health Services of Cook County, CCDOC's medical

provider.

MR. RAGEN: What paragraph are you at?

MR. FLAXMAN: Q Paragraph 5 on the second page. It says some other information. Is that paragraph describing you?

A It is.

Q Do you know who Jason Allan Brown is?

A I do not recall Jason Allan Brown. When is this? Okay.

Q Paragraph 12 starts by saying as part of the booking and intake on process on or about September 10, 2014 -- I'm just looking at page 4. That just starts by describing the booking and intake process on a certain date, September 10, 2014. And the two paragraphs down, paragraph 14, says later that same day -- later the same day -- I believe referring to September 10th, 2014 -- Jason met with defendant Lassen for a psychiatric screening.

A Okay.

MR. RAGEN: Is there a question?

MR. FLAXMAN: Q Well, my question is, do you understand this to be a lawsuit that was filed against you in relation to your role doing screening at the Cook County Jail?

A Yes.

Q Do you have any idea why you were not aware of this lawsuit?

A I mean, I know I've been deposed a handful of times, but I guess it wasn't clear to me I was in this role of that. Sometimes it can be -- I wish I could remember it more.

Q The last page of this --

A Last page.

Q It says -- it's page 12, so it's a double sided. Go to the back of that. It says, respectfully submitted, and it lists Anita Alvarez, who was then the State's Attorney of Cook County, then there's a /S/Andrea Huff who is listed as an Assistant State's Attorney. Do you know Andrea Huff is?

A I don't recall Andrea Huff. I have met a handful of state's attorneys, but without seeing pictures or faces --

Q So having looked at this, does this refresh your recollection that you have been sued at least once in connection with your job duties at the Cook County jail?

A I mean, that looks like what this says, so, yes, thank you for refreshing my recollection.

Q Are there any other cases where you were sued in connection with your employment at the Cook County Jail?

A Not that I know of.

Q But there might be ones you don't know about?

A Perhaps.

Q Do you have any idea why you wouldn't know about lawsuits that were filed against you?

MR. RAGEN: Objection, argumentative.

THE WITNESS: I work somewhere else. I haven't been here -- haven't been working at Cook County for a few years, and I feel like many people are often named it seems, so I feel like people -- I don't know.

MR. FLAXMAN: Let me take a quick break. I'm almost finished.

THE VIDEOGRAPHER: Going off the record at 11:38 a.m.

(Off the record)

THE VIDEOGRAPHER: Q Going on the record. This marks the beginning of media number 3. The time is 11:43 a.m.

MR. FLAXMAN: Q Dr. Lassen, did you look again at Exhibit No. 7A, that complaint?

A 7A?

Q I just thought I saw you looking at it.
A I just looked at it.
Q Having looked at it, does it -- do you remember anything else about it?
A No.
Q Okay. Just leave it.
Do you recall what hours you worked on March 19th, 2016?
A No.
Q Would the hours that you worked be recorded anywhere?
MR. RAGEN: Objection, speculation.
If you know.
THE WITNESS: They would be -- I'm trying to remember if we had swipe cards or some sort of check in, check out process.
MR. FLAXMAN: Q Do you remember if there was a check in, check out process?
A We would swipe cards to check in.
Q Would you swipe the card to check out?
A Yes.
Q Where did you do that? Where did you swipe the cards?
A The first floor of Cermak.

Q And we talked before about a calendar on Dr. Kelner's door. Do you remember that?
A Yes.
Q Did that contain your shift times?
A No.
Q Where was Dr. Kelner's door?
A Also in the first floor of Cermak, Cermak Hospital.
Q Are 2N and 2W on the second floor?
A Yes.
Q Is there a basement?
A Yes.
Q Do you know what's in the basement?
A The emergency room.
Q Did you ever send patients to the emergency room?
A Yes.
Q If a patient needed some kind of nonpsychiatric medical care, is that when you would send a patient to the emergency room?
A Yes.
Q Were the only doctors on 2N or 2W psychiatrists like yourself?
A The only -- routinely, yes.

Q When would a nonpsychiatrist doctor be on 2N or 2W?

A I mean, I would -- I would imagine they have medical consultants that would come in emergency then -- not emergency, just be consultants.

MR. FLAXMAN: I don't have any other questions.

MS. HAIDARI: Just a couple questions.

EXAMINATION

By Ms. Haidari:

Q Do correctional officers make psychiatric determinations for the restraints? Did that question make sense? I'll rephrase it.

Do correctional officers ever make the restraint determinations, the psychiatric restraint determinations?

A No.

Q And do you know if correctional officers ordered the restraints in this instance?

A They cannot order restraints.

Q And do you recall in what capacity sheriff officers were present on March 19th, 2016?

A Can you repeat that?

Q Do you recall in what capacity correctional officers were present on March 19th, 2016 when you saw

Angel Cruz?

A They were doing their routine duties at that time, and for close obs they would be near by the door to let me in.

Q Would they do anything -- would they come into the room?

A Sometimes.

Q Under what circumstance would they come into the room or the cell?

A I think if they felt there was concern for a patient harming him or herself or the staff injury.

Q Do you recall if on March 19th, 2016 correctional officers escorted you into the cell or came into the cell with you?

A They had to let me in, but I can't -- I cannot recall where they were standing.

Q Do you know if it was a sheriff -- Let me strike that.

You said that sheriff deputies, Cook County correctional officers, interchangeable, or nurses put on the ordered restraints, correct?

A That's my understanding.

Q Do you know if it was a CO who put on the restraints -- put the restraints on Angel Cruz?

A I do not.

MS. HAIDARI: That's all I have. Thank you.

EXAMINATION

By Mr. Ragen:

Q You talked a little bit about the timeframe, 4-hour timeframe and 15-minute timeframe. Do you recall that?

A Yes.

Q The 4-hour timeframe is the timeframe at which certain hospitals you'll check on a patient to make sure that they -- that it's appropriate for them to stay in restraints?

A Yes.

Q Is there anything special about the 4-hour timeframe like, for example, a 5-hour timeframe would that still be within the standard of care?

MR. FLAXMAN: Objection, foundation.

THE WITNESS: Seems universal across inpatient psychiatric units that it's a 4-hour determination.

MR. RAGEN: Q Okay. Was all of the care and treatment you rendered to this patient within the standard of care?

A I believe it was.

MR. RAGEN: Yeah, that's it.

FURTHER EXAMINATION

By Mr. Flaxman:

Q You saw Mr. Cruz on 2N, right?

A Yes.

MR. RAGEN: This is outside the scope, but I don't care.

MR. FLAXMAN: Just one more.

Q Were you also assigned to 2W on March 19th of 2016?

A We didn't -- we knew to cover -- like any weekends I just knew to cover both, so there's no one or the other.

MR. FLAXMAN: Thank you.

MR. RAGEN: I just do that because, I mean, it's fine, just know --

MR. FLAXMAN: I should have asked.

MR. RAGEN: Stay on the record.

It's just, you know, we're working really well on discovery, you know, like we should allow each other, you know, courtesies like this. You thought of a question afterward, that's totally fine with me to go outside the scope totally.

We will reserve.

THE VIDEOGRAPHER: Going off the record. The time

is 11:50 a.m.

(Off the record)

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

The within and foregoing deposition of the aforementioned witness was taken before CAROL CONNOLLY, CSR, CRR 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 in telephonically by Nadine Watts and then resworn in in person by Carol Connolly, examined upon oral interrogatories; the first 54 minutes of questions and answers were transcribed from videotaped audio by the undersigned, and the remaining questions and answers were taken down in person and transcribed 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 forementioned witness, at the time and place hereinabove referred to.

The signature of the witness was not waived, and the deposition was submitted, pursuant to Rule 30 (e) and 32 (d) 4 of the Rules of Civil Procedure for the

United States District Courts, to the deponent per copy of the attached letter.

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 this 11th day of October, 2019 A.D.

CAROL CONNOLLY, CSR, CRR
CSR No. 084-003113
Notary Public
One North Franklin Street
Suite 3000
Chicago, Illinois 60606
Phone: (312) 386-2000

Exhibit 29

Thank you for the opportunity to review this case. My opinions are provided below. Pursuant to my fee schedule, I charge $500 per hour and have spent 16 hours reviewing this case in preparation of drafting this report.

I am a physician licensed to practice medicine in Illinois. I am board certified in hematology, medical oncology, and internal medicine. My opinions listed below are given to a reasonable degree of medical certainty. My opinions are based upon my background as a hematologist and internal medicine physician practicing since 1999. It is also based on my training and following experience: medical school, internal medicine residency at Northwestern University, fellowship in Hematology and Oncology at Northwestern, my years practicing as a hematologist and oncologist at Rush University Medical Center and Northwestern Memorial Hospital, and my experience teaching at Rush University Medical College, and Northwestern University Feinberg School of Medicine. My opinions are also based on the medical records listed below, deposition transcripts, reports and other materials listed below.

Medical Records:

- Cermak Health Services Medical Records
- Hinsdale Hospital Medical Records
- St. Anthony Hospital Medical Records
- Cermak Health Services Restraint Policies
- Dr. Wakins' Autopsy Report
- Dr. Sozio's Autopsy Report
-

Other Records

- Countryside Police Department Records
- Illinois State Police Records
- Cook County Sheriff Police Records

Depositions

- Alabi, Augustus RN
- Anderson, Dwight
- Barkauskaite, Aiste RN
- Campbell, Michael
- Castillo, Joel
- Chatman, Lorraine
- Crawford, Brian
- Estes, Wanda RN
- Glindmeyer, Daphne MD
- Guerra. Robert
- Holtz, Timothy
- Johnson, Anita
- Kanel, Helen RN

- Kelner, David MD
- Koleva, Katia RN
- Krzyzowski, Cherri RN
- Lassen, Elizabeth MD
- Vargas, Leticia
- Manalastas, Manuel RN
- Marcolini, Evadne MD
- Nunez, Pierre
- Paschos, Steve MD
- Smith, Jerold
- Jason Sprague
- Sodt, Robert
- Weger, Meghan RN
- Yalamanchi, Ravi MD
- Zayed, Hythem MD

Disclsosures
- Daphne Glindmeyer, MD
- Evadne Marcolini, MD

Angel Cruz did not require anticoagulation while he was a patient at either Hinsdale Hospital or Cermak Health Services. Mr. Cruz was at very low risk of developing a clot in March of 2016. Mr. Cruz was young and had no underlying health issues. There are a number of ways to assess a patient's relative risk of developing a venous thromboembolism and Mr. Cruz would qualify as a low relative risk of developing a venous thromboembolism in any of them. The Caprini score looks at certain variables that would increase your risk factor for developing a venous thromboembolism, adds them, and arrives at a score. It was developed to determine a patient's risk for developing deep vein thrombosis in surgical patients, but is widely used by physicians outside of a surgery setting to determine a patient's risk for developing deep vein thrombosis. Among the variables that would increase a patient's risk of developing thromboembolism include the following: advanced age (over 40 years of age), recent history of surgery, varicose veins, inflammatory bowel disease, swollen legs, obesity, history of heart attack, congestive heart failure, serious infection, lung disease, bed rest for over 72 hours, PICC line, having your lower extremity casted, history of embolic events, family history of blood clots. According to the Caprini assessment, obesity is Mr. Cruz's only risk variable and his resultant Caprini score was 1 which indicates he was a low risk of developing a venous thromboembolism.

Although the standard of care would not require a physician to either (a) anticoagulate Mr. Cruz or, conversely, (b) refrain from anticoagulating Mr. Cruz at any point in time from March 12, 2016 to March 20, 2016, it would be in Mr. Cruz's best interest if he was not anticoagulated at that point in time. The standard dose of anticoagulation as prophylaxis against venous thromboembolism is subcutaneous heparin. Heparin is a drug that carries significant side-effects. One of the side effects that accompanies the administration of heparin is that a person is more likely to bleed, less likely to stop bleeding, and more likely to hemorrhage after

incurring trauma. Based on the medical records from Hinsdale Hospital, the records from Countryside Police Department, Cermak Health Services, and Dr. Sozio's and Watkins' autopsy reports, Mr. Cruz was frequently subjecting himself to self-induced trauma causing bruising throughout his body including, but not limited to his head. Additionally, he was noted to have been hitting his head on March 18 and 19. On March 18, he was documented as exhibiting a great deal of force in causing trauma to his head. Likewise, on March 19, he was documented as banging his head repeatedly against a wall. Giving an anticoagulant to a patient who is erratic, continues to cause self-harm in traumatic ways, and who causes himself head trauma could cause a fatal subdural hematoma or intracranial hemorrhage. Thus, the standard of care did not require that Mr. Cruz be anticoagulated at any point in time from March 12, 2016 to March 20, 2016.

It is unlikely that the deep vein thrombosis that caused Mr. Cruz's death was formed because of the events revolving around his period of restraint at Cermak Health Services. Emboli, such as the emboli that caused Mr. Cruz's death, typically form 10-14 days from the culprit event. In this case, while we cannot say with absolute certainty that clots causing Mr. Cruz's death did not originate because of the restraints that were employed at Cermak Health Services, it is more likely that the clots were formed because of events that happened prior to March 15, 2016.

Mr. Cruz first began exhibiting symptoms of a pulmonary embolus on or around 2:40 a.m. on March 20, 2016. Based on the findings made on autopsy, it is more likely than not that Mr. Cruz would not have survived these pulmonary emboli no matter what mitigating treatments were administered. Dr. Watkins' autopsy revealed that the pulmonary arteries were bilaterally occluded by multiple emboli. Moreover, these emboli extended into the smaller arterial branches bilaterally. Dr. Sozio's findings are consistent with Dr. Watkins' findings. Based on the fact that there were multiple emboli, the fact that they were found bilaterally, the fact that they occluding both pulmonary arteries, Mr. Cruz suffered a massive pulmonary embolism which was not survivable.

Lisa Boggio, M.D. 5/4/2021

CURRICULUM VITAE
LISA NOREEN BOGGIO, MS, MD

performed
Date of Birth: 11/24/1964
Citizenship: United States

I. EDUCATION

Postgraduate

1993-1996	Residency in Internal Medicine, Northwestern University, Chicago, IL
1996-1999	Fellowship in Hematology and Oncology, Northwestern University, Chicago, IL

Graduate

1989-1990	MS, Applied Physiology, Chicago, Medical School, North Chicago, IL
1990-1993	MD, Chicago Medical School, North Chicago, IL

Undergraduate

1983-1987	BA, Biology. Boston University, Boston, MA

II. CLINICAL APPOINTMENTS

2007 – Present	Assistant Professor, Rush University Medical Center
2007 – Present	Attending Physician, Department of Pediatrics, Division of Pediatric Hematology & Oncology
2007 – 2017	Attending Physician, Rush Medical Laboratories, Blood Bank, Therapeutic Apheresis
2017- Present	Attending Physician, Department of Medicine, Division of Hematology and Stem Cell Transplant, Therapeutic Apheresis
2007 – 2012	Attending Physician, Department of Medicine, Division of Hematology and Stem Cell Transplant
1999 – 2006	Instructor in Clinical Medicine, Northwestern University Medical School Department of Medicine, Division of Hematology and Oncology

III. CLINICAL SERVICE

2007 – Present	Clinical Director, Bleeding Disorders Multidisciplinary Clinic, held weekly in Aurora, Chicago, and Hoffman Estates
2012 – Present	Clinic director, General Adult and Pediatric Benign Hematology clinic 4 days per week. Including locations in Aurora, Chicago, Hoffman Estates
2007 – 2012	General Adult hematology clinic 3 days per week
2007 – 2012	Teaching Attending, Consultative Hematology Service, 4 months per year. An internal medicine resident-run service for inpatient hematology consults and daily lectures on benign hematology topics.

IV. CERTIFICATION AND LICENSURE

Board Certification

2009 Hematology Recertification
1999 Hematology
1999 Medical Oncology
1996 Internal Medicine

Licensure

Illinois License Number 036-091827
DEA number BB4921222

V. HONORS AND AWARDS

2016 Top 10 Abstract, Blood Journal. Recombinant Coagulation Factor IX Albumin Fusion Protein (rIX-FP) in hemophilia B: results of a phase 3 trial
2015 Best Poster, International Society for Pharmacoeconomics and Outcomes Research. . Validation of a new Hemophilia-specific burden scale for caregivers of children with hemophilia in the US. The HEMOphilia associated Caregiver Burden scale (HEMOCAB^{tm})
2010 Philanthropist of the Year, National Hemophilia Foundation
2008 Cibula Award, Volunteer of the Year, Hemophilia Foundation of Illinois
2003 David Green-Hau Kwaan Teaching Attending of the Year, Northwestern University
1996 First Place, Resident Research Symposium, Northwestern University

VI. SOCIETY MEMBERSHIPS

American Association of Blood Banks
American College of Physicians/American Society of Internal Medicine
American Society of Clinical Apheresis
American Society of Hematology
American Thrombosis and Hemostasis Network
Hemophilia and Thrombosis Research Society
International Society of Thrombosis and Haemostasis
World Federation of Hemophilia

VII. EDUCATIONAL ACTIVITIES

Rush University

2013 – Present Lecturer, Physician Assistant Program
-Hematology lectures, 2 hours yearly, 50 students/class
-Clinical Supervisor 10 hours/week, 4 months per year. Includes clinic supervision and three times weekly one hour lectures on hemostasis

2007 – Present Lecturer, Pediatric Hematology and Oncology Fellows, 3 students/class
- 4 lectures (1 hour each) per year on benign hematology topics

- Monthly Journal Club (1 hour each)
- Clinical Preceptor, University of Chicago fellows, Course in hemostasis. 2 months/year. Includes clinic supervision 4 days/week and three times weekly one hour lectures on hemostasis

2012 – Present Lecturer, Department of Medicine, Division of Hematology and Oncology Fellows 2 lectures (1 hour each) per year on benign hematology topics, 6 students/class

2007 – Present Rounds teaching attending, Hemophilia and Thrombophilia Center Care Plan Oversight Rounds. Weekly multidisciplinary rounds for Physicians, Fellows, Students, Nurses, Social Workers, and Pharmacists.

2014 – 2018 Lecturer, Medical School
Introductory course on Hematology. 3 lectures, 1 hour each, 50 students/class

2012 – 2018 Course Director and Organizer, Provider Shadow Program. 3 students/class 2 hour hands on program to educate Medical Science Liasons about coagulation and the identification, complications and treatment of persons with bleeding disorders. Twice monthly. Funded by an educational grant from Baxalta. $80,000/year

2008 – 2018 Lecturer, Provider Shadow Program – 4 hours, 6 months per year, 3 students/class. Funded by an educational grant from Baxalta. $60,000/year
Program to teach physicians, nurses, social workers and pharmacists about bleeding disorders. Available to centers with a small hemophilia program. Developed educational presentations on the topics of Bleeding Disorders Overview, Inhibitors, Recognition of bleeding, Complications of Bleeding

2007 – 2012 Bedside Rounds Teaching Attending. Adult Hematology Consult Service. 4 months/year. Service included 2-3 second and third year medicine residents and 1-2 medical students. Including both Rush and visiting students. Daily 1 hour lectures about patient care issues

2007 – 2012 Lecturer, Adult Hematology and Oncology case conference, 2 fellows per year (total 6 fellows). 1 hour weekly

2007 – 2012 Lecturer, Adult Hematology and Oncology Fellow educational course. Developed educational book for benign hematology conditions for the Adult Hematology and Oncology Fellows

Northwestern University:

1999 – 2006 Medical School
Lecturer, First year course on Hematology. 8 lectures, 1 hour each, 4 case conferences 2 hours each

1999 – 2006 Lecturer, Hematology and Oncology Fellows, 12 students/class
Hematology lectures, 1 hour monthly
5 months of clinical service one-on-one with fellows. (4 fellows/year)
Clinical Supervisor 10 hours/week, 4 months per year. Includes clinic supervision and three times weekly one hour lectures on hemostasis

1999 – 2006 Lecturer, Internal Medicine Residents, 30 students/class Monthly.

1999 – 2006 Lecturer, Internal Medicine Hematology and Oncology Fellows Board Review course, 1 hour monthly (12 fellows)

1999 – 2006 Teaching Conference Participation (each held 1 hour weekly)

Organizer, Weekly Hematology Case Conference

Mentees

2018 Perfusion student - Michael Imrie. Health project mentor. Anticoagulation during cell saver procedures. Completed

2016 Rush Medical student – Adam Kidwell. Weight based dosing in hemophilia. Completed

2015 Chicago Semester student – Deborah Tigovir. Completed a 3 month project evaluating physical therapy scores in hemophilia patients over the last 10 years. Completed

Community Education

Bleeding Disorders Alliance Illinois – Statewide patient advocacy group for persons with bleeding disorders.

Camp Warren Jyrch – Camp Medical Director. Develop education themes during a week-long camp. Daily teaching sessions x 5 days with theme incorporated into camp games and evening activities.

2002 – Present Develop and update SOPs for the Medical care of campers

2003 – Present Develop educational materials and an educational theme for each week of camp with educational materials provided (handouts and games). Develop policies and procedures for the medical staff: 4-6 RNs. Procedures reviewed yearly. Review all medical records of campers and staff and coordinate care with the camper's attending hematologist. 60-80 campers ages 7-18; 15 staff

Educational Themes by Year

2003 – Girls bleed too
2004 – When to treat a bleed
2005 – What does it mean to be a carrier
2006 – Genetics of bleeding
2007 – First aid for bleeding
2008 – What do you need to know about your disorder
2009 – Bleeding disorders other than hemophilia
2011 – Recognizing bleeding
2012 – The 5 steps to prevent complications in bleeding
2013 – Joint disease in bleeding disorders
2014 – Keeping it clean – preventing infections
2015 – Menstrual bleeding
2016 – Changes with puberty
2017 – Inheritance of bleeding
2018 – Basics of bleeding disorders
2019 – Identifying bleeding
2020 - Benefits of prophylaxis (virtual)

2010 – Present Camp Warren Jyrch Self Infusion Coloring book. Educational program for teaching boys and girls with bleeding disorders how to give themselves their factor using sterile technique. Taught to children ages 7 and up.

VIII. LEADERSHIP AND ADMINSTRATIVE APPOINTMENTS

2014 – Present Chair, Rush for Life Oversight committee
2014 – Present Rush for Life, Pharmacy 340b program medical director. This is a federal program that supports the Hemophilia Treatment Centers through the affordable acquisition and distribution of factor concentrates
2013 - Present Medical Director, Apheresis Center
2007 - Present Clinical Director, Hemophilia and Thrombophilia Center
2007 – 2012 Co-Director, Consultative Hematology Service
1999 - 2006 Director Rube Walker Apheresis Center at Northwestern University
1999 - 2006 Director Hemophilia Treatment Center at Northwestern University

Rush University Medical Center

2013 – Present Stem cell collection Quality Control committee
2014 – Present Chair, Rush for Life Oversight committee
- Develop and update Policies and Procedure Manual

2015 - Present Hematology Infusion Room SOP for Nursing
- Stimate Challenge Testing
- Factor Recovery and Survival Testing

2015 - Present Policy and Procedures HTC
- Self Infusion Class for patients

2015 – Present Rush HTC Newsletter – three times yearly informational newsletter for patients and families
2009 – 2012 Committee on Curriculum and Evaluation, Rush University Medical Center
2009 – 2012 Committee on Admissions, Rush University Medical Center
1999 – 2006 Northwestern University Office for the Protection of Research Subjects, Internal Review Board
1999 – 2006 Transfusion Committee, Northwestern Memorial Hospital

Volunteer

2003 – Present Medical Advisory Committee, Bleeding Disorders Alliance Illinois
2002 – Present Medical Director, Camp Warren Jyrch, Bleeding Disorders Alliance Illinois
- Policies and Procedures for admission to camp, treatment of patients, educational programs for patients, HIPAA, Quality control, Storage and maintenance of medications, Documentation of Treatment

2002 – 2009 State Hemophilia Advisory Board, Chair
1999 – 2008 Board Member, Hemophilia Foundation of Illinois (now Bleeding Disorders Alliance Illinois
1999 – 2005 Member, Advocacy Committee, Hemophilia Foundation of Illinois

National

2011 – Present American Society of Orthopedic Surgeons Committee on Thrombosis
2015 – Present Grant Review Committee, National Hemophilia Foundation

Hemophilia and Thrombophilia Research Society

2003 – Present Grant Review Committee
2003 – Present Hemostasis Committee
2016 – Present Women and Thrombosis Committee

American Thrombosis and Hemostasis Network
2016 – Present VENUS (VENous Thromboembolism Network US)
-Women with Thrombophilia and Thrombosis Committee, Co Chair
-Device associated Thrombosis Committee, Member
2016 – Present Grant Review Committee

American Association of Blood Banks
2016 – Present Apheresis Subsection Committee, Member

American Board of Internal Medicine
2020 - Present Exam writing committee

International
2020 - Present International society of Thrombosis and Haemostasis, Education committee
2020 - Present International Society of Thrombosis and Haemostasis, Subcommittee on Media-Based Learning
2013 – Present International Society of Thrombosis and Haemostasis, Subcommittee on Factor VIII and IX

Industry
2008 – 2015 Steering Committee for the Protect Clinical Trial. A long acting factor VIII for persons with Hemophilia A. Bayer Pharmaceuticals
2006 - 2008 Data Safety Monitoring Board Member, Nuvelo, Inc. 200

IX. COMMUNITY SERVICE

2018 – Present Rush Associate's Board, Rush University
1999 – Present Physician Volunteer, Bleeding Disorders Alliance Illinois, Camp Warren Jyrch
2003 – Present Medical Advisory Committee, Bleeding Disorders Alliance Illinois
2002 – Present Medical Director, Camp Warren Jyrch, Bleeding Disorders Alliance Illinois
2002 – 2009 State Hemophilia Advisory Board, Chair
1999 – 2008 Board Member, Hemophilia Foundation of Illinois Board of Directors
1999 – 2005 Member, Advocacy Committee, Hemophilia Foundation of Illinois

X. SCIENTIFIC AND SCHOLARLY ACTIVITIES

Membership or Offices in Professional Societies (terms)
2020 - Present Committee on Education
International Society of Thrombosis and Haemostasis
2019 – Present Committee on Examination
American Board of Internal Medicine, Hematology
2013 – Present Subcommittee on Factor VIII and IX
International Society of Thrombosis and Haemostasis
2003 - Present Hemostasis Committee

Hemophilia and Thrombophilia Research Society
2016 – Present VENUS: Women and Thrombosis Committee, American Thrombosis and Hemostasis Network, Co-Chair
2016 – Present VENUS: Device related Thrombosis Committee, Member
2016 – Present American Association of Blood Banks, Apheresis Committee, Member

Reviewer for Local Presentations
2018 – Present Rush Mentoring Program, Reviewer and Judge

Reviewer for Funding Agencies
2003 – Present Hemophilia and Thrombophilia Research Society
2016 – Present American Thrombosis and Hemostasis Network

Reviewer for Professional Meeting Abstracts
2005 - Present Hemophilia and Thrombophilia Research Society Annual Meeting

Reviewer for Professional Journals
2016 – Present Drugs
1999 – Present Blood Coagulation and Fibrinolysis
1999 – Present Haemophilia
2000 – Present Journal of the American Medical Association
2001 – Present Clinical Cardiology
2010 – Present Journal of Thrombosis and Haemostasis
2015 – Present The American Journal of Cardiology
1999 – 2014 Bone Marrow Transplantation
2001 – 2014 International Journal of Obstetrics and Gynecology
1999 – 2010 Thrombosis and Haemostasis

Technical Expert Panel
2017 Venous Thromboemobolism Prophylaxis in Major Orthopedic Surgery: Systematic review update. Comparative Effectiveness Review. Balk EM, Ellis AG, Di M, Adam GP, Trikalinos TA. Agency for Healthcare Research and Quality. 2017. No 191. https://www.effectivehealthcare.ahrq.gov/ehc/products/628/2480/thromboembolism-update-report-170622.pdf

Invited Presentations at Regional, National, and International Meetings
2019 Great Lakes Hemophilia Foundation, November 2019
Current Treatments in Bleeding Disorders
Milwaukee, Wisconsin

Bleeding Disorders Alliance Illinois, September 2019
Current Treatments in Bleeding Disorders
Chicago, Illinois

Coalition for Hemophilia B Annual Meeting, February 2019
Extended Half-Life Factor IX products

Orlando, Florida

Coalition for Hemophilia B, Regional meeting: Opeka, AL, April 2019
Women and Bleeding Disorders

Consumer Medical Symposium. Bleeding Disorders Alliance Illinois, May 2019
The Current Treatment Landscape and Emerging Therapeutics
Chicago, Illinois

2018 National Hemophilia Foundation Annual Meeting, October 2018
Proteins in Your Neighborhood: The coagulation cascade
Gene Therapy and New treatments: Teen Rap Session
Orlando, Florida

Coalition for Hemophilia B Regional Meeting: Concord, North Carolina, September 2018
B-HERO-S study. Implications in patient care

Coalition for Hemophilia B Regional Meeting: Pittsburgh, PA, September 2018
B-HERO-S study. Moderate and mild patient perspectives

National Hemophilia Foundation Inhibitor Summit: San Diego, August (3 Presentations)
Basics of Inhibitors.
Emicizumab, Is it right for you?
Teen Rap Session

National Hemophilia Foundation Inhibitor Summit: New Orleans. July (3 Presentations)
Basics of Inhibitors.
Immunology Beyond the Basics.
Teen Rap Session

Bleeding Disorders Alliance Illinois, Annual Meeting, May 2018
How I Treat

2017 Bleeding Disorders Alliance Illinois, Annual Meeting, October
New Treatments in Hemophilia

Symposium, International Society of Thrombosis and Haemostasis, July
Reaching higher in hemophilia A: Treatment with Afstyla. Program Co-Chair.
Berlin, Germany

Symposium, International Society of Thrombosis and Haemostasis, July
Afstyla in the Clinical Setting
Berlin, Germany

National Hemophilia Foundation Annual Meeting. (3 lectures) July
The Coagulation Cascade.

Ask the Experts: Inhibitors
Hormone Therapy
Chicago, IL

2016 Symposium, National Hemophilia Foundation Annual Meeting
Treatment of Hemophilia with Single Chain Factor VIII
Orlando, FL 7/22/16

2015

Symposium, 3rd Annual Presence Cancer Care Symposium
DOACs: What Clinicians Need to Know
St Joseph Presence Medical Center, Joliet, IL 10/10/15

Symposium, The Spring 2015 Update in Internal Medicine
Acquired Hemophilia
Richmond University Medical Center, Staten Island, NY 5/18/15

2013

Symposium, Innovations in Hematology and Oncology
Anticoagulation Therapy,
Provena St Joseph Hospital, Joliet, IL 6/13/13

Annual Meeting of the Illinois Association of School Nurses
Recognizing Bleeding Disorders,
Chicago, IL 4/13

BTG Asia Pacific Hematology Consortium
Hemophilia and Inhibitors
Hong Kong, China 2/13

BTG Asia Pacific Hematology Consortium
Case based discussion of Hemophilia and Inhibitors
Hong Kong, China. 2/13

2012

Symposium, Center for Advanced Training in Inhibitor Management
Acquired Hemophilia
Chicago, IL 5/12

Annual Meeting, Education Program for Patients, Bleeding Disorders Alliance Illinois
Hepatitis C
Utica, IL 4/12

2011

Annual Meeting, National Hemophilia Foundation
Hepatitis C
Chicago, IL 11/11

Symposium, Girls and Women's Bleeding Disorder Symposium, National Hemophilia Foundation

New Therapies for Bleeding
Chicago, IL 8/11

Annual Meeting, Illinois Society of Pediatric Dentists
Anticoagulation Management of Patients with Thrombosis
Chicago, IL 4/11

2010

Annual Meeting, Hemophilia Foundation of Illinois
Self Infusion, Workshop,
Bloomington, IL 5/10

Symposium, 2nd Annual Trends in Hematology for the Primary Care Physician
ITP: Treatment in the Age of TPO Agonists,
Advocate Lutheran General Hospital, Park Ridge, IL 3/10

2009

Symposium, National Hemophilia Foundation Annual Meeting
Treatment of Inhibitors in Hemophilia,
San Francisco, CA 10/09

Symposium, Rush Review of ASH.
Review of Coagulation
Chicago, IL 2/09

2008

Symposium, Patient Education Inhibitor Summit, National Hemophilia Foundation
Management of Factor Inhibitors
Chicago, IL 11/08

Symposium, Educational Inhibitor Summit, National Hemophilia Foundation
Factor IX Inhibitors
Denver, CO 7/08

2005

Annual Meeting, 12th Conference on Thromboembolic Conditions
Evaluation and Treatment of Acquired Hemophilia
Chicago, IL 11/05

Annual Meeting, National Hemophilia Foundation
Should Thromboprophylaxis be Used in Hemophilia Patients Undergoing Orthopedic Surgery?: Pro v Con. Arguments against.
San Diego, CA 10/05

Annual Symposium, Hemophilia and Thrombosis Research Society
Bleeding Disorders in Women
Chicago, IL 4/05

2003

Annual Meeting, 10th Conference on Thromboembolic Conditions
Warfarin: metabolism and complications of treatment

Chicago, IL 5/03

2002

Annual Meeting, The Great Lakes Thrombosis Debates, Hemophilia and Thrombophilia Research Society
The Use of Oral Contraceptives in the Factor V Leiden Heterozygous Woman
Chicago, IL 11/02

Annual Meeting, American College of Phlebology
Risks of Thrombosis in Sclerotherapy
Fort Lauderdale, FL 11/02

2001

Annual Meeting, Association of Pakistani Physicians of North America
Bleeding Disorders in Women
Chicago, IL. 7/01

Oral Presentations at Regional, National, and International Meetings

2019 Mahlangu, J, Boggio L, Hegemann, I. A Phase 1b/2 Study of the Safety, Tolerability, Pharmacokinetics, Pharmacodynamics and Efficacy of PF-06741086 in Patients with Severe Hemophilia A or B. International Society on Thrombosis and Haemostasis Congress

Invited Seminars and Lectures

2020 Acquired Hemophilia. Grand Rounds. Christ Hospital, Oak Lawn, IL.
November 19, 2020

Management of Inherited Bleeding Disorders. Grand rounds. Steering Committee and Presenter
UCLA, Olive View Cancer Center. September 1, 2020
Lankenau Hospital, Wynnewood, PA. October 15, 2020

Scienta CME - Online program, author and presenter. 6/10/2020 posted.
Hemophilia A. https://www.scientiacme.org/cme-324-111-0-0-22-hemophilia-a-cme
Hemophilia B. https://www.scientiacme.org/cme-325-111-0-0-0-hemophilia-b-cme

American Society of Hematology Highlights.
Individualizing Therapy for Hemophilia A. Steering Committee and Presenter
January 10, 2020. Seattle, WA
January 24, 2020. Dallas, TX

2019 Grand Rounds
Evaluation and Treatment of Bleeding in a Medically Ill Patient. Thorek Hospital, Chicago, IL. 5/16/19

2017 Grand Rounds
Immune Thrombocytopenia. Norwegian Hospital, Chicago, IL 3/29/18

Grand Rounds
Direct Oral Anticoagulants. Norwegian Hospital, Chicago, IL 11/30/17

Expert Roundtable Discussion: Beyond the Half-Life: What Does It Take To Be a Long-Acting Replacement Therapy in Hemophilia A? Medscape Educational Roundtable Discussion. Co-Chair, Berlin, Germany. 7/8/17

Product Theater: The role of Single Chain Factor VIII in the Clinical Setting. International Society of Thrombosis and Haemostasis. Berlin, Germany 7/10/17

2016 Grand Rounds, Hematology
Personalizing Prophylaxis Regimens in Patients with Hemophilia: How Can We Optimize the Use of Extended Half-Life Replacement Clotting Factors in Daily Practice
Vista Medical Center, Gurnee, IL 11/15/16

2015

Grand Rounds
Acquired Hemophilia, Evaluation and Treatment
Rush University Medical Center, Chicago, IL 5/20/15

Grand Rounds
Acquired Hemophilia
University Medical Center at Princeton, Plainsboro, NJ 5/19/15

Grand Rounds
Acquired Hemophilia, What Every Clinician Should Know
Illinois Masonic Medical Center, Chicago, IL 3/25/15

2013

Grand Rounds, Vista Medical Center
Hemophilia Update
Gurnee, IL 12/3/13

2012

Grand Rounds, Alexian Brothers Medical Center
DVT Prophylaxis
Elk Grove Village, IL. 12/12

Grand Rounds, Vista Medical Center East
Anticoagulation Management,
Waukegan, IL. 6/12

2010

Grand Rounds Arkansas Valley Regional Medical Center
Congenital Hemophilia A with High Titer Inhibitors,
La Junta, CO 2/10

Grand Rounds, Henry Ford Hospital
Congenital Hemophilia A with High Titer Inhibitors
Detroit, MI 1/10

2009

Grand Rounds, New England Medical Center
Congenital Hemophilia A with High Titer Inhibitors,
Boston, MA 11/09

2008

Grand Rounds, Rush University Medical Center
Anticoagulation Guidelines
Chicago, IL 11/08

Grand Rounds, Rush Copley Medical Center
Prevention of Venous Thromboembolism
Aurora, IL 2/08

2007

Grand Rounds, Lutheran General Hospital
Treatment of DVT
Park Ridge, IL 10/07

Grand Rounds, Rush University Medical Center Department of Medicine
Evaluation of Menorrhagia
Chicago, IL 6/07

Grand Rounds, Rush University Medical Center Department of Medicine
Evaluation and Management of Bleeding Disorders
Chicago, IL 2/07

2006

Grand Rounds, Resurrection Health Care
Heparin Induced Thrombocytopenia
Chicago, IL 11/06

Grand Rounds, Adventist Hinsdale Hospital
Diagnosis and Treatment of DVT
Hinsdale, IL 10/06

Grand Rounds, McLaren Regional Medical Center
Thrombocytopenia
Owosso, MI 10/06

2004

Educational seminar, Oncology/Hematology Associates of Northern Illinois
Hematology clinical vignettes
Gurnee, IL 01/04

2003

Grand Rounds, LaGrange Memorial Hospital
Evaluation of the thrombophilic patient
LaGrange, IL 10/03

Grand Rounds, Hinsdale Hospital

Hypercoagulable states
Hinsdale, IL 10/03

2002

Grand Rounds, Johns Hopkins University, Department of Hematology
Unexpected Bleeding
Baltimore, MD. 8/02

2001

Grand Rounds, Parkview Hospital, Department of Medicine
Anticoagulant Therapies
Fort Wayne, IN. 11/01

Grand Rounds, Marquette General Hospital, Department of Medicine
Heparin in 2001
Marquette, MI. 11/01

Grand Rounds, Southern Illinois Medical Center, Department of Medicine
Heparins 2001
Springfield, IL. 9/01

Grand Rounds, MD Anderson Medical Center
The Hematology Consult Service
Orlando, FL. 3/01

2000

Grand Rounds, St. Therese Medical Center, Department of Medicine
Sickle Cell Anemia Update.
Waukegan, IL. 9/00

Grand Rounds, Kishwaukee Community Hospital, Department of Medicine
Practical Issues in Thrombocytopenia
Dekalb, IL. 3/00

Invited Web-Based Lectures

2020 National Hemophilia Foundation. Roundtable on COVID-19 and Bleeding Disorders. Webinar. 6/30/2020

Scienta Continuing Medical Education

Hemophilia B: Optimizing Pharmacotherapeutic Management Strategies. 6/2020.
https://www.scientiacme.org/cme-325-111-0-0-0-hemophilia-b-cme

Hemophilia A: Optimizing Pharmacotherapeutic Management Strategies. 6/2020.
https://www.scientiacme.org/cme-324-111-0-0-22-hemophilia-a-cme

Other extramural agencies including industry

Baxalta – Shadow Program - $40,000

Develop educational program, presenting didactic lectures to participants (2/month) and providing hands-on clinical supervision for 4 hours/month

HRSA/MCHB – Hemophilia and Thrombophilia Center Core Grant - $43,858
Hemophilia and Thrombophilia care of patients, supervision of core staff which include physical therapy, social work, nutrition, pharmacy, nursing, dental, and psychology

Principal Investigator

Current

10/1/20 -	ECLIPSE: Screening and Lead-in Observational Protocol to Determine Potential Patient Eligibility for Inclusion in AAV Gene Therapy Clinical Trials in Hemophilia B. Freeline Therapeutics. $TBD
9/1/20 -	MIM8/Frontier 4513: Safety, tolerability, pharmacokinetics and pharmacodynamics of single and multiple subcutaneous doses of NNC0365-3769 (Mim8) in healthy subjects and in subjects with haemophilia A with or without inhibitors. NovoNordisk. $40,000
5/26/20 -	ATLAS OLE: A Phase 3 extension study to evaluate the efficacy and safety of fitusiran in patients with hemophilia A or B. Sanofi Genzyme. $100,000
5/29/20 -	ATHN10: Leveraging the ATHN dataset to document the state of rare coagulation disorders in the United States. ATHN. $900
9/30/11 –	Project # CDC-RFA-DD11-1103: Public Health Surveillance Prevention of Complications of Bleeding and Clotting Disorders; Great Lakes Hemophilia Foundation Sub Grant. $97,345
9/30/11 –	COMMUNITY COUNTS-Registry for Bleeding Disorders Surveillance, American Thrombosis and Haemostasis Network, CDC, Great Lakes Hemophilia Foundation Sub Grant. $24,690
2011 –	ATHN Population Profiles: Portal submission for Webtracker / Clinical Manager and the ATHN dataset. No Funding

Past

2/4/19 - 8/1/2020	Non-interventional study to collect data on bleeding episodes and health-related quality of life. NovoNordisk. $20,000
5/6/19 - 8/1/20	ATLAS: A Phase 3 study to evaluate the efficacy and safety of fitusiran in patients with hemophilia A or B. Sanofi Genzyme. $100,000
2017 - 7/21/20	ATHN5/Longitudinal, observational study of patients with HCV and bleeding disorders. $22,200
2/12/19 – 11/1/19	BMRN 270-902: A prospective Non-Interventional Study of Bleeding Episodes, Factor VIII infusions, and Patient-Reported Outcomes in Individuals with Severe Hemophilia A. BioMarin. $20,000
2/18/14 – 12/31/19	Molecular and Clinical Biology of VWD, Blood Center of Wisconsin . $10,317
2/1/18 – 2/1/19	INITIATE. Factor VIII inhibitor treatment with Wilate. OctaPharma. $30,000
7/26/17 – 11/30/18	A multicenter, open-label, multiple ascending dose study to evaluate the safety, tolerability, pharmacokinetics, pharmacodynamics, and efficacy of subcutaneous and/or intravenous PF-06741086 in subjects with severe hemophilia. Pfizer. $38, 471
12/1/15 –6/15/18	Single dose FIH study; Phase I/IIa clinical study assessing the safety, pharmacokinetics and pharmacodynamics of a long-acting recombinant Factor VIIa (MOD-5014) in adult males, OPKO, $344,038

4/1/15 – 2/1/18	Prospective, open-label, multicentre phase 3b study to assess the efficacy and safety of personalized prophylaxis with *Human-cl rhFVIII* in previously treated adult patients with severe haemophilia A (GENA 21b), Octa Pharma $27,112
2013 – 2016	Intra-cranial hemorrhage study: Medical record review of subjects with Hemophilia A and B who have been without inhibitors for the past five years and are receiving continuous prophylactic treatment, regular prophylaxis or on-demand. No Funding
10/1/14 – 7/1/16	A Phase 3 Prospective, Open-Label, Randomized, Cross Over Study to Evaluate Safety, PK and Efficacy of Coagulation Factor VIIa (Recombinant) in Congenital Hem A/B with Inhibitors to Factor VIII/IX, rEVO, $42,959
6/1/13 – 6/1/16	Determination of safety, efficacy, and pharmacokinetics of GreenGene TMF in previously treated patients 12 years of age or older diagnosed with severe Hemophilia A. Green Cross. $48,740
10/1/14 – 5/5/16	SUSTAIN: Phase II, multicenter, randomized, placebo-controlled, double-blind, 12-mos. Study to assess safety & efficacy of SelG1 in sickle cell patients with sickle cell-related pain crisis, Selexys. $52,000
2/18/14 – 12/31/15	R01 Comparative Effectiveness in the diagnosis of VWD, Blood Center of Wisconsin

Co-Investigator

Current

10/1/20 -	Observational retrospective clinical study on personalized PK-guided prophylaxis in patients with hemophilia A, Trio Health/Takeda. $TBD
10/1/20	Sample Collection from Donors with Bleeding Disorders. Precision Med. $TBD
1/6/20 -	IPTN Registry (International Pediatric Thrombosis Network). Observational study of pediatric thrombotic disease. No funding.
1/6/20 -	Fibryga Retrospective Study: Chart review of coagulation parameters in 10 adult and 10 pediatric patients on ECMO. No funding
1/25/19 -	ATHN7 – A Natural History Cohort Study of the Safety, Effectiveness and Practice of Treatment for People with Hemophilia. ATHN. $15,000
1/19/18 -	WAPPS-Hemo Web-based Application for the population pharmacokinetic service-Hemophilia. McMaster University. No funding
4/30/18-	Phase 3, open-label, randomized, multicenter trial of PK/PD of Edoxaban from birth to <18 years with confirmed VTE. Dupont. $30,000
8/1/18 -	ATHN8 – PUPs matter: A natural history cohort study of the safety, effectvenes, and practice of treatment for people with hemophilia. ATHN. $5,100
1/22/18 -	Safety and Efficacy of N8-GP in PUPs with Hemophilia A. NovoNordisk. $33,000
2012 –	Expression of Biomarkers in Hemophilic Arthropathy. Departmental funding
2000 –	Outcomes of Regional Consensus Treatment Guidelines for Management of Surgery, Invasive Procedures and Control of Hemorrhages in Patients with Bleeding Disorders and Management of Thrombosis & Thromboprophylaxis

	in Patients with Thrombophilia, Great Lakes Hemophilia Foundation. No funding
1996 –	Great Lakes Foundation HTC core grant. Health Research and Service Administration. HRSA. $43,585

Past

7/5/18 - 9/1/20	Hestia-3. A Randomized, Double-Blind, Parallel Group, Multicenter, Phase III Study to Evaluate the Effect of Ticagrelor vs Placebo in Reducing the Rate of Vaso-Occlusive Crises in Pediatric Patients with Sickle Cell Disease. $20,000
5/12/19 - 7/21/20	VerITI-8: Non-controlled, Open-label study for Immune Tolerance Induction in Severe Hemophilia A Subjects with Inhibitors. Bioverativ. $38,202
2017- 7/21/20	Knowledge and improvement of health literacy and numeracy in adolescent patients with Hemophilia A and B. Baxalta. $70,000
8/4/18 – 12/18/19	eThink: Study of the impact of hemophilia and its treatment on brain development, thinking, and behavior in children with hemophilia. NovoNordisk. $1994
6/1/15 – 2019	Open-label, multicenter evaluation of the safety & efficacy or recombinant, long-acting coagulation factor IX Fc fusion protein (rFIXFc) in the prevention & treatment of bleeding in previously untreated patients with severe Hemophilia B, Bioverativ. $28,468
8/22/16 – 6/1/18	Pediatric Inhibitor Study of ACE-910. Genentech/Roche/Chugai. $14,300
2017 – 6/1/18	A trial comparing eht pharmacokinetics of nonacog beta pegol and ALPROLIX (rFIXFc) in male patients with hemophilia B. NovoNordisk. $40,000
2/1/15 – 7/1/18	Identification and monitoring of acute joint bleeding using ultrasonography and blood biomarkers. Investigator Initiated – Baxalta. $226,150
2016 – 2018	Expanded Access Program Emicizumab. Genentech/Roche. $14,000
1/1/15 –12/1/18	My Life, Our Future, Genotyping for patients diagnosed with hemophilia A or B. ATHN/Bioverativ. $5,350
1/13/16 – 3/8/17	Randomized, open-label study to evaluate the PK and safety of Recombinant factor VIIIFc fusion protein (rFVIIIFc: BIIB031) Manufactured at 15K scale and at vial strengths up to 6000 IU in previous treated subjects with severe hemophilia A (ELEVATE). Biogen, $47,275
4/1/13 – 9/1/16	Immunogenicity, efficacy and safety of treatment with Human-cl rhFVIII in previously untreated patients with severe hemophilia A (GENA-05), OctaPharma. $45,634
4/1/14 – 7/2/16	Hemophilia Inhibitor Research Study (HIRS) – Phase III Inhibitor surveillance study. CDC, $38,340
11/1/14 – 8/1/16	Extension trial: Safety and efficacy of CSL 627 in the treatment of hemophilia A (CSL 627-3001), CSL, $97,555
7/1/14 – 8/1/16	Hemophilia A pediatric Study. CSL. $52,283
1/1/14 – 8/1/16	KidsDOTT, Prospective Multi-center evaluation of the duration of therapy for thrombosis in children: All Children's Hospital. $2,470
2014 – 2016	Capricorn Sickle cell Cohort, PCORnet.

6/1/12 – 3/30/16	Prospective inceptional cohort study of individuals with bleeding and clotting disorders. Departmental. $1,108,602
8/31/11 – 9/1/13	Experienced ITI study in patients with severe Hem A with inhibitor: The study will evaluate whether FVIII/vWF concentrates successfully induce immune tolerance in patients who have already experienced and failed immune tolerance induction with VWF-free concentrates. City of Hope. $5,500
4/1/12 – 8/31/13	Warfarin Pharmacokinetics in Pediatrics. Children's Hospital of Wisconsin. $3,500

BIBLIOGRAPHY

Original full-length manuscripts (published, in press, or submitted)

1. Mahlangu J, Lamas J, Morales J, Malan D, Zupancici-Salek, S, Wang M, **Boggio L**, Hegemann I, Mital A, Cardinal M, Zhu T, Sun P, Arkin S. Marstacimab, targeting human tissue factor pathway inhibitor in hemophilia. Blood. Submitted
2. Bhatt N, **Boggio L**, Simpson M. Using an educational intervention to assess and improve disease-specific knowledge, health literacy and numeracy in adolescents and young adults with hemophilia A and B. Haemophilia. 2021. 2/15/21 epub
3. Kwak J, Simpson M, **Boggio L**. Hemophilia: A review of perioperative management for cardiac surgery. Journal of Cardiothoracic and Vascular Anesthesia. 2020. Epub
4. Cohen A, **Boggio L**, Bauman L. VENUS Pregnancy Survey. Journal of Women's Health. 2020. Epub
5. DiGiandomenico S, Christopherson PA, Haberichter SL, Abshire TC, Montgomery RR, Flood VH; Zimmerman Program Investigators(**Boggio L**). Laboratory variability in the diagnosis of type 2 VWD variants. J Thromb Haemost 2021. 19(1):131-138
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Book chapters

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Peer-Reviewed Abstracts

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2. Song X, Enockson C, Fogg L, **Boggio L**, Simpson M, Hakobyan N. Circulating Biochemical Markers of Early Joint Bleeding: Validation Study in Humans. International Society of Thrombosis and Haemostasis, Melbourne Australia. July 2019
3. Mahlangu, J, **Boggio L**, Hegemann, I. A Phase 1b/2 Study of the Safety, Tolerability, Pharmacokinetics, Pharmacodynamics and Efficacy of PF-06741086 in Patients with Severe Hemophilia A or B. International Society of Thrombosis and Haemostasis, Melbourne Australia. July 2019. Oral presentation
4. Wang M, Simpson M, Boggio L, Mead H, Balasa V, Davis J. Real-World Consumption rFVIII Single Chain: US Population Experience. International Society of Thrombosis and Haemostasis, Melbourne Australia. July 2019
5. Rajpurkar M, Croteau S, **Boggio L**, Cooper DL. Low Risk of Thrombotic Events with NovoSeven: A safety analysis. International Society of Thrombosis and Haemostasis, Melbourne Australia. July 2019
6. Mahlangu, J, **Boggio L**, Hegemann, I. A Phase 1b/2 Study of the Safety,Tolerability, Pharmacokinetics, Pharmacodynamics and Efficacy of PF-06741086, an anti-TFPI Monoclonal Antibody, in Subjects with Severe Hemophilia A or B, with or without Inhibitors. American Society of Hematology Annual Meeting, San Diego, CA. December 2018
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15. Batt K, Recht M, Wang M, Quon D, **Boggio L**, Kessler C, Buckner TW, Neff A, Iyer N, Cooper DL, Kempton CL. EQ-5D-5L Visual Analog Scale (VAS) Scores Across Subgroups of US Adults With Hemophilia With Varying Patient Characteristics: Results From the Pain, Functional Impairment, and Quality of Life (P-FiQ) Study. Hemophilia and Thrombophilia Research Society Annual Meeting. April, 2016.
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19. **Boggio L**. The Global, Multi-Center, Phase III, Randomized, Efficacy, Pharmacokinetic and Safety Cross-Over Study (PERSEPT 1) of Two Dose Regimens of Eptacog Beta (rhFVIIa) in Congenital Hemophilia A and B Patients with Inhibitors to Factor VIII or IX (HABI) World Federation of Hemophilia, July 2016. Oral

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Dr. Boggio's Tesimony as an Expert Since May 1, 2017

Deposition Testimony

12 L 531 – Erickson v. Sauer, Lake County, Illinois

15 L 6370, Hennel v. Uropartners, Cook County, Illinois

14 WC Latoz v. Pitt Mining, Mt. Vernon, Illinois, Jefferson County

12 L 686 – Pawlik v. SunHealth, DuPage County, Illinois

Trial Testimony

12 L 531 – Erickson v. Sauer, Cook County, Illinois

Exhibit 30

I am a board-certified internal medicine physician with subspecialites in critical care and pulmonary medicine. I am licensed to practice in Illinois as a physician and have practiced medicine in Illinois since 1991. I practice medicine as a critical care physician and pulmonologist at Swedish Covenant Hospital, North Chicago VA Medical Center, and the Chicago Medical School and have since 2009. My opinions are based on my experience, education, teaching and clinical practice as outlined in my attached curriculum vitae. My opinions are made to a reasonable degree of medical certainty.

My opinions are based on a review of the following materials:

Medical Records:

- Cermak Health Services Medical Records
- Hinsdale Hospital Medical Records
- St. Anthony Hospital Medical Records
- Cermak Health Services Restraint Policies
- Dr. Wakins' Autopsy Report
- Dr. Sozio's Autopsy Report
-

Other Records

- Countryside Police Department Records
- Illinois State Police Records
- Cook County Sheriff Police Records

Depositions

- Alabi, Augustus RN
- Anderson, Dwight
- Barkauskaite, Aiste RN
- Campbell, Michael
- Castillo, Joel
- Crawford, Brian
- Estes, Wanda RN
- Glindmeyer, Daphne MD
- Guerra. Robert
- Holtz, Timothy
- Johnson, Anita
- Kanel, Helen RN
- Kelner, David MD
- Koleva, Katia RN
- Krzyzowski, Cherri RN
- Lassen, Elizabeth MD
- Vargas, Leticia
- Manalastas, Manuel RN
- Marcolini, Evadne MD

- Nunez, Pierre
- Paschos, Steve MD
- Smith, Jerold
- Sodt, Robert
- Weger, Meghan RN
- Yalamanchi, Ravi MD
- Zayed, Hythem MD

Disclsosures
- Daphne Glindmeyer, MD
- Evadne Marcolini, MD

I hold the opinion that the standard of care did not require Mr. Cruz to be anticoagulated while he was in restraints. Mr. Cruz was vigorously moving about at most of the times that he was admitted at Cermak Health Services and was not immobile for an amount of time in which you would expect a person to develop venous thromboemboli. When a patient is immobile for a period of time of 72 hours or more, that patient is at a high risk of developing a thromboembolism. In this case, Mr. Cruz was immobile for less than 24 hours. There is no medical literature that would suggest that the standard of care required restrained patients to be anticoagulated. To the contrary, the medical literature available as of 2016 suggested that anticoagulation of restrained patients has no appreciable effect. In a patient like Mr. Cruz, who was extremely likely to incur physical trauma upon himself, the danger in anticoagulating Mr. Cruz in which he has a much higher likelihood of incurring a dangerous hemorrhage greatly outweighed any benefit that would have been obtained through anticoagulation.

I hold the opinion that it was more likely that the clots that Mr. Cruz incurred first as deep vein thrombi that later became pulmonary emboli originated from the trauma of the events on the morning of March 12, 2016. Mr. Cruz was at a relatively low risk of developing a clot as result of his immobility while restrained both at Hinsdale Hospital and Cermak Health Services. It is also unlikely that that the trauma Mr. Cruz incurred on March 12, 2016 would result in clots in a young man whose only other risk factor is obesity, but it seems that of these three events, the clots developing as a result of the trauma on March 12 were the most likely precipitating event.

I also hold the opinion that Mr. Cruz's pulmonary embolism was not a survivable event. When Mr. Cruz suffered his pulmonary embolism on or around 2:40 a.m. on March 20, 2016, the clot burden that was later seen on autopsy indicated that it was more likely than not that Mr. Cruz could not have survived this event. The Cook County Medical Examiner performed an autopsy and histology on Mr. Cruz that indicated that Mr. Cruz multiple clots occluded both branches of his pulmonary artery. Moreover, a number of significant clots had migrated to the smaller branches of the pulmonary arteries. In my experience as a pulmonologist, the principal treatment measure that one could employ if a patient has a known pulmonary embolism is the administration of tissue plasminogen activator. This drug should only be administered if the patient is known or is highly likely to have incurred a pulmonary embolism. There is nothing from the medical records that would lead me to believe that Mr. Cruz's code shortly after 2:40

a.m. was highly likely due to a pulmonary embolism as there were a number of other medical conditions that would need to be considered as the potential cause of his symptoms. Further diagnostic work-up would be necessary to arrive at a diagnosis of pulmonary embolism. One does not administer tissue plasminogen activator until pulmonary embolism is diagnosed or until all other potential causes are ruled out.

I spent 5 hours reviewing this case as of May 4, 2021 and my hourly rate is $400 per hour.

Eric Gluck, M.D.

CURRICULUM VITAE

Eric Howard Gluck, M.D.

OFFICE ADDRESS: Director of Critical Care Services
Swedish Covenant Hospital
5145 North California Avenue
Chicago, Illinois 60625

OFFICE PHONE: 773.293.3200 egluck@aol.com

MARITAL STATUS: Married, September 6, 1978 (Margaret Ostram)
Children: Heidi Nan, August 1, 1981
Paul Matthew, December 13, 1983
Molly Bea, September 20, 1989

EDUCATION: City College of New York, B.S., 1972
New York Medical College, M.D., 1975

INTERNSHIP: Beth Israel Medical Center, New York, 1975-1976

RESIDENCY: Beth Israel Medical Center, New York, 1976-1978

FELLOWSHIP: Pulmonary Fellowship, University of Utah
College of Medicine, 1978-1980

ACADEMIC:

February 2015
Senior Lecturer
St George's University of London
Medical School
London, UK

July 2009 - present
Chief Academic Officer
Swedish Covenant Hospital

July 1998 to Present
Professor of Medicine
Finch University of Health Sciences/The Chicago Medical School
3333 Green Bay Road
North Chicago, IL 60064

January 1994 to July 1998
Associate Professor of Medicine
Finch University of Health Sciences/ The Chicago Medical School
3333 Green Bay Road
North Chicago, Illinois 60064

March 1991 to December 1993

Associate Professor of Medicine
Section of Pulmonary and Critical Care Medicine
Rush-Presbyterian St. Luke's Medical Center
1725 West Harrison Street, Suite 306
Chicago, Illinois 60612

Assistant Professor of Medicine
University of Connecticut Medical School
Farmington, Connecticut
1980 - 1991

PROFESSIONAL:

January 2000 to present
Director of Critical Care Services
Swedish Covenant Hospital
5145 North California Avenue
Chicago, Illinois 60625

Chief, Medical Service 1997-1999
North Chicago VA Medical Center
3001 Green Bay Road
North Chicago, IL 60064

January 1994 to 1999
Section Chief Pulmonary and Critical Care Medicine
North Chicago VA Medical Center
3001 Green Bay Road
North Chicago, Illinois 60064

Division Chief Critical Care Medicine-1993- present
The Chicago Medical School
North Chicago, Illinois

Division Chief Pulmonary Medicine 1994-Dec 1999
The Chicago Medical School
North Chicago Illinois

Section of Pulmonary & Critical Care Medicine 1991-1993
Rush-Presbyterian St. Luke's Medical Center
Chicago, Illinois
1991 - 1993 Sept 1996 to Jan 2000

March 1991 - December 1993
Associate Director of Respiratory Therapy
Rush-Presbyterian St. Luke's Medical Center

1725 West Harrison Street, Suite 306
Chicago, Illinois 60612

Private Practice 1980-1991
Hartford Lung Physicians
Hartford Connecticut

BOARD CERTIFICATION:

National Board of Medical Examiners	1976
American Board of Internal Medicine	1978
Subspecialty, Pulmonary Medicine	1980
Subspecialty, Critical Care Medicine	1991/2001/2011

LICENSURES:

New York	1976 - 1980
Utah	1979 - 1980
Connecticut	1980 – 1991
Illinois	1991 - Present

SPECIAL COURSES:

Laser Workshop, The Institute for Applied Laser Surgery, Inc., 1984

PROFESSIONAL SOCIETIES:

Society of Critical Care Medicine (Fellow)
American College of Chest Physicians (Fellow)
The Chicago Institute of Medicine [Fellow]
American Thoracic Society
Society of Sigma XI
Alpha Omega Alpha
American Society of Law, Medicine and Ethics

AWARDS:

Chemistry Honors Society	1972
Analytical Chemistry Award	1972
Merck Award for Excellence in Medicine	1975
Resident of the Year	1977
John C. Leonard Teaching	1982
Award of Excellence in Teaching	1982
Who's Who of Rising Americans	1990
Governors Community Service Award-ACCP	2000
Teacher of the Year	2001
Preceptor of the Quarter	2009
Clinical Educator of the Year	2010
Clinical Educator of the Quarter	2010
Outstanding Clinical Preceptor	2012, 2013, 2014, 2015, 2019

LECTURES: Critical Care Nursing Course

University of Utah College of Nursing,
“Anatomy and Physiology of the Respiratory System",
and “Analysis of Blood Gases", September, 1978 and
February, 1979.

LDS Hospital Critical Care Nursing Course,
"Acid Base Metabolism and: Analysis of
Blood Gases”, September, 1978.

Connecticut Society for Respiratory Therapy,
"High Frequency Ventilation, When, Why?",
January, 1984.

Emergency Nurses Association, North Central
Connecticut Chapter
"The Physiologic Effects of Asthma and Emergency
Care', November 4, 1987.

Connecticut Society for Respiratory Therapy,
“Jet Ventilation", November 4, 1987.

Symposium - "Use of Inhaled Corticosteroids",
American College of Allergy & Immunology,
March 16, 1988, Anaheim, California.

Connecticut Society of Respiratory Therapy -
"Auto-PEEP and its Clinical Implications".

Niel Institute of Medicine-Lille, France,
"Effect of Ultra High Frequency
Jet Ventilation on Patients with ARDS",
April, 1990.

Resuscitation of Patients with Respiratory Failure,
N.E. Symposium of Emergency Medicine.

New York State Society of Respiratory Care,
Annual Symposium - Alternate Modes of Ventilation
November, 1991.

Pulmonary Grand Rounds/Bay State Medical Center
Ultra High Frequency Jet Ventilation,
November, 1991.

Cook County Medical Society - Review course
in Critical Care Medicine
Emergency Treatment of Asthma
November, 1991.

Mechanical Ventilation - Update ACCP Post Graduate

Course, December 13, 1991.

Pulmonary Grand Rounds - Chicago
Osteopathic Hospital Asthma Update, March, 1992.

Connecticut Society Respiratory Care
Ultra High Frequency Jet Ventilation Update,
April, 1992

Pulmonary Intensive Care Update - National Finish Meeting.
Tempire, Finland May, 1992.

Fourth Pulmonary Fellows symposium,
Occupation Lung Disease - Ft. Lauderdale, Florida
May, 1992.

Kansas City Society of Respiratory Care
Weaning from Mechanical Ventilation
May, 1993.

Iowa Society Respiratory Care
Ultra High Frequency Ventilation, June, 1993.

Connecticut Society of Respiratory Care,
Helium Therapy, April 1993.

Third International Symposium on High Frequency Ventilation - Can protocols be written for ventilator control of gas exchange during HFV?
Dusseldorf, Germany, April, 1993.

Challenges in Critical Care; Respiratory Care Department of Dartmouth-Hitchcock Medical Center: Weaning from mechanical ventilation; April, 1994.

Illinois Society of Respiratory Care: Reducing costs of ventilating patients; High Frequency Ventilation; June, 1994.

California Society of Respiratory Care: Reducing costs of ventilating patients; High Frequency Ventilation; June, 1994.

National Meeting on Monitoring in the ICU, Sapporo, Japan; Reducing duration of mechanical ventilation; June,1994.

Special Symposium on ICU Medicine, Beijing, China; Reducing stays on mechanical ventilation;

June, 1994.

Respiratory Society Meeting; Taipei, Taiwan; Optimizing the care of ventilator patients; June, 1994.

Huff and Puff Society of San Francisco: Weaning from Mechanical Ventilation; May, 1994.

Special Symposium; LSU University Medical Center, New Orleans; Weaning from Mechanical Ventilation; May, 1994.

Minnesota Society Respiratory Care - Treatment of ARDS in 1990's, September, 1994

Course Director- Chicago Critical Care Symposium July 1995

International Congress of Internal Medicine-Manila Phillipines; COPD - current concepts in management and Iatrogenic respiratory failure; Feb 1996.

University of Southern California- Barlow Respiratory Hospital Symposium on Mechanical Ventilation; The Use of Protocols inWeaning from Mechanical Ventilation. April 1996

University of Miami- 1st Annual Doug Onorato Memorial Lecture; The use of inhaled heliox in the management of acute airway obstruction. June 1996

Course Director-Chicago Critical Care Symposium Aug 1996

Course Director-Chicago Critical Care Symposium July 1997

Computerization of Weaning Protocols-plenary session, American College of Chest Physicians Nov 1999

American Academy of Physician Assistants-Annual Meeting; Chicago Ill, June 2000- Diagnosis and treatment of Pulmonary Embolism

American Academy of Physician Assistants-Annual Meeting; Chicago Ill, June 2000- Treatment of Congestive Heart Failure

Illinois Masonic Hospital- Medical Grand Rounds- Chicago Ill 2000- Use of Non invasive positive pressure ventilation

St Francis Hospital- Medical Grand Rounds- Evanston, Ill 2000- Use of Non-Invasive Positive Pressure Mechanical Ventilation

Our Lady of the Resurrection Medical Center- Chicago Ill 2001- Update on the Pathophysiology of Sepis.

Norwegian Medical Center- Chicago Ill 2001- Update on the Pathophysiology of Sepis.

APEC- Downers Grove Ill 2001 Update on the Pathophysiology of Sepis.

American College of Chest Physicians – National Meeting, Philadelphia, PA- 2001- Rules and Regulations in the ICU.

New York State Society of Respiratory Therapy- 25 Years of Weaning from Mechanical Ventilation – Oct 2001
Chairperson and Speaker, ALA Healthy Lung Expo 2010, Chicago, Ilinois

COMMITTEE APPOINTMENTS:

Ethics Committee – Chair 2001- present
Critical Care Committee- Chair- 2001- present
Investigational Review Board – CMS- 1995-present
Infection Control Committee
Graduate Medical Education Committee (Swedish Covenant Hospital)
Chairman VISN 12 Taskforce - Innovations in delivery of health care
Deans Committee - CMS January 1997
Finance Committee - American College of Chest Physicians-1996
Research Committee - Chicago Medical School-'95

ABSTRACTS
Eric Howard Gluck, M.D.

1. Brown CC, Gluck EH, Ostram M, "Respiratory support of oleic acid induced adult respiratory distress syndrome with ultra high frequency jet ventilation". Clinical Research, 34:3A, 1986.

2. Gluck EH, Frey TM, 'Measurement of airway pressures in pigs during ultra high frequency jet ventilation". Clinical Research, 34:4A, 1986.

3. Gluck EH, Ostram M, Weinberg B, Use of ultra frequency jet ventilation in patients with ARDS'. Chest, 92:2:67SA.

4. Gluck EH, Mesologites D, Orlando R, "Ultra high frequency jet ventilation in the physiological assessment of pigs with bronchopleural fistula". Chest, 92:2:107SA, August, 1987.

5. Gluck EH, Brown CC, Ostram M, "Ultra high frequency jet ventilation compared to conventional ventilation in the treatment of oleic acid induced ARDS in pigs". Chest, 92:2:67SA, August, 1987.

6. Gluck EH, Frey TM, "Airway pressure measurement in the living pig undergoing ultra high frequency jet ventilation using retrograde catheter technique". Chest, 92:2:109SA, August, 1987.

7. Gluck EH, Renouf R, Shiue ST, Gluck M, 'Effect of ultra high frequency jet ventilation on gas exchange in experimentally induced emphysema. Amer. Rev. Resp. Dis., 137:471A, April, 1988.

8. Shiue ST, Thrall RS, Gluck EH, 'Analysis of bronchoalveolar lavage fluid from rats treated with ultra high frequency jet ventilation'. Amer. Rev. Resp. Dis., 137:374A, April, 1988.

9. Gluck EH, Heard S, Fahey P, "Ultra High Frequency Jet Ventilation in ARDS-Multicenter Results". Chest, 96:2:174SA August, 1989.

10. Winston C, Gluck EH, "Augmented absorption of pneumothoraces using helium-oxygen mixtures. Radiological Society of North America, 1991

11. Keating, Markewitz, Onorato, Gluck EH, "Effect of ventilatory mode on hemodynamics in a porcine trauma model". CCM, Vol. 19, April, 1991.

12. Pettel C, Mohr J, Mathews J, Piraus A, Gluck EH, "Use of UHFJV in management of ARDS; Anesthesiology 73(3):A256, 1990.

13. Lamothe PH, Ujehelyl MR, Gluck EH, "Hemodynamic actions of histamine antagonists during endotoxin induced sepsis; Journal of Clin. Pharm, 32(s):745, August 1992.

14. Gluck EH, Balk R, Casey L, Heydorn P, Nawas Y, Silver M, Bone R, "Esophageal pressure measurements allow more aggressive weaning from chronic mechanical ventilator support. ARRD, 47(4):4:873, April, 1993.

15. Gluck EH, Balk R, Casey L, Nawas Y, Silver M, Bone R, Predicting weanability in chronically ventilated patients", Chest, 48(5):A673, May 1994

16. Gluck EH, Lopez P, Tamul P; The effect of trigger location on the delay between inspiratory effort and gas delivery to the patient. Chest 1995;108;S142

17. Gluck EH, Tamul P; Blasius gas equation can predict the effective endotracheal tube diameter; Chest 1995;108;S142

19. Akbarullah S, Gluck EH; The role of price and study quality on the purchase of medical equipment; Chest 1995;108;S186

20. Gluck EH, Keating K, Kaufman'L, Heard S, Conrad S; Multicenter evaluation of the effectiveness of esophageal balloon manometry during weaning. J of Crit Care Med; 24(l);104A

21. Bader IH, Gluck EH, Rosman J; Comparison of effects of beta 2 agonists nebulizer with oxygen and heliox. Chest 1996; 110; S33

20. Gluck EH, Maldonado, F, Sorresso, D, Gazmuri R. ; Improved care delivery utilizing an intensivist hospitalist system in a Veterans Affairs Hospital. Critical Care Med;1999; Vol 27, No1: A155.
21. Istanbouly S, Gluck EH; Inner City Asthma Triggers are the same as Suburban Triggers. In press. To be presented at the ATS meeting 2003.
22. Bass A, Gluck EH; The validity of the mead equation for predicting optimal respiratory rate in the setting of mechanical ventilation. Chest 2004; 126; 4 S902
23. Gluck E and Maki D; Procalcitionin can decrease antibiotic doses under new CMS guidelines. CCM 2016; Vol 44;12 abs 1481

PUBLICATIONS:
Eric Howard Gluck, M.D.

1. Gelb A, Gluck EH, Solon A, and Garcia I, "Granulomatous vasculitis of the upper gastrointestinal tract: A case report". Mt. Sinai Journal of Medicine, 45:2, March-April, 1978.

2. Armstrong JD, Gluck EH and Hughes JMB, "Measurement of lung water with helium dilution". Thorax, 1983.

3. Littenberg B, and Gluck EH, "Controlled trial of methylprednisolone in the emergency treatment of acute asthma". New England Journal of Medicine, 314:3, January 16, 1986, pp. 150-152.

4. Nino A, Berman M, Gluck EH, Conway M, Fisher J, Dougherty J, and Rossi M, "Drug-induced left ventricular failure in patients with pulmonary disease". Chest, 94:4, October, 1987.

5. Orlando R, Gluck EH, and Cohen M, "Ultra high frequency and Broncho-Pleural Fistula". Arch. Surgery, vol. 1123, pp. 591, May, 1988.

6. Gluck EH. "Diagnosis of asthma", J of Resp. Dis. 9:S19 - S23, 1988.

7. Schiue ST and Gluck EH, "Use of helium-oxygen mixtures in the support of patients with status asthmaticus and respiratory acidosis". Journal of Asthma, 26(3) pp. 177-180, 1989.

8. Gluck EH, Onorato D, Castriotta R, "On the use of helium oxygen mixtures in intubated patients with status asthmaticus and respiratory acidosis". Chest, 98 pp. 693-698, 1990.

9. Gluck EH, "Use of helium in patients with bronchospasm; clinical advances in the treatment of asthma". 2 (3) pp. 6-9. 1991.

10. Veenstra R, Gluck EH. "A clinical librarian program in the Intensive Care Unit". CCM 20(7); 1038-1042, 1992.

11. Bone R, Eubanks D, Gluck EH. "Beyond the basics: Operating the new generation of ventilators". J Crit. Illness 7(5); pp.- 770-788, 1992.

12. Korst RJ, Orlando R, Yeston N, Molin M, DeGraff A, Gluck EH. "Validation of respiratory mechanics software in microprocessor controlled ventilators". CCM 20 (8) 1152-1156.

13. Gluck EH, Bone RC, Eubanks DH. "The technique of instituting mechanical ventilation"; 7(8):1319-1328, Journal of Crit III. 1992

14. Gluck EH. "Hospital emergency room treatment of acute exacerbations of asthma". Hospital Formulary (27) 1119-1130; November, 1992.

15. Gluck EH, Eubanks D, Bone RC. "Techniques for weaning a patient from mechanical ventilation". J of Crit Illness; 8(l):121-129; January, 1993.

16. Gluck EH, Heard S, Mohr J, Patel S, Calkins JM. "Ultra high frequency ventilation in the treatment of adults with severe ARDS - a preliminary report"; Chest; 103:1413; May, 1993.

17. Bone RC, McElwee NE, Eubanks DH, Gluck EH. "Analysis of indications for intensive care unit admission". Chest, 1993; 104:1806-11.

18. Bone RC, McElwee NE, Eubanks DH, Gluck EH. "Analysis of indications for early discharge from the intensive care unit". Chest 1993; 104:1812-17.

19. Franklin C, Gluck EH. "The assessment of new technology: who pays for it? Thorax; 48(7):721, July. 1993.

20. Gluck, EH, Barkoviak MJ, Balk R, Casey L, Silver M, Bone R; Medical effectiveness of esophageal balloon pressure manometry in weaning patients from mechanical ventilation: Crit Care Med; 23;504-509; March 1995

21. Gluck EH; Chaos in Research; Thorax; 49;713; July 1995

22. Gluck EH and Keogh B; Application of High Frequency Ventilation in Patients with Acute Respiratoy failure. Clinical Pulmonary Medicine; 1995;2(l):58-65.

23. Gluck EH and Corgian L; Predicting eventual success or failure to wean in patients receiving long term ventilation. Chest 1996; 110(4); 101 8-1024

24. Sorresso D, Wagner D, Gluck EH. Postoperative assessment and management of the pneumonectomy patient; Anesthesia Today; 1996; 7(2):14-17

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26. Gluck EH, Sorresso D. Critical Care of the Obsteric Patient. Hospital Physician; April 1998; 3: (1): 1-8.

27. Rodriquez, O, Gluck EH. Sandouk, A. Nosocomial infections in the intensive care unit. Hospital Physician, August 1998; 3: (3):1-12.

28. Samuel J, Gluck, EH, Upper Airway Obstruction.
Hospital Physician, September 1998: 3:(4)

29. Sorresso D, Gluck EH; Hemodynamic Monitoring in the Intensive Care Unit, Hosp Phys, Jan 1999; 4:(1)

30. Sorresso D, Khayr W, Gluck EH; Antibiotic Usage in the Intensive Care Unit, Hosp Phys, April 1999: 4:(2)

31. Sarrigiannidis A, Gluck EH; Update on Mechanical Ventilation in the Intensive Care Unit, Hosp Phys, Aug 1999; 4(3)

32. Gluck EH, McLean M; Ethics in the Intensive Care Unit, Hosp Phys, Dec 1999, 4(4)

33. Snyder R, Gluck EH; Gastrointestinal Diseases in the Intensive Care Unit, Hosp Phys, Feb 2000, 5(1)

34. SnyderR, GluckEH; Bridging to Organ Transplantation: Lung, Heart and Liver, Hosp Phys, Jan 2000, 5(2)

35. Lutchman D, Gluck EH; Neurologic Emergencies in the Intensive Care Unit; Hosp Phys, March 2000; 5(3)

36. Gluck EH: Ethics in the ICU: Hosp Phys April 2000 5(4)

37. Coulson S, Gluck EH, Acute Coronary Syndrome, Hosp Phys March 2001 6(1)

38. Dugan D, Gluck EH, Informed Consent in the ICU, Hosp Phys June 2001 6(2)

39. Dugan D. and Gluck EH, Discussing Life Sustaining Treatments: An Overview and Communications Guide for Primary Care Physicians. Comp Therapy; Spring 2004; Vol 30 (1); 25-36

40. Patel B, Sheridan P, Detjen P, Dnnersberger D, Gluck E, Malamut K, Whyte S, Miller A, Harshaw Q; Success of a comprehensive school based asthma intervention on clinical markers and resource utilization for inner city children with asthma in Chicago: the Mobile CARE Foundation's Asthma Management Program. J of Asthma; 2007; 44, 2, March;113-118

41. Procalcitonin Decrease Over 72 hours in US critical care units predicts fatal outcome in sepsis patients: Philipp Schuetz*[1], Paula Maurer[2], Vikas Punjabi[3], Ami Desai[3], Devendra N Amin#[2] and Eric Gluck#[3] *Critical Care* 2013, 17:R115

42. Real-world use of procalcitonin and other biomarkers among sepsis hospitalizations in the United States: A retrospective, observational study; Gluck EH, Nguyen B, Yalamanchelli K et al; Plos; Oct 17, 2018; https;//doi.org/10.1371/journal.pone.0205924

43. Procalcitonin(PCT) guided antibiotic stewardship: an international experts consensus on optimized clinical use: Philip Schuetz….Eric Howard Gluck….and Kordo Saeed. Clin Chem Lab med 2019; https://doi.org/10,1515/cclm-2018-1181

44.

Chapters and Reviews and Editorial Boards:

1. Endotracheal Intubation and Mechanical Ventilation Quick reference to Internal Medicine: Igaku Shoin, Ltd, New York: Bone R, Rosen R, Editors, 1994.

2. Trauma Management for the Internist: Quick Reference Textbook of Internal Medicine; lgaku Shoin, Ltd, New York: Bone R, Rosen R, Editors 1994

3. Mechanical Ventilation: Principles and Management of Critical Care Medicine: CV Mosby, Chicago: Parillo J, Bone R, Editors: (1995).

4. Non-traditional Mechanical Ventilation: Principles and application of respiratory care equipment: Mosby CV, Eubanks DH and Bone R, Editors, Chicago. May, 1994.

5. Year Book of Critical Care Medicine - Co- Editor 1992-1998, 2000

6. Year Book of Pulmonary Medicine - Co-Editor 1992-1995

7. Consulting Editor- Hospital Physician- Critical Care Medicine 1995-1998

8. High Frequency Ventilation - Acute Respiratory Distress in Adults; Evans T and Haslett C, Editors; Chapman and Hall Medical, London, UK. 1996

9. Series Editor- Hospital Physicians- Critical Care Medicine – Jan 1998 to present

10. Associate Editor - Audio Reviews - Chest Section. - Aug 1998 to present

11. Editor- Practical Reviews in Chest Medicine-Oakstone Medical Publishers, Brimingham Ala. Jan 2000 to present

12. Mechanical Ventilation: in Critical Care: Mosby, Gluck EH, Sarringainidis A, Dellinger P: Parillo and Dellinger editors: (2001)

13. Altered Mental Status: in Textbook of Neurointensive Care: Saunders, Philadelphia PA. Editors; Layon AJ, Gabrielli A and Friedman W.; 2004

DRUG RESEARCH
Eric Howard Gluck, M.D.

1982-1983	Co-investigator, Drug Study for Schering Corp., "A Multicenter Long Term Study Comparing the Safety and Efficacy of Albuterol Nebulizer solution 2.5 mg, with Isoproterenol Nebulizer Solution 2.5 mg Delivered by a Compressed-Air Powered Nebulizer to Reverse Bronchospasm".
1983-1984	Co-Investigator, Drug study for Schering Corp., "A Long-Term Study Comparing the Safety and Efficacy of Albuterol Nebulizer Solution, 2.5 mg Isoetharine Nebulizer Solution, 2.5 mg delivered by a compressor powered nebulizer to reverse bronchospasm".
1983-1984	Co-investigator, Drug study for Perdue-Frederick Co., Multi-Investigator open-label study of Uniphyl in patients with asthma, asthmatic-bronchitis or COPD.
1982	Co-Investigator, Drug study for Adria corp., "Early detection of Adriamycin toxicity".
1984	Co-investigator, Drug study for Warner-Lambert/ Parke-Davis Pharmaceutical Research Division, "The effect of sodium meclofenamate in premenstrual asthma".
1985-1986	Co-Investigator, Drug study for Schering Corp., “The effect of single doses of Labetalol and Atenolol on ventilatory function in patients with bronchial asthma”.
1985-1986	Co-Investigator, Drug study for Schering Corp., “Albuterol solution for inhalation in acute asthma”.
1985-1987	Co-Investigator, Drug study for Boehringer-Ingelheim Ltd., “Oxitropium bromide BA 253 90 day multicenter study”.
1985-1987	Co-Investigator, Drug study for Smith Kline and French Laboratories, “Comparative study of the safety and efficacy of monocid versus ceftriaxone for the treatment of community acquired lower respiratory tract infection in patients with chronic lung disease”.
1986-1987	Co-Investigator, Drug stuidy for Smith, Kline and French Laboratories, “Comparison of Tagamet and Placebo in the prophylaxis of Upper Gastrointestinal Bleeding due to Stress- Related Gastric Mucosal Damage”.
1987-1988	Investigator, Drug study for Cutter Biological “Intravenous Gamma Globulin in the treatment of steroid dependent asthma”.
1987-1988	Co-Investigator, Drug study for Schering Corp., “Study of the effects of adding proventil repetabs to theodur in patients with moderate to severe obstructive airway disease”.
1987-1988	Co-Investigator, Drug Study for Schering Corp., “Proventil solution for inhalation for home Use”.

1987	Co-Investigator, Drug Study for Carter-Wallace, Inc., Placebo controlled comparison of the effectiveness and safety of axelastine and controlled release theophylline in the management of theophylline dependent asthmatics".
1987-1989	Co-Investigator, Drug Study for Boehringer-Ingleheim Ltd., "Twelve-week, double blind, parallel study of atrovent solution in COPD patients who are on concurrent alupent therapy".
1988	Co-Investigator, Drug Study for Schering Corp., "Comparison of theodur 300 mg BID to 450 mg TID".
1988-1989	Co-Investigator, Drug Study for Nix-O-Tine Pharmaceuticals, "Efficacy and safety of repository corticotropin injection (NP0001) as an aid in smoking cessation".
1988	Co-Investigator, Drug Study for Pfizer Central Research, "Azithromycin in the treatment of acute lower respiratory tract infections
1989	Co-Investigator, Drug Study for G.D. Searle and Co., "A Multicenter comparison of the safety and efficacy of Lomefloxacin and Cefeclor in the treatment of acute exacerbation of chronic bronchitis".
1989	Co-Investigator, Drug Study for Boehringer-Ingleheim Ltd., "Multiple dose comparison of the combination of lpratropium and Albuterol with its components in a twelve-week parallel study in adults with chronic obstructive pulmonary disease (COPD)".

Exhibit 31

MELISSA PIASECKI, M.D.
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BOARD CERTIFIED IN PSYCHIATRY AND FORENSIC PSYCHIATRY

William R. Ragen
Supervisor- Medical Litigation
Civil Actions Bureau
Cook County State's Attorney's Office
1500 Richard Daley Center
Chicago, IL 60602

May 3, 2021

Re: Leticia Vargas (Est. Angel Cruz)

Case 18-cv-1865

Dear Mr. Ragen:

At your request, I reviewed documents related to Angel Cruz (DOB 5.31.95), with regards to the referral question below. To complete this report, I reviewed the following records:

Amended Complaint 18-cv-1865
Cook County Department of Corrections Policy I-01: Restraint and Seclusion, Posted: 3.14.16; 12.4.17
Cermack Health Services Medical records
Hinsdale Hospital Records
St. Anthony Hospital Records
Pathology report, T. Sozio, DO, 12.14.17
Countryside Police Department Incident report 49-16-01171

Deposition transcripts and associated exhibits:
Augustus Alabi, Dwight Anderson, Aiste Barkauskaite, Michale Campbell, Joel Costillo, Brian Crawford, Wanda Estes, Robert Guerra, Timothy Holtz, Anita Johnson, Helen Kanel, Cherri Krzyzowski, Leticia Varga, Manuel Manalastas, Pierre Nunuz, Steve Paschos, Jerrold Moth, Meghan Weger, Elizabeth Lassen and Hythem Zayed

Case Summary: Mr. Angel Cruz was a 20-year-old man who was admitted to the Cook County Department of Correction's Cermack Psychiatric Special Care Unit on 3.15.16 and who died on 3.20.16. Leticia Vargas, Mr. Cruz's mother and administrator of his estate, has filed a civil suit alleging, among other things, that Dr. Steve Paschos and other employees "failed to meet the standard of care by not administering an

anticoagulant prophylaxis, such as subcutaneous heparin, to prevent deep vein thrombosis while plaintiff was restrained." Mr. Cruz was under the care of Dr. Paschos from 3.15.16 until 3.19.16. Dr. Lassen, who worked on the weekend, cared for Mr. Cruz on 3.19.16.

Mr. Cruz was arrested on 3.12.16 and charged with attempted murder after stabbing his mother and stepfather. The day prior, he made nonsensical statements. At the time of his arrest, he made bizarre statements and was brought to a hospital for psychological evaluation. He was admitted to a local hospital (Adventist Hinsdale Hospital) with an encounter diagnosis of "Acute Febrile Illness, homicidal ideation, psychosis." During the hospitalization, Mr. Cruz "slammed" his body into a supervising police officer. He was placed in "violent" restraints, treated with psychiatric medications (Geodon, Haldol and Risperdal) and administered heparin at 0919 on 3.13.16. He was discharged around 0830 on 3.14.16 to the custody of police.

Following his admission to Cook County Department of Corrections on 3.15.16, Mr. Cruz was noted to be psychotic (hallucinations and delusions) and to have an elevated BMI of 41. He was admitted to the psychiatric unit (2 North), prescribed Risperdal 1 mg twice a day for treatment of psychotic symptoms, placed on Close Observation status with fifteen minute checks. Mr. Cruz demonstrated agitation, aggression and self-harm behaviors. On the evening of 3.16.16 he received an emergency dose of Haldol 5 mg IM and then slept.

On 3.17.16, Mr. Cruz was agitated, beating the cell door and naked. He attempted to push his way out of the cell and received emergency medication (intramuscular Thorazine, Ativan, Benadryl) at 15:39. Several hours later, he wrapped a blanket around his neck and smeared feces. He was placed in the therapeutic seclusion room and administered prn medication (intramuscular Thorazine, Ativan, Benadryl) at 20:15. He returned to a regular cell at 22:25.

Around 05:00 on 3.18.16, Mr. Cruz appeared to be responding to internal stimuli and was administered prn medication (intramuscular Thorazine, Ativan, Benadryl). That evening, his agitation escalated and he jumped off his bed and attempted to strike his head against the wall. At 18:00, he was placed in five point restraints and was administered prn medication at 18:15 (intramuscular Thorazine, Ativan, Benadryl), emergency medication at 19:27 (intramuscular Thorazine, Ativan, Benadryl) and prn Valium at 20:39. His regular dose of Risperdal was increased to 2 mg twice and day and administered with the Valium.

On 3.19.16 at 01:00 Mr. Cruz was administered emergency medication (intramuscular Thorazine, Ativan, Benadryl). A prn dose of Valium and the regular dose of Risperdal 2 mg were administered at 09:37. At 11:15 he was released from restraints. Mr. Cruz was in restraints for 17 hours and 22 minutes. During this period he was offered fluids, had his vital signs monitored and had his limbs periodically released for range of motion exercises (3/19 at 00:39, 04:22, 07:55). Mr. Cruz's vital signs remained normal.

Mr. Cruz was agitated at 21:43. He was observed banging his head and had labored breathing. He received intramuscular Thorazine, Ativan and Benadryl. By 23:57, he appeared to be sleeping. On 3.20.16 at 02:35, Mr. Cruz was observed standing naked and asking for help, and then laid down. At 02:45 Mr. Cruz fell and was found lying unresponsive in a puddle of body fluids. At 02:54 a Code Blue was called and emergency responders arrived at 03:00. Mr. Cruz was transported to St. Anthony Hospital, where he died at 04:08. A pathology report indicated that the cause of death was a pulmonary embolism.

Referral Question: Did Dr. Paschos and Dr. Lassen meet the standard of care in the treatment of Mr. Cruz during the period 3.18.16- 3.19.21?

I offer my opinion to a reasonable degree of medical certainty:

Dr. Paschos and Dr. Lassen adhered to the standard of care in his care of Mr. Cruz. This finding is based on the following:

1. Dr. P Paschos's and Dr. Lassen's orders for use of restraints followed best practices and standard of care as follows:

A. Less restrictive approaches (verbal, environmental and pharmacologic) were attempted prior to use of restraints.
B. The use of restraints was clinically indicated. Mr. Cruz demonstrated clear signs of imminent and significant danger of self-harm by jumping off his bed, repeatedly hitting his head and smearing feces.
C. The period of restraint occurred in a medical setting where nurses provided 24 hour care to inmates.
D. Mr. Cruz was placed on a specialty bed during the period of restraint.
E. Dr. Paschos was present and assessed Mr. Cruz at the time the restraints were placed.
F. An on-call medical provider was available by phone for consultation at all times.
G. All professionals involved in placing Mr. Cruz into restraints were trained in the use of restraints.
H. Each physician order for restraints was for a maximum duration of four hours.
I. Mr. Cruz's Restraints were discontinued as soon as safely possible.
J. Mr. Cruz had regular monitoring by nursing and correctional staff throughout the period of restraint. He was monitored for overall wellbeing, circulation, skin integrity, application of restraints and vital signs.
K. Mr. Cruz was offered liquids, food and restroom throughout the period of restraint.

2. Anticoagulation carried significant risks and unclear benefits for Mr. Cruz. Dr. Paschos and Dr. Keller did not order anticoagulant medications for Mr. Cruz when he was restrained. Not using anticoagulant medication for this patient represented appropriate clinical judgment supported by risk-benefit analyses. The use of close, monitoring, hydration and range of motion exercises were clinically appropriate measures used by Mr. Cruz's care team to reduce the risk of potential complications of

restraint use.

A. Mr. Cruz was observed to have a high level of agitation with risk of physical injury. According to medical records, he was banging his head, beating fists on the cell door and floor, thrashing, jumping off his bed in attempts to hit his head against the wall and pushing against correctional officers when his cell door was opened. He was at high risk for resuming these or similar behaviors that could lead to significant impact and injury. Anticoagulation with a medication such as heparin would have significantly elevated his risk of bleeding, including an intracranial bleed, if he resumed these behaviors.

B. Published research literature on restrained psychiatric patients indicates that the use of anticoagulation for prophylaxis of thrombosis is not supported by evidence of effectiveness. Researchers have found that restrained patients without anticoagulation had no increased incidence of clotting compared to similar patients who received anticoagulants. In a highly agitated patient, the risks of bleeding complications from anticoagulation are prominent and outweigh any identifiable benefits.

Statement of Compensation:

The Cook County State's Attorney's Office and I have an agreement for a hourly rate of $400/hour.

Please contact me if you have any questions about this report.

Sincerely,

Melissa Piasecki, M.D.

Curriculum Vitae

MELISSA PIASECKI, M.D.
Forensic Psychiatry
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BOARD CERTIFIED IN PSYCHIATRY AND FORENSIC PSYCHIATRY

Please note that Dr. Piasecki is not acting in the name of any academic institution when she provides forensic services.

Current Position: University of Nevada, Reno School of Medicine:

2015—present	Executive Associate Dean
2012—2019	Senior Associate Dean, Office of Academic Affairs
2008— 2012	Associate Dean, Office of Faculty Affairs and Development
2007— 2008	Assistant Dean for Faculty Development
1995—present	Academic Appointments at University of Nevada, Reno School of Medicine —Assistant Professor of Psychiatry (1995) —Associate Professor of Psychiatry with Tenure (2002) —Professor of Psychiatry (2008)

Other Academic Affiliations:

2005—present	Clinical Professor in Psychiatry, University of Hawai'i, John A. Burns School of Medicine
2005—present	Faculty, National Judicial College
2005—present	Faculty, National Council of Juvenile and Family Court Judges

Education:

Post Graduate:

2004—2005	Fellowship in Forensic Psychiatry University of Hawai'i School of Medicine
1991—1995	University of Vermont, Burlington, Vermont General Psychiatry Residency
1994—1995	Chief Resident

Medical School:

1987—1991	Washington University School of Medicine in St. Louis —M.D. 1991 —Alpha Omega Alpha

Undergraduate:

1983—1987	Washington University in St. Louis —Bachelor of Arts, 1987 —Scholar's Program in Medicine (combined undergraduate and medical school admission, 1983) —Phi Beta Kappa

Certification:

1992	Diplomate of the National Board of Medical Examiners
1997	American Board of Psychiatry and Neurology Certification General Psychiatry (expiration 2027)
2007	American Board of Psychiatry and Neurology Certification Forensic Psychiatry (expiration 2027)

Active Licensure:

Nevada #7478
Hawaii #MD12982

Memberships:

American Psychiatric Association
American Academy of Psychiatry and the Law
Gold Foundation Honor Society, Inducted 2009

Teaching Awards:

1995 Medical Student Teaching Award for Residents

1999 Tenth Annual Nancy Roeske Certificate for Excellence in Medical Education (American Psychiatric Association)

1999 Junior Faculty Development Award, Association for Academic Psychiatry

1999 Department of Psychiatry Residents' Faculty Teaching Award

1999 Teacher of the Year, Region X, Association for Academic Psychiatry

2000 University of Nevada, Reno School of Medicine's E.W. Richardson Excellence in Teaching Award

2002 Outstanding Full-time Clinical Teacher Award, University of Nevada School of Medicine Class of 2002

2004 Outstanding Full-Time Clinical Teacher Award, University of Nevada School of Medicine Class of 2004

Regular Teaching Activities:

Medical Students

1995—2010	Clerkship in Psychiatry, Director, Supervisor, Instructor, Examiner
1995—2010	Electives in Psychiatry, Director
1995—2010	Introduction to Patient Care, small group leader MS1and MS2
1995—2012	Human Behavior: Instructor, small group leader, oral examiner MS1
1997—2002	Psychiatric Medicine Course Director and Instructor MS2

1997—present	Medical Neuroscience Complex Brain Function, Instructor MS1
1997—2012	Med 610 Teaching and Learning in Medicine, Instructor MS4
2003—2012	Psychiatric Medicine Instructor

Physician Assistant Students

2018-present	Psychopharmacology, Professional Development

Law Students

2016—present	Guest Instructor, University of Nevada Las Vegas Boyd School of Law (Immigration Law, Mental Health Law, Psychology and Law)

Residents

1995—present	Resident Seminars in Geriatric Psychiatry Psychopharmacology, Mood and Psychotic Disorders, Teaching Medical Students, Neuroscience of Emotions and Sexuality, Psychiatry and Civil Rights; Coordinator for Psychopathology seminar series (2004), Forensic Psychiatry seminar series (2006-present), and Psychopharmacology series (2007-2011)
1995—2019	Resident Supervision: Consultation Liaison Psychiatry
1995—1999	Coordinator, Departmental Journal Club

Other

1997—2018	Doctoral Dissertation Committees (Departments of Psychology, Social Psychology)
2000	Guest Instructor, Undergraduate Psychology Course
2017-present	Guest Instructor, Undergraduate SCI 120

Clinical and Forensic Activities:

1992—1995	Vermont State Hospital; Waterbury, VT
1994—1995	Champlain Valley Physician's Hospital; Plattsburgh, NY
1994—1995	Psychiatric Consultant, Northwest Regional Correctional Facility; St. Albans, VT
1995—2010	Outpatient Private Practice, University Health Systems, Reno, Nevada
1995—2002	Outpatient Psychiatry, Nevada Rural Clinics
1995—2004	Inpatient Psychiatry, Sierra Nevada Veterans Affairs Medical Center, Reno, Nevada
1995—2001	Department of Probation and Parole, Reno, Nevada
1998—present	Consultation-Liaison Psychiatry, Renown Medical Center, Reno, Nevada
1998—2009	Consultant, Washoe County Detention Facility
2005—present	Consultant Nevada State Board Medical Examiners
2006—2019	Court Appointed Evaluator, Washoe County Commitment Court, Sparks, NV
2012 -present	Consultant Nevada State Board Veterinary Medical Examiners
2012—present	Consultant Nevada State Board of Osteopathic Medicine
2013—present	Board of Examiners for Social Workers
2014—2020	Consultant to the Department of Justice, Office of Civil Rights
2014—2015	Consultant to State of Alaska; Review Mental Health Statutes

2016—2019 Expert Consultant to Monitor, *Franco v. Holder*

Selected Presentations:

For Legal Professionals:

"Alternatives to Juvenile Detention in Rural Communities," Workshop Sponsored by National Council Juvenile and Family Court Judges, Redding, CA 11.05

"Attorney Stress and Burnout," Washoe County Public Defenders, Reno, NV, 4.06.

"Psychiatric Diagnosis and Not Guilty by Reason of Insanity," Nevada Bar Association, Reno and Las Vegas, NV, 4.06.

"Methamphetamine in Tribal Lands," National Council of Juvenile and Family Court Judges, Annual Conference Milwaukee, WI, 7.06.

"Assessment and Treatment Alternatives for Addictions," National Council of Juvenile and Family Court Judges, Reno, NV, 9.06.

"Understanding Methamphetamine," National Council Women Judges, Las Vegas, NV, 10.06.

"Assessments for Dangerousness," Nevada Bar Association, Las Vegas and Reno, NV, 11.06.

"Methamphetamine: Science and Ceremony," with Richard Laughter, M.D., Navajo Tribal Judges, Window Rock, AZ, 12.06.

"Psychiatric Disabilities," National Judicial College, Reno NV, 10.05, 10.06, 6.07.

"Essentials of DUI," National Judicial College, Reno, Nevada, 2006 and 2007

"Pre and Post-Conviction Matters" National Judicial College, Reno, Nevada, 2007

"Substance Abuse and the Adolescent Brain," National Council of Juvenile and Family Court Judges, Fall College Reno, NV, 9.07.

"Mental Retardation in Capital Cases," Nebraska District Court Judges, Omaha, Nebraska, 8.07.

"Mentally Ill Youth in the Justice System," National Meeting Juvenile Probation Officers, Albuquerque, NM, 9.07.

"Understanding Mental Retardation in Capital Cases," Louisiana State Judicial Conference, Lafayette, LA, 4.08., Alabama State Judicial Conference, Orange Beach, AL, 9.08.

"The Many Faces of Malingering," State Bar of Nevada Annual Meeting, Santa Barbara, CA, 6.08.

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"Persuasive Use of teaching Technology," Nevada Bar Association, Reno and Las Vegas, NV, 11.08.

"Mental Retardation and Risk Assessment in Capital Cases," Managing the Capital Case in Virgina, Richmond, VA, 2.09.

"Adolescent Brain Development: A Field Guide for Juvenile Justice Professionals," Keynote, 36th National Conference on Juvenile Justice, National Council of Juvenile and Family Court Judges, Orlando, FL, 3.09.

"Competency for Immigration Hearings," Department of Justice, Executive Office of Immigration Review Legal Training Conference, Washington D.C., 8.09.

"Driving Under the Influence," Arkansas AOC Impaired Driving Case Fundamentals, Eureka Springs, AR, 9.09.

"Mental Retardation in Capital Cases," Best practices in managing capital cases, National Judicial College, Oklahoma City, OK 8.09, Birmingham, AL, 10.09.

"Managing Sex Offenders," Judicial Council of California - Administrative Office of the Courts, Winter Judicial Education Program, San Francisco, CA, 1.10.

"Mental Health Law," Grant Sawyer Center for Justice Studies Judicial degree program, Reno, NV, 1.10.

"A Methamphetamine Primer for Legal Professionals," CACJ Conference, Monterey, CA, 2.10.

"Substances and the Adolescent Brain: A Field Guide for Judges," 37th National Conference on Juvenile Justice, National Council of Juvenile and Family Court Judges, Las Vegas, NV, 3.10.

"Impaired Driving Case Essentials: Drugs and Alcohol," National Judicial College, Albuquerque, NM, 7.10.

"Immigration Competency," Department of Justice, Executive Office of Immigration Review Legal Training Conference, Washington D.C., 7.10.

"Addiction: Updates and Strategies," National Judicial College, Special Courts, Reno, NV, 8.10.

"*What were you thinking*? Adolescent Brains and Behavior," Fall College, National Council of Juvenile and Family Court Judges, Reno, NV, 9.10.

"Understanding Psychiatric Diagnosis," Alaska Bar Association Meeting, Anchorage, AK, 10.10.

"Methamphetamine: Short and Long Term Impact on the Brain and Behavior," FDSI Conference, Boise, ID, 10.10.

"Updates on Sex Offender Assessment," Nevada State Public Defender's Office, Carson City, NV, 12.10.

"What Reseach Tells Us About Sex Offenders," (Webinar) National Judicial College, Reno, NV, 1.11.

"Mental Health Trends in Child Psychiatry," Washoe County Public Defender & Washoe County Dept. of Social Services, Reno, NV, 1.11.

"Assessing Treatment Recommendations," Washoe County Public Defender & Washoe County Dept. of Social Services, Reno, NV, 1.11.

"*You Did What?* Understanding the Adolescent Brain and Substance Abuse," 38th National Conference on Juvenile Justice, National Council of Juvenile and Family Court Judges, Reno, NV, 3.11.

"Trends in Child Psychiatry: Risks and Benefits of New Medications," 38th National Conference on Juvenile Justice, National Council of Juvenile and Family Court Judges, Reno, NV, 3.11.

"Co-Occurring Disorders," Alaska Bar Association Annual Meeting, Fairbanks, AK, 4.11.

"12 Step Programs," "Competency Evaluations and Reports," and Mock Competency Hearing," National Judicial College Course on Co-Occurring Mental and Substance Use Disorders, Reno, NV, 5.11.

"Managing the Capital Case in Oklahoma," National Judicial College, Oklahoma City, OK, 6.11.

"Advanced PowerPoint," Workshop with J. Sawyer, State Bar of Nevada, Las Vegas, NV and Reno, NV, 6.11.

"Co-Occurring Disorders," Court Improvement Conference, Reno, NV, 7.11.

"Impaired Driving for Arkansas," National Judicial College, Little Rock, AK, 7.11.

"Behavioral Science Evidence," National Judicial College Course on Scientific Evidence and Expert Testimony, Reno, NV, 8.11.

"Pharmacological Effects of Drugs and Alcohol," National Judicial College, Reno, NV, 8.11

"Mental Retardation," National Judicial College Course on Capital Cases for Appellate Judges, Reno, NV, 8.11.

"Impaired Driving Essentials," National Judicial College/ Arkansas Judicial Education Center, Hot Springs, AR, 9.11.

"What Research Tells Us About Sex Offenders," (Webinar) National Judicial College, Reno, NV, 10.2011

"New York: Sex Offender and Victim Issues," (Webinar) with Hon. J. McCarthy, National Judicial College, Reno, NV, 11.11.

"Mental Health Injuries," National Business Institute, Anatomy and Physiology 101 for Attorneys, Las Vegas, NV, 11.11.

"Mental Retardation in Capital Cases," (Webinar) Appellate Courts, National Judicial College, Reno, NV 5.12.

"Mental Health Issues in a Legal Setting," University of Nevada Reno (Judicial Studies Program), Reno, NV 1.13.

"The Adolescent Brain- Culpability and Competency," National Council of Juvenile and Family Court Judges, Reno, NV 4.13.

"Drugged Driving Essentials for New Mexico Municipal Court Judges," National Judicial College, Albuquerque, NM, 5.2013.

"Designer Drugs," National Conference on Juvenile Justice, National Council of Juvenile and Family Court Judges, Seattle, WA, 7.13.

National Judicial College Symposium, Reno, NV, 9.13.

"Understanding Co-Occurring Mental and Substance Abuse Disorders," Webcast, National Judicial College, Reno, NV, 9.13.

"Substance Abuse in the Legal Profession and the Affordable Care Act: Clinical and Legal Issues," with Stacey Torvino, J.D., Ph.D. and Chad Cross Ph.D.UNLV, Boyd School of Law, Las Vegas, NV, 11.13.

"Addiction, Behavior and the Brain," with Julie Brain, CACJ/ CPDA Capital Case Defense Seminar, 2.14.

"Understanding Addiction," Ely Family Law Conference, 3.14.

"Mental State at the Time of the Crime," UNLV Boyd School of Law Faculty Conference Series, Las Vegas, NV, 3.14.

"Scientific Evidence and Expert Testimony," National Judicial College Reno, NV, 5.14.

Panel Moderator Interprofessional Symposium on Health Care Disparities, UNLV Boyd School of Law, Las Vegas, NV, 4.14.

"Advanced Issues Involving Co-Occurring Disorders," National Judicial College Reno, NV, 9.14.

"Risk Factors for Prescription Drug Addiction," Nevada HIDTA Summit, Las Vegas, NV, 12.14.

"The Science of Substance Abuse," Nevada Legal Services, Las Vegas, NV and Reno, NV, 12.2014.

"Inteprofessional Panel of Health Care Workforce Issues," Panelist with F. Marouf, and V. Carreon, UNLV Boyd School of Law, Las Vegas, NV, 2.15.

"Understanding Your Client's Addiction," CACJ/ CPDA Capital Case Defense Seminar, 2.15; NDIA, 4.15.

"History of Opioid Substitution," Southern Association for the History of Medicine and Science, Boyd School of Law, Las Vegas, NV, 3.16.

Annual Meeting, National Council of Juvenile and Family Court Judges, Las Vegas, NV, 3.16.

"Pharmacology of Drugs and Alcohol," National Judicial College Reno, NV, 5.2016, 7.16.

"Advanced Issues in Cases Involving Co-Occurring Mental Health & Substance Abuse Disorders," National Judicial College Reno, NV, 8.16.

"The Opioid Crisis," (Panel), National Judicial College, Las Vegas, NV, 10.16.

"Judicial Bias," Joint Military Judges Training, Tampa, FL, 2.17.

"The Balance, "Nevada Legal Services' Children's Law Conference, Incline Village, NV, 4.17.

"Mental Health Matters," State Bar of Nevada, Reno, NV, 5.17.

"The Top 10 Risk Factors for Substance Abuse," Advisory Council for Prosecuting Attormeys Annual Conference, Laughlin, NV, 9.17.

"Risk Factors for Substance Use in Legal Professionals and What to do About Them", Nevada Population Health Conference, United Health, 12.17.

"Balancing Client Representation and Attorney Wellbeing," Second Annual Children's Law Conference, Reno, NV, 9.18.

"Complex Care Needs: Outcomes and Impact of Treatment Timing and Dosage," (Panel Presentation), American Society Bioethics and Health,

Annual Meeting, Anaheim, CA, 10.18

"Immigration Law and Mental Health," Guest Lecturer, UNLV Boyd School of Law, 10.18

"Managing Challenging Family Law Cases: Substance Abuse and Co-Occurring Disorders," National Judicial College and National Council for Juvenile and Family Court Justice, Reno, NV 10.18

"Traffic Issues in the 21st Century: Pharmacology of Drugs and Alcohol," National Judicial College, Reno, NV, 10.18

"The Sprawl of Adverse Childhood Experiences." Forensic Mental Health Association of California, Annual Meeting, Monterey, CA, 3.19

"Mapping Risk Factors to Interventions for Change," Illinois Probation and Parole 2019 Spring Training Conference, Moline, IL, 4.19

"Pharmacology of Drug and Alcohol Use," Indiana Spring Judicial Conference, Indianapolis, IN, 5.19

"What's on the Menu? Evidence-Based Options to Support Professional Wellness," National TASC Annual Meeting, Cleveland, OH, 5.19

"Pharmacology of Drugs and Alcohol," Impaired Driving Case Essentials, National Judicial College, Reno, NV, 6.19

"Wellness is a Behavior," American Correctional Association Annual Meeting, Boston, MA, 8.19

"Behavior Change in Community Corrections," American Probation and Parole Association, Annual Meeting, SanFrancisco, CA, 8.19

"Pharmacology of Drug and Alcohol Use," Special Topics for Arkansas Administrative Offuce of the Courts, Little Rock, AK, 9.19

"Addiction Essentials," Indiana City and Town Court Annual Conference, Indianapolis, IN, 10.19

"How Could I Ever Forget? Secondary Trauma in Legal Professionals," Annual Meeting of the National Asian Pacific American Bar Association, Austin, TX, 11.19

"Police De-Escalation: Reducing Force and Building Community Trust." Panel Discussant, Sponsored by UNLV Boyd School of Law, Las Vegas, NV, 11.19

"Mental Health Law," Grant Sawyer Center for Justice Studies Judicial degree program, Reno, NV, 1.10.20

"Pharmacology and Toxicology," Drugged Driving Essential, National Judicial College, Reno, NV, 9.15.20

"Sentencing: Mental Health Issues," Nevada Appellate Courts Distance Education, 9.16.20.

Piasecki, M. "Co-Occurring Conditions" Managing Challenging Family Law Cases, National Council for Juvenile and Family Court Justice 10.20.20

Piasecki, M. "Implicit Attitudes and Bias." UNLV, Boyd School of Law 10.23.20

Piasecki, M "Judicial Wellness and Resilience During COVID-19," General Jurisdiction Course, Nevada Judicial College 10.26.20

Piasecki, M. "Co-Occurring Conditions: Mental and Substance Use Disorders." General Jurisdiction Course, Nevada Judicial College 10.27.20

Piasecki, M.: "Avoiding Burnout During COVID- What's At Stake for Attorneys?" Nevada State Bar 10.27.20

Piasecki, M, Floerke, S. "Ethics of Bias, Burnout and Self Care." Nevada Judicial College 2.2.21

Piasecki, M., Godoy, T. "Decoding Medical Records." Office of Missouri State Public Defender 2.2.21

Haslem, H. and Piasecki, M, "Addressing Burnout During Times of Uncertainty." Forensic Mental Health Association of California, Annual Meeting (virtual), 4.1.21

<u>For Medical, Medical Education and Mental Health Professionals</u>:

"Mixed Anxiety and Depression" at Depression Awareness Recognition and Treatment (DART) Conference, Stowe, VT, 1994.

"P450 Drug Interactions." University of Nevada Family Medicine Residency, Reno, NV, 1995.

"Anxiety in Geriatric Patients" Veterans Administration Medical Center, Reno, NV, 1996.

"Antidepressant Medications: Their Potential for Toxicity," Convention of the American Association of Applied and Preventative Psychology, University of Nevada, Reno, NV, 1996.

"Nicotine and Psychiatric Illness," University of Nevada, Reno School of Medicine Department of Psychiatry Grand Rounds, Reno, NV, 8.97.

"Depression in Primary Care," Carson Tahoe Hospital, Carson City, NV, 11.97.

"Pathological Gambling," American Medical Student Association Regional Conference, Sparks, NV, 10.97

"Nicotine and Psychiatric Illness," Nevada Mental Health Institute, Sparks, NV, 1.98.

"Bipolar Disorder and Look-Alikes," Carson Tahoe Hospital, Carson City, NV, 6.98.

"Treatment of Psychosis," Nevada Association of Family Practice, Annual Meeting, Lake Tahoe, NV, 2.99.

"Psychopharmacology in Women," First Lady's Conference on Women's Health, Las Vegas, NV, 9.99.

"Psychotropic Drug Interactions," Nevada Mental Health Institute, Sparks, NV, 10.99.

"Social Phobia," Nevada Association for Physician Assistants, Reno, NV, 11.99.

"Dopaminergic Agents for Depression," Nellis Hospital Department of Primary Care, Las Vegas, NV, 2.99.

"Smoking Cessation," University Medical Center, Las Vegas, NV 8.99

"What's New in Psychopharmacology," Vocational Rehabilitation, Reno, NV, 5.00.

"The Teaching Portfolio," Workshop, Association for Academic Psychiatry Meeting, Taos, NM, 10.00.

"Assessment of Suicide Risk," Elko General Hospital, Elko, NV, 10.00.

"Clinician-Patient Communications," Workshop with Kohlenberg, K., University of Nevada, Reno School of Medicine Psychiatry Resident Retreat, Reno, NV, 11.00.

"Evaluations of Not Guilty by Reason of Insanity," Workshop Nevada Division of Mental Health and Developmental Services, Reno and Las Vegas, NV, 11.05.

"NGRI and Antisocial Personality Disorder: A Challenge to State Hospitals," American Academy of Psychiatry and the Law Annual Meeting, Montreal, QC, Canada, 10.05.

"Prescription Drug Abuse," Workshops sponsored by the Nevada Bureau of Alcohol and Drug Treatment, Reno and Las Vegas, NV, 7.2005, 6.2006.

"Neuroscience of Addiction," Two Day Workshop Co-sponsored by Center for Substance Abuse Technology , Las Vegas, NV, 4.2006 and Phoenix, AZ, 3.07.

"Psychiatric and Legal Aspects of Methamphetamine," Northern Nevada Adult Mental Health Systems, Sparks, NV, 5.06.

"Correctional Psychiatry," CME Course American Psychiatric Association Annual Meetings, Co-Director Toronto, Canada, 5.06; Course Director San Diego, CA, 5.07.

"Methamphetamine: Science and Ceremony," with Richard laughter, M.D., Center for Substance Abuse Technology , Native American Consortium, Reno, NV, 11.06, Reno and Las Vegas, NV 6.07.

"Using Digital Video in Problem Based Learning," (Workshop) With Kohlenberg, B., Kha, M., Shull, J. and Matuzak, J. WGEA, Honolulu, HI, 4.07.

"Forensic Aspects of Antipsychotic Use," University of Nevada, Reno School of Medicine, Atypical Antipsychotics, Statewide CME Event, (Program Chair) Reno and Las Vegas, NV, 5.07.

"Capacity," Renown Medical Center CME Program, Reno, NV, 5.07.

"Forensic Aspects of Child Abuse," Queen's Hospital, Bangkok, Thailand, 11.07.

"Co-Occuring Disorders," Center for Application of Substance Abuse Technology, Reno and Las Vegas, NV, 2.08.

"Finding the Right Words: How to Document Professionalism Behaviors," Workshop with Dupey, P., Gillis, M., Hug-English, C., Jacobs, N.N., Western Group Educational Affairs annual meeting, Asilomar, CA, 4/08; American Association of Medical Colleges national meeting, San Antonio, TX, 11.08.

"Malpractice Stress," Nevada Independent Doctors Insurance Exchange, Las Vegas, NV, 4.08.

"Negotiation Skills for Faculty," Co-Facilitator with Andreea Seritan, M.D. University of Nevada, Reno School of Medicine, Reno, NV, 8.08.

"Crafting the Conversation: Faculty Feedback of Student Professionalism," Workshop Piasecki, M., Dupey, P., Gillis, M., Hug-English, C., Jacobs, N.N., Kuhls, D., Trong, H. Western Group Educational Affairs annual meeting, Santa Fe, NM, 4.09.

"Developing a case-based program addressing errors in reasoning in child and adolescent psychiatry," with M. Gillis, PhD. Annual Meeting Association for the Advancement of Philosophy and Psychiatry, San Francisco, CA, 5.09.

"Critical Tools for Psychiatrists: Borrowing From the Forensic Toolbox," U.S. Psychiatric and Mental Health Congress, Las Vegas, NV, 11.09.

"Post Traumatic Stress Disorder," International Conference: Military Medicine and Disaster, Phramongkutklao Hospital, Bangkok, Thailand, 11.00.

"Teaching Medical Professionalism: Using Technology to Create Tools," 10thThai Medical Education Conference, Phramongkutklao Hospital Bangkok, Thailand, 11.09.

"Essential Skills in Medical Education," 10thThai Medical Education Conference, Phramongkutklao Hospital Bangkok, Thailand, 11.09.

"Malpractice Myths and Evidence," Nevada Psychiatric Association Annual Meeting, Las Vegas, NV, 2.10.

"Medication Assisted Treatment," Center for the Application of Substance Abuse Technology workshop, Reno and Las Vegas, NV, 3.10.

"Six Easy Steps to Effective Feedback: A Guide for Addressing Professionalism Lapses," Piasecki, M., Dupey, P., Gillis, M., Hug-English, C., Jacobs, N.N., Kuhls, D., Trong, H. Western Group Educational Affairs annual meeting, Asilomar, CA, 4.10.

Visiting Professor, Tripler Army Medical Center, Department of Psychiatry, (Topics in Medical Student and Resident Education) Honolulu, HI, 9.10.

"Psychiatric Risk Assessment," Grand Rounds, Tripler Army Medical Center, Department of Psychiatry, Honolulu, HI, 9.10.

"Axis II Blues: Personality Disorders," Nevada Department of Vocational Rehabilitation Annual Meeting, Reno, NV, 9.10.

"DSM-IV: Friend or Foe?" Center for the Application of Substance Abuse Technology workshop, Reno and Las Vegas, NV, 11.10.

Visiting Professor, Khon Kaen University, Department of Psychiatry, (Topics in Medical Education and Forensic Psychiatry), Khon Kaen, Thailand, 1.2011.

"Medical Education in Psychiatry," Faculty of Medical Sciences, National University of Laos, Vientiane, Lao People's Democratic Republic, 1.11.

"Legal 2000 Updates," In-service, Northern Nevada Medical Center, Sparks, NV, 2.11.

"Ethical Issues in Informed Consent," Internal Medicine Updates, University of Nevada, Reno School of Medicine, Las Vegas, NV, 5.11.

"Teaching and Assessing Professionalism in Medical Education," 72nd Thai Congress of Pediatrics, Bangkok, Thailand, 10.11.

"In the Wake of War: Understanding the PTSD-Violence Connection in Veterans of Recent Wars," U.S. Psychiatric and Mental Health Congress, Las Vegas, NV, 11.11.

"From Sign-outs to Hand-offs: Risky Business for Busy Residents," M. Bar-on, M. Piasecki and S. Wahi-Guruaj, AAMC Annual Meeting, Denver, CO, 11.11.

"Addiction: New Frontiers," Center for the Application of Substance Abuse Technology, Reno, NV, 11.11.

"Informed Consent and Monitoring of Psychiatric Medications:
Beyond The Medical Visit," Roitman, N., Kalinowski, C., Piasecki, M., Clark County Department of Family Services, Las Vegas, NV, 11.11, 12.11.

"Legal 2000 for Health Care Professionals," CME Webinar to rural Nevada sites, Rural Access/ Office of Continuing Medical Education, Reno, NV, 12.11.

"Trends of Psychotropic Medications Use in Children- What You Need to Know," CAN Prevention Conference, Reno, NV, 4.12.

"Drugs, Alcohol and Dementia in the Baby Boomer Generation," Washoe County Guardian Conference, Reno, NV, 3.12.

"Does methamphetamine cause brain damage?" Nevada DETR conference, Reno, NV, 9.12.

"Opioid Risk Management," IND Annual Training, Las Vegas, NV, 4.12 and 11.12; Reno, NV, 10.12.

"The utility of Mixed-Trial Implicit Relational Assessment Procedure (MT-IRAP) for decision making in organizations," Smith, G. S., Houmanfar, R., Reimer, D., Piasecki, M., Shonkwiler, G., & Jacobs, N. N**.**, R. Houmanfar (Chair). The role of communication and verbal networks in organizational change. Symposium conducted at the Organizational Behavior Management Network, Garden Grove, CA, 2.13.

"The Insanity Plea: Mental State at the Time of the Crime," Department of Psychiatry Grand Rounds, University of Nevada, Reno School of Medicine, Reno, NV, 4.13.

"Implementation of a Mixed Trial-Implicit Relational Assessment Procedure (MT-IRAP) in medical education". Smith, G. S., Jacobs, N.N**.,** Houmanfar, R., Piasecki, M., Shonkwiler, G., and Tolles, R. Paper presented at the Association of American Medical Colleges, Western Group on Educational Affairs, Irvine, CA, 4.13.

"A behavioral systems analysis of collaborative leadership during curricular restructuring at the University of Nevada, Reno School of Medicine: A story of faculty engagement and growth," Houmanfar, R., Piasecki, M., Shonkwiler, G.,

Remier, D., Jacobs, N.N and Tolles, R. Paper presented at the Association of American Medical Colleges, Western Group on Educational Affairs, Irvine, CA, 4.13.

"The Role of MT-IRAP as an Assessment Tool in the Design of Training Program in Medical School," Smith, G., Houmanfar, R., Shonkwiler, G., Jacobs, N.N**.,** Tolles, R. & Piasecki, M. Paper presented at the Association for Behavior Analysis International (ABAI) 39th Annual Convention; Minneapolis, MN, 5.13.

"DSM 5 Classification, Criteria and Use," Panel Presentation, University of Nevada, Reno School of Medicine, Reno, NV, 8.13.

"Behavioral Systems Analysis to Inform Faculty Development," with J. Hagen et al, Group on Faculty Affairs Annual Meeting, Minneapolis, MN, 8.13.

"Culture Change in a Medical School: The Role of Behavioral Assessments," T. Schwenk, M. Piasecki, T. Baker. Skinner lecture, Association for Behavioral Analysis International, Annual Meeting, Chicago, IL, 5.14.

"Create, Adapt, Adopt: The Customized Adoption of the Association of American Medical College's Faculty Forward Survey," with J. Hagen et al. Association for Behavioral Analysis International, Annual Meeting, Chicago, IL, 5.14.

"Sharing Sensitive Data: Tools and Strategies," with J. Hagen et al, Group on Faculty Affairs 2014 Annual Meeting, Boston. MA, 7.14.

"What's New in Psychiatric Diagnosis?" Vocational Rehabilitation Annual Conference, Reno, NV, 9.14.

"Psychiatric Workforce in Nevada," UNLV-UNSOM Interprofessional Health Equity Symposium, Las Vegas, NV, 10.14.

"Mental Health Care, Immigration Detention and Deportation: Ethical, Clinical and Legal Issues," American Society for Bioethics and Humanities Annual Meeting, San Diego, CA, 10.14.

"The Ethics of Pro-Se Competency in Immigration Proceedings," American Academy of Psychiatry and the Law Annual Meeting, Chicago, IL, 10.14.

"Fitnss for Duty Evaluations for Pilots: FAA Standards,"American Academy of Psychiatry and the Law Annual Meeting, Chicago, IL, 10.14.

"Boundaries in the Digital Age," Update on Psychiatry, University of Arizona, Tucson, AZ 2.2015; Renown Medical Center, Reno, NV, 5.15.

"Collaborative Learning and Mental Health Law Reform in Alaska," Health Law Professor's Conference, American Society if Law, Medicine and Ethics, St. Louis, MO, 6.15.

"Project ECHO for Connected Care," Hitachi Social Innovation Forum, Connected Care: Advancing Healthcare through Social Innovation, Las Vegas, NV, 4.16.

Smith, G., Brayko, C., Kuhls, D. A., Jacobs, N., Houmanfar, R., Piasecki, M. P., "Assessing implicit attitudes of burnout among medical students," AAMC WGEA Tucson, AZ, 4.16.

Jacobs, N., Baker, T., Smith, G., Candido, A., Houmanfar, R., Kuhls, D. A., Piasecki, M. P. "The implicit relational assessment procedure (IRAP): How implicit bias is assessed and addressed at UNSOM," Diversity Summit, University of Nevada, Reno School of Medicine, Reno, NV, 4.16.

Szarko, A., Brayko, C., Houmanfar, R., Smith, G., Jacobs, N., Baker, T., Piasecki, M. P., Kuhls, D. A., "Determining the Effects of ACTraining on Measures of Implicit Attitudes and Burnout: A New Spin on Curriculum Training in Medical Education" ABAI, Chicago, IL, 5.16.

Smith, G., Houmanfar, R., Szarko, A., Baker, T., Jacobs, N., Piasecki, M., Kuhls, D. A., "The Adaptation of the Implicit Behavioral Assessment Technology to Guide Curriculum Development" ABAI, Chicago, IL, 5.16.

Piasecki, M. "Balancing Career and Life," Find Your Mentor Program, Tokyo Medical Dental University, Tokyo, Japan, 1.17.

Piasecki, M. "Accreditation in Medical Education," Tokyo Medical Dental University, Tokyo, Japan, 1.17.

Piasecki, M. "The Multiple Mini-Interview," Tokyo Medical Dental University, Tokyo, Japan, 1.17.

Smith, A., Oates, K., Jacobs, N., Brayko, C., Piasecki, M. P., Harding, B., Glogovac, D. L., "Rethinking diversity at one medical school: Narrowing the focus to increase impact," WGEA Annual Meeting, 2.17.

Szarko, A., Brayko, C., Houmanfar, R., Smith, G., Esquierdo-Leal, J., Froehlich, M., Jacobs, N., Baker, T., Piasecki, M. P., "Managing Burnout in the Curriculum at UNR Med," Northern Nevada Diversity Summit, University of Nevada, Reno, NV, 3.17.

Piasecki, M. P., "The role of implicit attitude assessment in a behavior analytic intervention of social issues", Association for Behavior Analysis International Annual Convention, 5.17.

Jacobs, N., Smith, G., Oates, K., Piasecki, M. P., "Inclusivity: Collaborative Mixed-Methods Approach Group on Diversity and Inclusion and Group on Women in Medicine and Science Summit, Palm Springs, CA, 5.17.

Hagen, J., Jacobs, N., Piasecki, M., “Diversity Now: Powerful searches,” Group on Diversity and Inclusion and Group on Women in Medicine and Science Summit, Academic, AAMC, Palm Springs, CA, 5.17.

Hagen, J., Jacobs, N., Piasecki, M. P., "Standing Search Committee: Diversity Faster," Group on Diversity and Inclusion and Group on Women in Medicine and Science Summit, Palm Springs, CA, 5.17.

Piasecki, M “Burnout in Medical Education: Costs and Interventions,” Grand Rounds, University of Arizona College of Medicine, Tucson, AZ, 11.17.

Piasecki, M. P., Brayko, C., Houmanfar, R., Szarko, A., Smith, G., Jacobs, N., Baker, T., "Integrating Behavior Analytic Frameworks to Meet the Needs of a Medical School and the Medical Profession," Association for Behavior Analysis International 9th International Conference, Paris, France, 11.17

Visiting Professor, Department of Psychiatry, Faculty of Medicine, Khon Kaen University, Thailand, 1.18.

Piasecki, M., Oates, K. and Smith, A., “The LCME Self-Study: An Agent for School-Wide Engagement, Transparency and Innovation,” WGEA Annual Meeting, Denver, CO, 3.18

Houmanfar, R., Croswell, L and Piasecki, M “Interdisciplinary Collaboration in Behavior Analysis,” Association for Behavior Analysis International (ABAI) 38th Annual Convention, San Diego, CA, 5.18

Piasecki, M. “The Role of the Psychiatrist in Fitness for Duty Evaluations,” University of Hawaii Department of Psychiatry Grand Rounds 9.18

Piasecki, M. “Rules of the Road,” Best Practices and Tools for Prescribing Controlled Substances,” UNR Med in collaboration with Nevada State Board of Medical Examiners, 11.18

Piasecki, M. “Ethics and Opioid Prescribing,” Best Practices and Tools for Prescribing Controlled Substances,” UNR Med in collaboration with Nevada State Board of Medical Examiners, 4.19, 9.19

Piasecki, M. “What’s in Your Toolbox? Positive Psychology Tools to Support Professional Wellness.” Psychiatry Grand Rounds, UNR Med, Reno, NV, 6.19

Piasecki, M. “Suicide Prevention in High Risk Populations.” American College of Physicians, Nevada Chapter Annual Meeting, Las Vegas, NV, 11.19

Piasecki, M., Packham, J. and Hunt, S. “Mental Health Workforce Supply and Demand in Nevada.” Nevada Population Health Conference. Las Vegas, NV, 11.19

Piasecki, M. and Hagen, J. “Physician Suicide: What to Know, What to Do.” Internal Medicine Grand Rounds, UNR Med, Reno, NV, 1.20

Piasecki, M. and Vaughn Allen, M. “Treating Pain: Ethical and Clinical Considerations.” Carson Tahoe Hospital, Carson City, Nevada, 7.20

Piasecki, M. and Vaughn Allen, M. Difficult Conversations about Suicide,” Carson Tahoe Hospital, Carson City, Nevada, 8.20

Piasecki, M. “Ethics and Opioids,” Triple Play UNR Med in collaboration with Nevada State Board of Medical Examiners, 9.26.20

Piasecki, M. “Drugged Driving Essentials: Pharmacology and Toxicology.” National Judicial College 9.15.20

Piasecki, M. “Sentencing: Behavioral Health Needs.” Nevada District Judges 9.16.20

Piasecki, M. “Positive Psychiatry: What is It and Why Now?” University of Hawai’i Grand Rounds 10.16.20

Piasecki, M. "Science of Happiness and Resilience in 2021." Nevada Physician's Wellness Coalition, 1.14.21

Piasecki, M. "Ethics: Practical Models and Thought Processes for Complex Dilemmas," Best Practices & Tools for Prescribing Controlled Substances, UNR Med 2.5.21

Publications:

Articles:

` Thienhaus, O.J., Piasecki, M.P., "Suicide Risk Assessment." Psychiatric Services, 3.1997.

Thienhaus O.J., Piasecki, M.P., "Assessment of Psychiatric Patients--Risk of Violence." Psychiatric Services, 49:9, 1129-1147, 1998.

Potter, A., Corwin, J., Lang, J., Piasecki, M.P., Lenox, R., Newhouse, P.A., "Acute effects of the selective cholinergic channel activator (nicotine agonist) ABT-418 in Alzheimer's disease." Psychopharmacology, 142:334-342, 1999.

Netski, A., Piasecki, M.P.; "Lithium-Induced Exacerbation of Stutter." (letter) The Annals of Pharmacotherapy, 35:7 961 2001.

Piasecki, M.P. Steinagel, G., Antonuccio, D.O. and Kohlenberg, B.S; "Unblinding in a Study of an SSRI." Journal of Behavior Therapy and Experimental Psychiatry, 3 67-71 2002.

Piasecki, M.P., Steinagel, G, Thienhaus, OJ, and Kohlenberg, BS; "An Exploratory Study: The Use of Paroxetine for Methamphetamine Craving." Journal of Psychoactive Drugs, 34(3) July-Sept 301-304 2002.

Thienhaus, O.J., Piasecki, M.P.; "Assessment of Geriatric Patients in the Psychiatric Emergency Service." Psychiatric Services, 2004.

Kohlenberg, B.S., Antonuccio, D.O., Hayes, S.C., Gifford, E.V., & Piasecki, M.P. "Suitability of Bupropion SR for Nicotine Dependent Smokers: Problems in a Practice Setting." Psychotherapy and Psychosomatics, 73 252-254, 2004.

Gifford, E. V., Kohlenberg, B. S., Hayes, S. C., Antonuccio, D. O., Piasecki, M. P., Rasmussen-Hall, M. L., & Palm, K. "Applying a Functional Assessment Model

to Smoking Cessation: An Initial Trial of Acceptance and Commitment Therapy." Behavior Therapy, 34 (4) 689-706, 2004.

Hayes, S.C., Wilson, K.G., Gifford, E.V., Bissett, R., Piasecki, M.P., Batten, S.V., Byrd, M. and Gregg, J. "A Preliminary Trial of Twelve-Step Facilitation and Acceptance and Commitment Therapy with Polysubstance-Abusing Methadone-Maintained Opiate Addicts." Behavioral Therapy, 35 667-688 2004.

Mason, M.N., Johnson, C.E. and Piasecki, M. "Ziprasidone-induced acute dystonia." (letter) American Journal Psychiatry, 162(3):625-6 2005.

Piasecki, M.P. "Death Row Inmates and Mental Health." (Legal Digest) The Journal of the American Academy of Psychiatry and the Law, 33(3) 406-408 2005.

Gifford, E.V., Kohlenberg, B**.,** Hayes, S.C**.,** Pierson, H., Piasecki, M., Antonuccio, D.O., & Palm, K.. Does Acceptance and Relationship Focused Behavior Therapy Contribute to Bupropion Outcomes? A Randomized Controlled Trial of FAP and ACT for Smoking Cessation. Behavior Therapy, 10.1016, 2011.

Baker, T., Schwenk, T., Piasecki, M., Smith, G., Reimer, D., Jacobs, N., Shonkwiler, G., Hagen, J. & Houmanfar, and R. Change in a Medical School: A Data-Driven management of Entropy. Journal of Organizational Behavior Management, 35:95-122, 2015.

Baker, T., Smith, G., Jacobs, N., Houmanfar, R, Tolles, R., Kuhls, D., Piasecki, M. A deeper look at implicit weight bias in medical students. Advances in Health Science Education Theory and Practice, 2016.

Maraccini, A, Houmanfar, R., Slonim, A., Williams, L., Piasecki, M. An Interprofessional Approach to Train and Evaluate Communication Accuracy and Completeness during the Delivery of Nurse-Physician Student Handoffs, Journal of Interprofessional Education & Practice, 2018

Abstracts and Poster Presentations:

Abstract: "Cognitive Effects of Nicotinic Agents in Alzheimer's and Parkinson's Disease," Newhouse, P.A., Potter, A., Corwin, J., Piasecki, M. American College of Neuropsychopharmacology Annual Meeting, 1994.

Poster: "Integrating PBL into a Psychiatry Clerkship: A Proposal" Piasecki M.P. presented at Western Group on Educational Affairs, Monterey, CA, 1996.

Poster: “The Self Assessment of Problem Solving Skills in a Problem Based Learning Curriculum,” Piasecki M.P., Erickson B., presented Western Group on Educational Affairs, Asilomar, CA, 1998.

Poster: “The Difficult interview: A Curriculum for Second Year Medical Students”; presented Western Group on Educational Affairs, Piasecki M.P., Erickson B., Asilomar, CA, 1998.

Poster: “Factors Contributing to Patient Adherence in Smoking Cessation Treatment.” Gifford, E.V., Walsh, K.M., Piasecki M.P., Kohlenberg B.S., Hayes S.C., & Antonuccio D.O., presented at the Association for the Advancement of Behavior Therapy, New Orleans, LA, 2000.

Poster: “Innovation in Behavior Therapy for Nicotine-Dependent Smokers: Experiential Avoidance, Acceptance, and Smoking Cessation.” Gifford E.V., Piasecki M.P, Kohlenberg B.S., Antonuccio D.O. and Thienhaus O.J. presented at Nevada Biomedical Research and Education Conference, Las Vegas, NV, 2001.

Poster: “Bupropion SR for Nicotine Dependent Smokers: A Practical Treatment for Veterans?” Kohlenberg, B.S., Gifford, E.V., Antonnucio, D.O., Piasecki, M.P., Hayes, S.C., presented at Society for Research on Nicotine and Tobacco annual meeting, Seattle, WA 2001.

Poster: “FACT: Functional Analytic Therapy (FAP) and Acceptance and Commitment Therapy (ACT) Integration: Applications for Smoking Cessation,” Gifford, E., Hayes, S., Antonuccio, D., & Piasecki, M. Presented at the Association for the Advancement for Behavior Therapy, 35th Annual Convention, Philadelphia, PA, 2001.

Poster: “Posttreatment and Process Data from a Randomized Clinical Smoking Cessation Trial Comparing Acceptance and Commitment Therapy with Transdermal Nicotine Replacement,” Gifford, E., Kohlenberg, B., Piasecki, M., Hayes, S., and Antonuccio, D. Presented at the Association for the Advancement for Behavior Therapy, 35th Annual Convention, Philadelphia, PA, 2001.

“Measuring the Process of Organizational Change: A Quantitative and Qualitative Analysis of Curricular Change in a Medical School,” Reimer, D., Houmanfar, R., Shonkwiler, G., Jacobs, N., Tolles, R. & Piasecki, M. Behavior Analysis Research Faire; Reno, NV, 2012.

"Emerging Leadership: A Qualitative Analysis of Faculty Comments about Curricular Change at the University of Nevada, Reno School of Medicine," Shonkwiler, G., Houmanfar, R., Reimer, D., Jacobs, N., Tolles, R. & Piasecki, M. Paper presented at the Western Group for Educational Affairs (WGEA) Regional Meeting in Pacific Grove, CA, 2012.

Poster: "Measuring the Process of Organizational Change: A Quantitative and Qualitative Analysis of Curricular Change in a Medical School," Reimer, D., Houmanfar, R., Candido, A., Shonkwiler, G., Jacobs, N., Tolles, R. & Piasecki, M. Association for Behavior Analysis International (ABAI) 38th Annual Convention; Seattle, WA, 2012.

Poster: "Project ECHO Nevada: Using Interprofessional Teams to Improve Health Care in Nevada," Etchegoyhen, L., Klass, E., Packham, J., Piasecki, M., O'Brien, M. 4th Annual MedEdPORTAL Poster Session and Reception on Innovation in Health Education, AAMC Annual Meeting San Francisco, CA, .2012.

Poster: "Project ECHO Nevada: Using Interprofessional Teams to Improve Health Care in Nevada," Etchegoyhen, L., Klass, E., Ackerman, G., Redding, J., Piasecki, M., O'Brien, M. FLEX Annual Meeting, Kona, HI, 2013.

Poster: "Faculty Perspectives on Curricular Change: Institutions with Multiple Campuses," Hagen, J., Kuhls, D., Shonkwiler, G., Walvoord, E., Tolles, R., Jacobs, N., Houmanfar, R., Reimer, D., Palmer, Gusic, M.E., Piasecki, M. AAMC GRMC, Phoenix, AZ, 2014.

Poster: "Measuring Organization Culture and Change in a U.S. Medical School," Piasecki, M., Hagen, J., Reimer, D. and Houmanfar, R., On The Organization, Annual Meeting, Oxford, England, 2014.

Poster: "Shining A Light On Implicit Bias: The Use Of A Novel Assessment In Medical Education." Moore, S., Baker, T., Piasecki, M., Jacobs, N., Shonkwiler, G., Houmanfar, R. Smith, G. and Tolles, R. UNLV-UNSOM Interprofessional Health Equity Symposium, Las Vegas, NV, 2014.

Poster: "Revisions to Alaska Mental Health Statutes," Gordon, S., Piasecki, M., Kahn, G. and Nielsen, D., UNLV Academic Showcase, Las Vegas, NV, 2015.

Poster: "An Interprofessional Health Disparities Symposium," Kuhls, D., Tovino, S., Douinis, G., Piasecki, M., et al. UNLV Academic Gala, Las Vegas, NV, 2015.

Poster: “Dual-Role Conflicts in Forensic Mental Health Evaluations,” Piasecki, M., Gordon, S. Neuroethics Network annual meeting, Paris, France, 2016.

Poster: “Ethical dilemmas surrounding physician wellness and burnout.” Brayko, C., Smith, G., Szarko, A., Candido, A., Houmanfar, R., Jacobs, N., Baker, T., Ishibashi, K., Piasecki, M., Schwenk, T. Cambridge Consortium for Bioethics Education annual meeting, Paris, France, 2016.

Poster: “Engineering Inclusivity: A Standing Search Committee Looks at Candidate Data,” Hagen, J., Jacobs, N., Piasecki, M. AAMC GFA conference, Vancouver, BC, Canada, 2016.

Poster: "Addressing Burnout in Medical School through Acceptance and Commitment Training,” Froehlich, M. , Szarko, A., Jacobs, N., Smith, G. S. Houmanfar, R, Piasecki, M. Baker, T., AAMC Western Group of Educational Affairs (WGEA). Austin, TX, 2018.

Poster: “Mission-Based Diversity Groups: From Definition to Data and Beyond,” Jacobs, N., Piasecki, M., Smith, A., Myers, S. AAMC Group on Diversity and Inclusion, Annual Meeting, Chicago, IL 4.19

Poster :”Developing an Implicit Measure of Burnout with Medical Students,” Smith, G., Houmanfar, R., Jacobs, N., Baker, T., Froehlich, M., Szarko, A., Brayko, C., Piasecki, M. AAMC Western Group on Educational Affairs Annual Meeting, Reno, NV, 4.19

Poster: Supporting Pathways for Women in Academic Medicine through the ADAM Program. Jacobs, N., Smith, A., Dougherty, J., Piasecki, M., & Hagen, J. Group on Women in Medicine and Science Poster Session 2019 AAMC Annual Meeting, Phoenix, AZ, 11.19

Chapters:

Newhouse, P.A., Potter, A., Piasecki, M.P. et al. “Nicotinic Modulation of Cognitive Functioning in Humans.” In: International Symposium on Nicotine: The Effects of Nicotine on Biologic Systems II, Clarke, PBS, Quik, M., Thurau, K., Aldkofer, F. (Eds.) Birkhauser, Boston, MA, 1995.

Piasecki, M.P., “Antidepressant Medications: A Review of their Potential Toxicities.” In Prescription Privileges for Psychologists: A Critical Appraisal. (Eds.) Hayes, S.C. and Heiby, E.M., Context Press, Reno, NV, 1998.

Piasecki, M.P., "Classification of Mental Disorders." In Pearls of Wisdom. Rebecca Schmidt (Ed.), Boston Medical Publishing, 1999.

Antonuccio, D.O., Lewinsohn, P., Piasecki, M.P., Ferguson, R., "Major Depressive Episode." In Effective Brief Therapy: A Clinician's Guide. Academic Press, 1999.

Piasecki, M.P.,"Nicotine and Mood." In Nicotine in Psychiatry: Emerging Trends in Psychopathology and Therapeutics (Eds.) Piasecki M.P., and Newhouse P.A., American Psychiatric Press, Washington D.C., 2000.

Gifford, E.V., Kohlenberg, B.K. Piasecki, M.P., and Webber, E.J. "The forensic assessment of substance abuse." In O'Donohue, W. & Levensky, E. (Eds.) Handbook of forensic psychology. Elsevier Press, 2004.

Piasecki, M.P. "Women in Corrections." In Thienhaus, O.J. and Piasecki, M.P.(Eds.) Correctional Psychiatry: Practice Guildelines and Strategies, Civic Research Institute Press, New York, NY, 2007.

Encyclopedia of Substance Abuse, Gary Fisher and Nancy Roget Eds., Sage Publishing, 2008.

Anxiolytics, Cardon, N., Sharp, S. and Piasecki, M.P.
Antidepressants, Prasad, C. and Piasecki, M.P.
Mood Stabilizers, Parras, M. and Piasecki, M.P.
Antipsychotics, Anit, L. and Piasecki, M.P.
Prevention Policy, Levin, M., Draper, C. and Piasecki, M.P.

Mental Retardation and the Death Penalty, Piasecki, M.P. and Elwyn, T., in Capital Cases: A Benchbook, Brunson, W., Burns, D. and Wosje, R. (Eds) National Judicial College, 2009.

Books:

Piasecki, M.P. and Newhouse, P.A. (Eds.) Nicotine in Psychiatry: Emerging Trends in Psychopathology and Therapeutics, American Psychiatric Press Inc., Washington D.C., 2000.

Piasecki, M.P. Clinical Communication Handbook, Blackwell Publishing, Malden MA, 2003.

Thienhaus, O.J. and Piasecki, M.P. (Eds.) Correctional Psychiatry: Practice Guildelines and Strategies, Civic Research Institute Press, New York, NY, 2007.

Guerrero, A. and Piasecki, M.P. (Eds.) Problem Based Learning in Psychiatry and Behavioral Science, Springer Publishing, New York, NY, 2008.

Thienhaus, O.J. and Piasecki, M.P. (Eds.) Correctional Psychiatry: Practice Guildelines and Strategies; Volume II, Civic Research Institute Press, New York, NY, 2013.

Jacobs, N.N., Alicata, D., Guerrero, A. and Piasecki, M.P. (Eds.) Problem Based Learning in Psychiatry and Behavioral Science 2nd Edition, Springer Publishing, New York, NY, 2016.

Other Publications:

Piasecki, M.P, and Zuchowski, S.J. "Not guilty by reason of insanity" Nevada Lawyer pp 21-23, 2006.

Piasecki, M.P. and Antonuccio, D.O. "The DSM Debate: Potential Harms Related to Psychiatric Diagnosis" AAPP newsletter, Volume 17(2), pp 15-18, 2010.

Contributor to National Judicial College Sentencing Sex Offenders: A Model Curriculum for Judges, CD/ DVD, 2010.

Grants:

Nancy Roget (Principal), Melissa Piasecki (Supporting), CDC Frontier Regional FASD Training Center 1U84DD000888-01 Project Period: 09.30.2011—9.29.2014.

Sara Gordon (Principal), Melissa Piasecki (Co-PI), Alaska Statutory Review, Alaska Mental Health Trust 2014—2015.

Administration and Service:

Department of Psychiatry

Chair, Department of Psychiatry Medical Education Committee 2000—2011

Vice Chair for Medical Education, Department of Psychiatry (Reno) 1998—2008

Chair, Continuing Medical Education Committee, Coordinator of Department Grand Rounds Series 2005—2010

Assistant Medical Director, University Mental Health Professionals (Department of Psychiatry outpatient practice group) 1997—2004

Residency Education Committee 2000—2011

University of Nevada, Reno School of Medicine

Clerkship Coordinator's Committee1995—2008
Chair 1996—1999

Year 1 & 2 Course Coordinator's Committee 1996—2002

Chair, LCME Subcommittee on Clinical Departments 2001

Co-Chair, LCME Subcommittee on Faculty 2009

Faculty Council Psychiatry Representative 1998--2000

Search Committees: Family Medicine Chair 2001, Dean School of Medicine 1999, Chair of Pharmacology Department 1998, Chair of Psychiatry 2010, Director of the UNR School of Community Health Science (Committee Chair) 2011, Director of Sanford Center 2012-2013, Chair of Psychiatry 2012—2013 (Committee Chair)

Professionalism Committee, Chair Faculty Development Subcommittee 2006—2011

Medical Director, Office of Continuing Medical Education, 2011—present

Chair, UNR Med LCME Steering Committee, 2016-18

University of Nevada, Reno

Excellence in Teaching Program Advisory Committee 2003—2004

Excellence in Teaching Program Faculty Consultant 2004

Conflict of Interest Committee 2010—present

Accreditation Task Force 2012—2013

Title IX Deputy Officer 2016—2020

NSHE

Member, UNLV Boyd School of Law Health Law Advisory Board 2015—2019

State of Nevada

Nevada Suicide Review Task Force member 2014—2015

Nevada Population Health Planning Committee member 2016—2020

Nevada State Boards consultant 2006—present

Board of Medical Examiners
Board of Osteopathic Medicine
Board of Social Workers
Chiropractic Physician's Board
Veterinary Board

National

Editorial Board: National Psychiatric Resident In-service Training Examination (PRITE) 2005—2012

LCME Survey Team member, 2013, 2014, 2015, 2016, 2017

Department of Justice, consultant to Office of Civil Rights, 2014-2020

Consultant to Federal Monitor, Franco et al v Holder, 2016—2018

April 2021

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BOARD CERTIFIED IN PSYCHIATRY AND FORENSIC PSYCHIATRY

Four Year Record of Testimony

2021

People v. Conway, 4.28.21, Competency Hearing, Sierra County, CA

Keil, Zeiser, Dean, Betz and Doe v. Edward Beardon and Missouri DOC, 4.16.21 Deposition

People v. Winkler, 4.19.21 Competency Hearing, San Joaquin County, CA

People v, Hannon, 4.19.21 Diversion Hearing, San Joaquin County, CA

State v. Paquette, 3.25.21, jury trial Elko County, NV

People v. Williams, 3.10.21 Diversion Hearing, San Joaquin County, CA

People v. Young, 3.2.21 Competency Hearing, San Joaquin County, CA

People v Gilliam, 3.2.21 Competency Hearing, San Joaquin County, CA

Donna Lynn Malone vs. Wicomico County Maryland and Wellpath, LLC 2.19.21 deposition testimony, Reno, NV

2020

State v. Peterson 12.31.20 Competency Hearing, Lyon County, NV

State v. Bernal 11.6.20. jury trial Lyon County, NV

Lisle v. Warden Ely State Prison, 11.12.20, Federal Court hearing, Washoe County, NV

State v. Hall, 7.20.20 hearing, San Joaquin County, CA

State v. Robinson, 6.17.20 jury trial, San Joaquin County, CA

State v. Diaz, 3.13.20, Diversion Hearing, San Joaquin County, CA

State v. Cisneros, 6.23.20 Competency Hearings, Stanislaus County, CA

April 2021

State v. Mentaberry, 1.23.20, jury trial Elko County, NV

2019

State v. Trejo, 12.11.19, jury trial, San Joaquin County, CA

Dempsey v. Nevada, 12.5.19, Habeas Corpus hearing, Washoe County, NV

State v. Sanchez, 10.2.19, jury trial, Washoe County, NV

State v. Sidhu, 6.4.19, bench trial, Clark County, NV

State v. Daigle, 7.13.19, jury trial, Calcasieu Parish, LA

State v. Frolich, 5.20.19 and 6.6.19 risk assessment hearings, (video testimony) Clark County, NV

State v. Petrocelli 5.16.19, jury trial, Washoe County, NV

Robinson v. Correct Care, 3.4.19, deposition, Washoe County, NV

State v. Woodard, 4.5.19, competency hearing, video testimony to Clark County, NV

State v. Happy, 3.1.19, jury trial, Washoe County, NV

2018

Commitment Court 12.27.18 Washoe County, NV

State v. Lambdin 12.13.18 hearing, Washoe County, NV

State v Breiner, 11.19.18 jury trial, Sacramento, CA

Prioleau v Correct Care, 11.12.18 deposition, Columbia SC

Rogers v Timothy Filsom, et al, 10.24.18, hearing Federal Court, Las Vegas, NV

State v Teifle, competency hearing, Carson County, NV

State v. Westmoreland, competency hearing, Washoe County, NV

State v. Laak, 8.13.18, jury trial Clark County, NV

State v. Ward, 7.28.18, jury trial Elko County, NV

April 2021

State v. Pundyke, 7.23.18, jury trial Washoe County, NV

State v. McWilliams, 7.16.18, hearing Washoe County, NV

State v. Sandoval, 6.11.18, sentencing hearing Santa Clara County, CA

State v. Pundyke, 3.6.18, hearing Washoe County, NV

State v. Bracamontes, 3.22.18, jury trial Sacramento County, CA

State v Brown, 4.5.18, Phone testimony, Louisiana

State v. Lazar, 5.11.18, Carson County, NV

2017

State v. Weatherton, trial testimony, 12.27.17, Riverside County, CA

Gallagher Deposition, 10.10.17, Washoe County, NV

State v. Gaussubia, trial testimony, 10.6.17, Santa Clara County, CA

State v. Weatherton, trial testimony, 8.15.17, Riverside County, CA

State v. Slaughter, trial testimony 6.26.17, Clark County, NV

State v. Steward, trial testimony 6.13-14, 2017, Plumas County, CA

State v. LeFlore, trial testimony 5.16-17., 2017, Clark County, NV

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Fee Schedule 2021: This fee schedule applies to medicolegal, forensic psychiatric, psychiatric expert and/or independent medical examination evaluations.

Time spent in interviews and testing, travel, record review, collateral interviews, meetings with attorneys/ administrators, audio/visual material review, research and report preparation is billed at $400/hour.

Deposition time is billed at $500/hour and estimated payment is due in advance. Written cancellation must be received at least 48 hours in advance for refund. Court time is billed at $400/hour.

Travel: All travel time is billed “door to door.” If your agency requires forms to be submitted for travel, please these in advance.

Exhibit 33

Dartmouth-Hitchcock

DEPARTMENT OF EMERGENCY MEDICINE

Dartmouth-Hitchcock Medical Center
Emergency Medicine
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Lebanon, NH 03756
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Dear Attorneys Flaxman,

I have reviewed the reports from Drs. Boggio and Gluck, and I have formed the following opinions in response. I am being compensated at the rate of $500 per hour for my work in preparing this rebuttal expert report, which required 2 hours.

Dr. Boggio refers to the Caprini score, which was developed for surgical patients, and is not utilized in the emergency or acute care setting. I am not aware of any literature even considering whether the Caprini score is an appropriate tool for a patient who is forcibly restrained like Angel.

I attach a copy of the 2013 version of the Caprini Risk Assessment Model. If Angel had been scored with the Caprini tool, he would get 1 point for BMI >25, and 1 point for restricted mobility (medical patient currently on bed rest). Dr. Boggio erroneously states that bed rest must exceed 72 hours to receive this point for lack of mobility. This is incorrect. The definition of "restricted mobility" at page 7 of the attached is "any individual who is unable to ambulate continuously more than 30 feet." This is quite different from someone like Angel who had his limbs and mid-section restrained to a bed.

In addition, the attached version of the Caprini score assigns an additional point when the patient will be in surgery longer than 2 hours. Based on these factors, the Caprini score would recommend the use of pneumatic compression devices and/or graduated compression stockings, which were not provided to Angel.

The Caprini score (available at https://www.mdcalc.com/caprini-score-venous-thromboembolism-2005) includes this advice (from the button "Next Steps): "While many hospitals have developed institution-wide policies for VTE prophylaxis based on risk assessment models, the decision for type and duration of VTE prophylaxis should ultimately be left up to the surgeon's best clinical judgment based on individual patient factors." The best clinical judgment for Angel's case would have been to protect him against the risk of VTE since he was immobilized, either with medication or by executing appropriate limb release, as required by the jail's protocols.

Also notable is that experts using the Caprini score stress the importance of face-to-face patient interviews rather than relying on record review. See page 5 and footnote 41 of the attached. Dr. Paschos, the physician who ordered restraints for Angel, did not perform a face-to-face interview, even though Jail protocol required one and his records claim that he did one.

Dr. Boggio states that emboli typically form 10-14 days from the culprit event. Dr. Boggio does not provide any reference for this claim, and I am not aware of any facts or data that support this assertion. Dr. Gluck also speculates about when the emboli formed, again without providing any reference for what I believe to be speculation.

Irrespective of when the thrombus formed, Heparin would have prevented formation of a deep venous thrombosis. That is, heparin would have prevented any clot from becoming larger, and if part of the clot embolized (broke off to travel toward the lung), heparin would have prevented it from affecting the cardiopulmonary circulation.

We know from the autopsy report that Angel had bilateral deep venous thromboses. This supports my opinion that the administration of heparin was imperative to prevent embolization of thrombus from the legs, traveling to the lungs, and causing death.

We do not know if Angel had deep venous thrombi prior to his incarceration, nor do we know if he had cancer, but we do know that when he was immobilized, any preexisting thrombi would have a greater chance of propagation and embolization with immobility without prophylaxis. In short, if we could know that the emboli formed before Angel arrived at the Jail, this would not change my opinion that the treatment at the Jail caused Angel's death.

Both Drs. Boggio and Gluck assert that Angel's pulmonary embolus was not a survivable event. This is not supported by the medical records. The autopsy showing that there were bilateral pulmonary emboli supports the fact that prophylaxis could have prevented these emboli from occurring and/or traveling to the lungs and lodging there. In any case, it is still not accurate to suggest that a massive pulmonary embolism is not survivable. We treat them in the emergency department with tPA ("tissue plasminogen activator") and surgically they are treated with embolectomy as well as arterial directed tPA. Dr. Gluck's suggestion that tPA would be appropriate only after further diagnostic work-up highlights the failure to treat Angel.

All of my opinions are made with a reasonable degree of medical certainty.

Dated: June 1, 2021

Evie Marcolini MD

Original Article

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Completion of the Updated Caprini Risk Assessment Model (2013 Version)

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Abstract

The Caprini risk assessment model (RAM) has been validated in over 250 000 patients in more than 100 clinical trials worldwide. Ultimately, appropriate treatment options are dependent on precise completion of the Caprini RAM. As the numerical score increases, the clinical venous thromboembolism rate rises exponentially in every patient group where it has been properly tested. The 2013 Caprini RAM was completed by specially trained medical students via review of the presurgical assessment history, medical clearances, and medical consults. The Caprini RAM was completed for every participant both preoperatively and predischarge to ensure that any changes in the patient's postoperative course were captured by the tool. This process led to the development of completion guidelines to ensure consistency and accuracy of scoring. The 2013 Caprini scoring system provides a consistent, thorough, and efficacious method for risk stratification and selection of prophylaxis for the prevention of venous thrombosis.

Keywords

thromboprophylaxis, risk stratification, deep vein thrombosis, pulmonary embolism, Caprini risk assessment

Date received: 01 February 2019; accepted: 20 February 2019.

Background

Pulmonary embolism (PE) and deep vein thrombosis (DVT), collectively known as venous thromboembolism (VTE), represent a major public health dilemma that affects 350 000 to 600 000 Americans annually.[1] Venous thromboembolism remains the most preventable cause of death in hospitalized patients and is known to cause significant morbidity with associated health-care expenditure.[2] After a primary thromboembolic episode, VTE recurs in approximately 25% of patients over the subsequent 10 years. Complications associated with VTE include postthrombotic syndrome after DVT (20%-50% incidence) and chronic thromboembolic pulmonary hypertension after PE (0.1%-3.8% incidence).[3] These conditions negatively impact quality of life and individual productivity while adding burden to the patient, their support system, and the health-care system at large.

There has been a marked increase in federal and national efforts over the last decade to increase both awareness and treatment of this avoidable outcome. In 2008, the Surgeon General and the Director of the National Heart, Lung and Blood Institute announced a "Call to Action to Prevent Deep Vein Thrombosis and Pulmonary Embolism." The Call to Action emphasized public awareness about risk factors, triggering events, and symptoms of venous thrombosis and PE and encouraged the development of evidence-based practices for screening, prevention, diagnosis, and treatment of venous thrombosis and PE.[4] From 2006 through 2008 in recognition of the high attributable risk of DVT and PE due to hospitalization, the National Quality Forum, the Joint Commission, and the Centers for Medicare and Medicaid Services all instituted policies and measures to reduce VTE and promote appropriate prophylaxis to at-risk patients in the hospital setting.[5] In 2008, the eighth edition of the American College of Chest Physicians (AT8) guidelines for the prevention of VTE endorsed the need for an "active, formal strategy" to prevent hospital-induced VTE. The authors felt that available risk assessment models (RAMs) were minimally validated and impractical to use.[6] They proposed that thrombosis prophylaxis should be provided for groups of patients where clinical trial data were available. It

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has been subsequently shown that since many patients in clinical practice did not fit the criteria for clinical trials, a specific analysis of each individual's risk factors was a better approach. The availability of the electronic medical record has facilitated collection of these data and assisted in the implementation of RAMs. As a result, over the past 5 years, individual thrombosis risk assessment has become accepted practice in most surgical specialties.

There are multiple quantitative VTE RAMs available for use in clinical practice. The Padua Prediction Score and IMPROVE RAMs were designed to address VTE risk in medical patients.[7,8] The ninth edition of the American College of Chest Physicians Antithrombotic Therapy and Prevention of Thrombosis guideline (AT9) has recognized only 2 risk assessment tools in the nonorthopaedic surgical population, the Rogers Score, and the Caprini Score.[9] The Rogers Score has been validated in general, vascular, and thoracic surgery in a single study. The score is based on variables that were found to be independent predictors of VTE risk such as surgical procedure, female sex, and a variety of other individual patient characteristics.[10] Unlike the Caprini RAM, the Rogers score does not take into account certain VTE risk factors including any personal or family history of VTE and thrombophilia. Several other issues have been identified with using this model. Firstly, the categorizations by which variables are assigned point values are not easy to follow and have been noted as "cumbersome" to use.[9,10] Secondly, the study that was used to validate this RAM did not clearly state which patients received prophylactic measures for VTE, and what type they received (ie, mechanical, pharmacological).[9]

Caprini Risk Assessment Tool for VTE

A group of physicians, nurses, and scientists led by Dr Caprini developed a risk assessment scoring system first published in 1991.[11] Individual risk factors were assigned one or more points according to their relative risk of resulting in a thrombotic event. Factors such as surgery or cancer received 2 points, whereas varicose veins or oral contraception were assigned one point. The initial assignment of points was based on the relative risk of thrombosis for each risk factor using current literature at that time. For example, cancer or past history of thrombosis were stronger risk factors than swollen legs. The total score for each patient was compared to the incidence of clinically evident VTE events at 30 days to validate the model. An exponential increase in thrombotic events with increasing score has been observed for every group properly tested. This allowed for categorizing patients into low-, moderate-, and high-risk groups based on the thrombosis event rate for each group. Using this stratification data, the type, duration, and strength of prophylaxis could be tailored to the level of risk. The clinical VTE event rate for each group could be compared to the patients' risk of bleeding, resulting in prophylaxis tailored to provide optimal thrombosis protection.

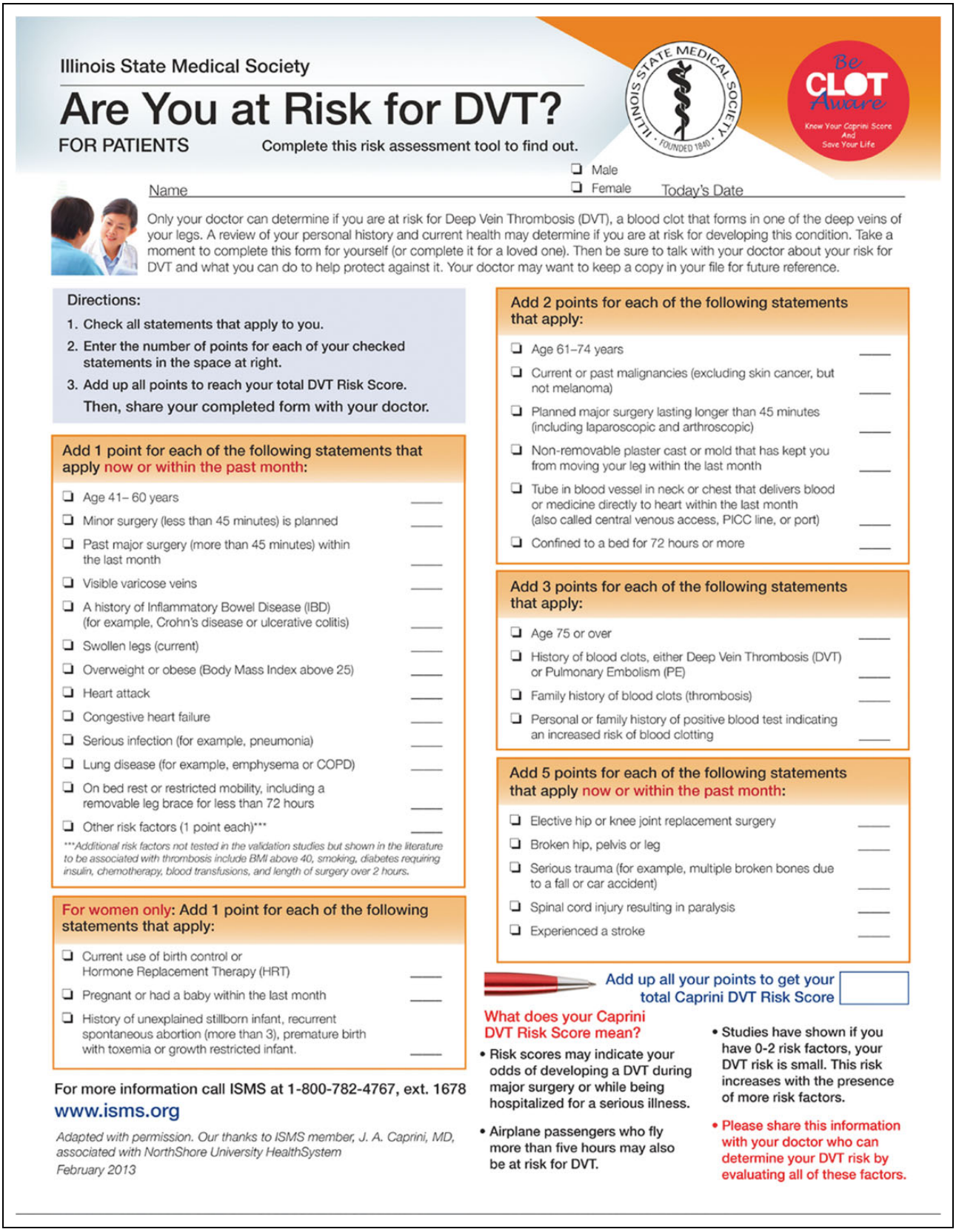
Since its introduction in 1991, the Caprini RAM has been validated in over 250 000 patients in more than 100 clinical trials worldwide.[12-22] One should note that the cutoff score between risk groups varies depending on the surgical population that is tested. AT9 defines the high-risk group as a score of 5 or greater for general surgery patients.[9] This cutoff point, however, is not appropriate for all surgical specialties. Since then, a score of 12 has been shown to be the very high-risk cutoff for those with hip fractures.[12] A companion manuscript submitted for publication in this journal involving total joint arthroplasty included 1078 patients to establish the very high-risk cutoff in this population. Krauss et al found that total joint arthroplasty patients with a score of 10 or greater were at high risk of VTE, and the authors presented data that this very high-risk group would benefit from traditional anticoagulants.[23] Patients with a lower score could safely receive aspirin according to their findings. A large, prospective, multicenter trial to test these concepts is currently in development.

Drugs administered to prevent VTE carry their own risks, specifically minor to major bleeding events. Thus, individualization of prophylaxis treatment based on calculated risk factors will prevent unnecessary prophylaxis for patients deemed low risk while providing prophylaxis for patients who are high risk. Ultimately, the appropriate treatment options are dependent on precise completion of the Caprini RAM. An inaccurate medical history or incorrect interpretation of criteria contained in the RAM could result in an erroneous Caprini score, thereby leading to an incorrect treatment assignment for the patient.

Recently, Pannucci and colleagues performed a meta-analysis of selected publications using Caprini scores to investigate benefits and harms of chemoprophylaxis among surgical patients individually risk stratified for VTE. They evaluated 13 studies; 11 (n = 14 776) contained data for VTE events, and 8 (n = 7590) contained data for clinically relevant bleeding with and without chemoprophylaxis. The most important finding was a 14-fold increase in VTE risk (from 0.7% to 10.7%) among surgical patients who did not receive chemoprophylaxis, and patients with higher Caprini scores were significantly more likely to have a thrombotic event. The benefit of perioperative VTE chemoprophylaxis was only found among surgical patients with Caprini scores equal to or greater than 7.[24] One must remember that this study selected the purest 13 of the nearly 100 clinical trials, and these results may not apply to all patient groups. This meta-analysis, however, demonstrates the value of the Caprini score in classifying patient risk to selectively use anticoagulants without exposing entire populations to anticoagulants, as was popular in the past.

The 2013 version is the most recent iteration of the Caprini RAM.[25] This version differs from preceding versions in that it includes additional risk factors not tested in validation studies but shown in the literature to be associated with thrombosis. These identified risk factors include BMI above 40,[26,27] smoking,[28,29] diabetes requiring insulin,[30,31] chemotherapy,[32,33] blood transfusions,[34,35] and length of surgery over 2 hours.[36,37]

During our validation study of the 2013 Caprini RAM in arthroplasty patients, scoring was completed by specially trained medical students via review of the presurgical assessment history, medical clearances, and medical



Illinois State Medical Society

Are You at Risk for DVT?

FOR PATIENTS Complete this risk assessment tool to find out.

Be CLOT Aware — Know Your Caprini Score And Save Your Life

❑ Male ❑ Female

Name Today's Date

Only your doctor can determine if you are at risk for Deep Vein Thrombosis (DVT), a blood clot that forms in one of the deep veins of your legs. A review of your personal history and current health may determine if you are at risk for developing this condition. Take a moment to complete this form for yourself (or complete it for a loved one). Then be sure to talk with your doctor about your risk for DVT and what you can do to help protect against it. Your doctor may want to keep a copy in your file for future reference.

Directions:

1. Check all statements that apply to you.
2. Enter the number of points for each of your checked statements in the space at right.
3. Add up all points to reach your total DVT Risk Score.

Then, share your completed form with your doctor.

Add 1 point for each of the following statements that apply now or within the past month:

- ❑ Age 41– 60 years ____
- ❑ Minor surgery (less than 45 minutes) is planned ____
- ❑ Past major surgery (more than 45 minutes) within the last month ____
- ❑ Visible varicose veins ____
- ❑ A history of Inflammatory Bowel Disease (IBD) (for example, Crohn's disease or ulcerative colitis) ____
- ❑ Swollen legs (current) ____
- ❑ Overweight or obese (Body Mass Index above 25) ____
- ❑ Heart attack ____
- ❑ Congestive heart failure ____
- ❑ Serious infection (for example, pneumonia) ____
- ❑ Lung disease (for example, emphysema or COPD) ____
- ❑ On bed rest or restricted mobility, including a removable leg brace for less than 72 hours ____
- ❑ Other risk factors (1 point each)*** ____

****Additional risk factors not tested in the validation studies but shown in the literature to be associated with thrombosis include BMI above 40, smoking, diabetes requiring insulin, chemotherapy, blood transfusions, and length of surgery over 2 hours.*

For women only: Add 1 point for each of the following statements that apply:

- ❑ Current use of birth control or Hormone Replacement Therapy (HRT) ____
- ❑ Pregnant or had a baby within the last month ____
- ❑ History of unexplained stillborn infant, recurrent spontaneous abortion (more than 3), premature birth with toxemia or growth restricted infant. ____

Add 2 points for each of the following statements that apply:

- ❑ Age 61–74 years ____
- ❑ Current or past malignancies (excluding skin cancer, but not melanoma) ____
- ❑ Planned major surgery lasting longer than 45 minutes (including laparoscopic and arthroscopic) ____
- ❑ Non-removable plaster cast or mold that has kept you from moving your leg within the last month ____
- ❑ Tube in blood vessel in neck or chest that delivers blood or medicine directly to heart within the last month (also called central venous access, PICC line, or port) ____
- ❑ Confined to a bed for 72 hours or more ____

Add 3 points for each of the following statements that apply:

- ❑ Age 75 or over ____
- ❑ History of blood clots, either Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) ____
- ❑ Family history of blood clots (thrombosis) ____
- ❑ Personal or family history of positive blood test indicating an increased risk of blood clotting ____

Add 5 points for each of the following statements that apply now or within the past month:

- ❑ Elective hip or knee joint replacement surgery ____
- ❑ Broken hip, pelvis or leg ____
- ❑ Serious trauma (for example, multiple broken bones due to a fall or car accident) ____
- ❑ Spinal cord injury resulting in paralysis ____
- ❑ Experienced a stroke ____

Add up all your points to get your total Caprini DVT Risk Score ____

What does your Caprini DVT Risk Score mean?

- Risk scores may indicate your odds of developing a DVT during major surgery or while being hospitalized for a serious illness.
- Airplane passengers who fly more than five hours may also be at risk for DVT.
- Studies have shown if you have 0-2 risk factors, your DVT risk is small. This risk increases with the presence of more risk factors.
- Please share this information with your doctor who can determine your DVT risk by evaluating all of these factors.

For more information call ISMS at 1-800-782-4767, ext. 1678

www.isms.org

Adapted with permission. Our thanks to ISMS member, J. A. Caprini, MD, associated with NorthShore University HealthSystem

February 2013

Figure 1. Caprini Risk Assessment Model (version 2013).

Are You at Risk for DVT?

Only your doctor can determine if you are at risk for Deep Vein Thrombosis (DVT), a blood clot that forms in one of the deep veins of your legs. A review of your personal history and current health may determine if you are at risk for developing this condition. Please take a moment to complete this form for yourself (or complete it for a loved one). Then be sure to talk with your doctor about your risk for DVT and what you can do to help protect against it.

1. Please select your AGE :

- ☐ 0 - 40 years old (0 points)
- ☐ 41 - 60 years old (1 point)
- ☐ 61 - 74 years old (2 points)
- ☐ Age 75 or older (3 points)

Score: _____

2. Add 1 POINT for each statement that applies to you:

- ☐ Within the last month, I have had surgery under general or regional anesthesia that lasted for MORE THAN 45 minutes.
- ☐ Within the last month, I have had or currently have varicose veins. (NOT spider veins)
- ☐ Within the last month, I have had or currently have swollen legs.
- ☐ Within the last month, I have had a heart attack.
- ☐ Within the last month, I have had or currently have a serious infection and was hospitalized, for example pneumonia, cellulitis, etc.
- ☐ I have a history of inflammatory bowel disease (includes Crohn's or ulcerative colitis).
- ☐ I have or have had congestive heart failure.
- ☐ I have a chronic lung disease (for example COPD, emphysema) NOT including asthma.

Score: _____

3. For WOMEN ONLY, add 1 POINT for each statement that applies to you:

- ☐ I currently use birth control (oral contraceptive pills, skin implantable devices, hormonal patches, IUD with hormones, depo shot) or hormone replacement therapy. Not including condoms or barrier devices.
- ☐ I am pregnant or had a baby within the last month.
- ☐ I have a history of an unexplained stillborn infant, THREE (3) or more spontaneous abortions, premature birth with preeclampsia, or baby born smaller than appropriate (low weight at birth).

Score: _____

4. Add 2 POINTS for each statement that applies to you:

- ☐ My doctor told me I have cancer, leukemia, lymphoma, or melanoma.
- ☐ In the last month I have had a non-removable plaster cast or mold that has kept me from bending and/or walking normally on this leg.
- ☐ In the last month, I have had or currently have a PICC line, Port, or central venous access catheter in my neck or chest that delivers blood or medicine directly into my heart.

Score: _____

5. Add 3 POINTS for each statement that applies to you:

- ☐ I have had a blood clot in my legs, arms, abdomen, or lungs.
- ☐ Has anyone in the family (parents, grandparents, aunts, uncles, siblings, cousins) suffered from a blood clot?
- ☐ Have you or any blood relative ever been told that you have an abnormal blood test indicating an increased risk of blood clotting?

Score: _____

6. Please select points for each statement that applies to you

- ☐ I have been in bed for LESS than THREE (3) DAYS associated with sustained walking of fewer than 30 feet. (1 point)
- ☐ I have been in bed for THREE (3) or MORE DAYS associated with sustained walking of fewer than 30 feet. (2 points)

Score: _____

7. Add 5 POINTS for each statement that applies to you:

- ☐ Within the past month, I have had a hip or knee joint replacement surgery. (include if scheduled surgery)
- ☐ Within the past month, I have had a broken hip, pelvis, or leg.
- ☐ Within the past month, I have had a serious trauma (for example multiple broken bones due to fall or car accident).
- ☐ Within the past month, I have had a stroke (clot or hemorrhage in the brain, transient ischemic attack).
- ☐ Within the past month, I have had a spinal cord injury with paralysis

Score: _____

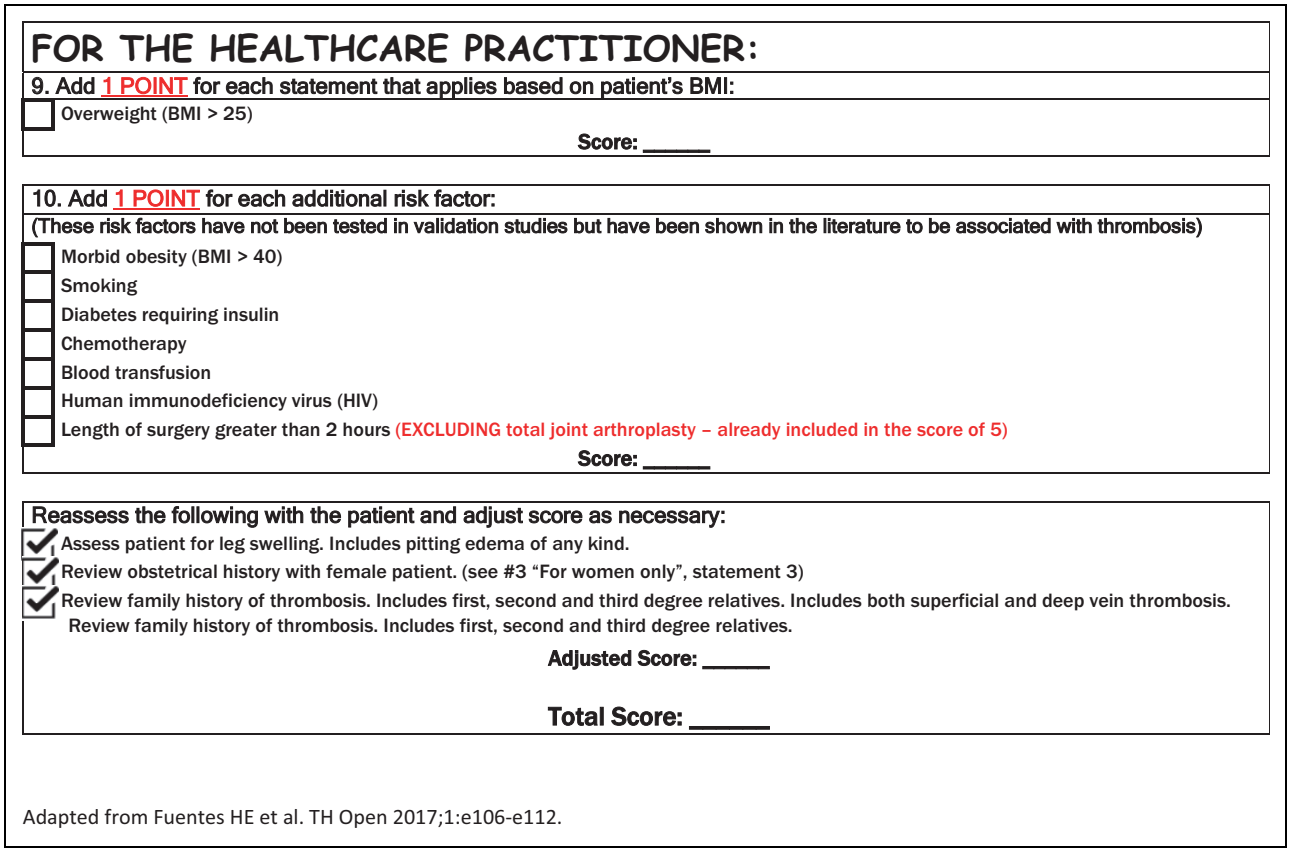
8. If you have a SCHEDULED SURGERY coming up, please select an option.

- ☐ I have a scheduled surgery under general or regional anesthesia for LESS THAN 45 minutes. (1 point)
- ☐ I have a scheduled surgery under general or regional anesthesia for MORE THAN 45 minutes, including laparoscopic or arthroscopic. (2 points) (EXCLUDING total joint replacement – already included in the score of 5)

Score: _____

(over)

Figure 2. Patient-friendly tool (Caprini RAM version 2013) - side 1. Completed by the patient -side 2. Completed by the Healthcare Provider.



FOR THE HEALTHCARE PRACTITIONER:

9. Add 1 POINT for each statement that applies based on patient's BMI:

☐ Overweight (BMI > 25)

Score: _____

10. Add 1 POINT for each additional risk factor:

(These risk factors have not been tested in validation studies but have been shown in the literature to be associated with thrombosis)

☐ Morbid obesity (BMI > 40)
☐ Smoking
☐ Diabetes requiring insulin
☐ Chemotherapy
☐ Blood transfusion
☐ Human immunodeficiency virus (HIV)
☐ Length of surgery greater than 2 hours (EXCLUDING total joint arthroplasty – already included in the score of 5)

Score: _____

Reassess the following with the patient and adjust score as necessary:

☑ Assess patient for leg swelling. Includes pitting edema of any kind.
☑ Review obstetrical history with female patient. (see #3 "For women only", statement 3)
☑ Review family history of thrombosis. Includes first, second and third degree relatives. Includes both superficial and deep vein thrombosis.
Review family history of thrombosis. Includes first, second and third degree relatives.

Adjusted Score: _____

Total Score: _____

Adapted from Fuentes HE et al. TH Open 2017;1:e106-e112.

Figure 2. (Continued.)

consults. Any questions or concerns were escalated to Dr Caprini. The Caprini RAM was completed for every participant both preoperatively and predischarge to ensure that any changes in the patient's postoperative course were captured by the tool (Figure 1).

Completion Guidelines

The patient or the patient's health-care advocate should complete the risk assessment tool.[38] In 2017, Fuentes et al tested multiple versions of a patient-friendly Caprini risk score worksheet until they created a tool that, when completed first by the patient, and then by a physician trained to interpret the Caprini RAM, yielded a high correlation of agreement. The average time to complete the tool was 5 minutes for the patient and then 6 minutes for the physician to finalize the score.[38] Having the patient complete the validated patient-friendly risk assessment in advance of the day of surgery in the presence of family members is vital, especially to provide details concerning family history of thrombosis and obstetrical complications (where applicable). Personal experience has taught us that on many occasions, questions regarding family history of thrombosis in first-, second-, and third-degree relatives are not asked or are addressed in a superfluous manner.[39] Patients who have this history have an increased level of risk, equivalent to those who have a personal thrombophilic defect.[40]

Pannucci and Fleming have stressed the importance of face-to-face patient interviews rather than relying on record review.[41] One of the most common errors is failure to ask all of the pertinent questions. Retrospective database reviews are flawed since it is not known if all of the questions were presented to the patient or if their responses reflected an accurate interpretation of the question. This is especially true of obstetrical complications which may reflect possible antiphospholipid syndrome being carried by a preoperative patient later in life. These antibodies are a powerful stimulus for VTE. Family history is the most frequent issue that is overlooked. To reemphasize, a history of past VTE or family VTE history is one of the most prevailing risk factors responsible for postoperative thrombosis, including untimely death.[38]

The immediate preoperative period on the day of surgery is strongly discouraged for completion of the Caprini RAM. It is an anxious time for the patient and family and a comprehensive, accurate assessment may not be captured. We have found that the presurgical testing visit is an optimal opportunity for the patient and family to fill out the patient-friendly form. The entire document is then reviewed by the health-care provider, preferably the person responsible for the preoperative history and physical. Knowledge regarding a detailed history and physical is necessary to precisely complete the tool for optimal patient outcomes with respect to thrombosis.

The Caprini RAM is a dynamic tool, requiring ongoing evaluation of the patient during their hospital course and the postoperative recovery period. Changes in clinical status could result in a change in the score, thereby resulting in a new score and potentially a revised treatment option. For example, a postoperative infection necessitating a central line for antibiotics would increase a patient's score, and subsequently, the incidence of VTE. A patient sent home after a short hospitalization may be unexpectedly immobile due to postoperative pain or weakness and might develop leg swelling due to inactivity. This may increase their chance of suffering a thrombotic event in the outpatient setting.

Accurate interpretation of the 2013 version of the Caprini RAM is discussed below. The Caprini RAM requires detailed patient information for successful risk assessment. Thus, a tool with patient-friendly text has been created for the 2013 version of the Caprini RAM and is now completed by all of our patients in presurgical testing, which occurs up to 21 days prior to surgery (Figure 2).

Conclusion

The Caprini RAM is a dynamic tool, requiring ongoing evaluation of the patient during their hospital course and the postoperative recovery period. Changes in clinical status could result in a change in the score, thereby resulting in a new score and potentially a revised treatment option. The 2013 Caprini scoring system provides a consistent, accurate, and efficacious method for risk stratification and selection of prophylaxis.

Add 1 POINT for each of the following criteria that apply NOW OR WITHIN THE PAST MONTH:	Criteria interpretation for the health-care provider
☐ Age 41-60 years	
☐ Minor surgery (less than 45 minutes) is planned	The length of surgery must also include the anesthesia time
☐ Past major surgery (more than 45 minutes) within the last month	Major surgery within the past month only
☐ Visible varicose veins	Patients with visible bulging veins would receive a score of 1. This risk factor does not refer to a patient with spider veins or a patient with a history of surgically removed varicose veins
☐ History of inflammatory bowel disease (IBD; eg, Crohns disease or ulcerative colitis)	This risk factor include both active and inactive inflammatory bowel diseases such as ulcerative colitis or regional ileitis. This would not include irritable bowel syndrome or diverticulosis
☐ Swollen legs (current)	Swollen legs include pitting edema of any level, loss of definition of the bony prominences, obscured surface foot veins, or indentation of the leg when a stocking is removed. This factor refers to either 1 or 2 legs affected
☐ Overweight or obese (body mass index [BMI] above 25 kg/m^2)	This weight level was associated with patients developing symptomatic thrombosis following total hip replacement. The combination of BMI greater than 25 kg/m^2 and oral contraceptive use in women increased the thrombotic risk 10-fold[42-44]
☐ Heart attack	This refers to acute myocardial infarction (MI) that occurred within the past month
☐ Congestive heart failure	This risk factor include patients who have had an episode within the last month. Additionally, patients who are currently being treated with medication for CHF are included, even if they had not had an acute episode within the past month. An ejection fraction alone should not be used when determining whether a patient meets this criteria
☐ Serious infection (eg, pneumonia)	A "serious infection" is defined as a patient who requires hospitalization and intravenous antibiotics for treatment. For example, if a patient has a cellulitis requiring hospitalization with IV antibiotics they would receive one point for this risk factor. Treatments that are less severe and are managed on an outpatient basis with oral antibiotics are not included. Serious infections would include diverticulitis, bacterial infection of the bladder and lungs, and septicemia
☐ Lung disease (eg, emphysema or COPD)	In addition to emphysema or COPD this risk factor also includes any interstitial lung disease or patients with abnormal pulmonary function tests. This would include, but not limited to, any patient with sarcoidosis, pulmonary fibrosis, pulmonary hypertension, and bronchiectasis. Patients who present with more than one diagnosis meeting the criteria for lung disease will receive a point for each diagnosis. For example, if the patient has a diagnosis of sarcoidosis and COPD they would receive a total of 2 points for this risk assessment. Asthma is not considered a "lung disease" for the purpose of the risk assessment score. Additionally, patients with restrictive pulmonary disease related to obesity would not be included in this criteria

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Add 1 POINT for each of the following criteria that apply NOW OR WITHIN THE PAST MONTH:	Criteria interpretation for the health-care provider
☐ On bed rest or restricted mobility, including a removable leg brace for less than 72 hours	Restricted mobility (bedrest) is defined as any individual who is unable to ambulate continuously more than 30 feet. "Restricted mobility" would also apply to any patient who is unable to ambulate using both leg muscles. For example, a patient who requires crutches and is nonweight bearing would be considered as restricted mobility even though they can ambulate 30 feet. Patients who are using a cane or walker for stability are not included in this group if they are using their calf muscles for ambulation[45]
Other risk factors (1 POINT each) that apply NOW OR WITHIN THE PAST MONTH:	These risk factors have not been tested in validation studies but have been shown in the literature to be associated with thrombosis
☐ BMI above 40	[26,27]
☐ Smoking within the last month	Smoking is defined as the inhalation of anything that burns, including tobacco, marijuana, or vaping[28,29]
☐ Diabetes requiring insulin	Only insulin products are included in the risk assessment score. This does not include any other oral or parenteral medications used for the treatment of diabetes[30,31]
☐ Chemotherapy	Chemotherapy treatments used for any medical condition are included in the scoring. For example, a patient receiving methotrexate for Rheumatoid Arthritis, regardless of the dose given, would receive a point for this risk factor. Patients diagnosed with essential thrombocytosis taking hydroxyurea would also receive a point here, in addition to 3 points for "personal history of positive blood test indicating increased risk for blood clotting"[32,33]
☐ Blood transfusion(s)	One point is added for one or more blood transfusions[34,35]
☐ Length of surgery over 2 hours	Actual current surgery time exceeding 2 hours, including anesthesia time. Do not add to the "5" for total hip or knee replacement surgery[36,37]
FOR WOMEN ONLY: Add 1 POINT for each of the following criteria:	Criteria interpretation for the health-care provider
☐ Current use of birth control or hormone replacement therapy (HRT)	This includes estrogen contraceptives of any type. This also includes estrogen-like drugs, including raloxifene, tamoxifen, anastrozole, and letrozole. Exemestane has not been shown to increase the risk of DVT. Recent publications have shown that there is no increased risk of DVT in men who are on long-term testosterone therapy; therefore, testosterone is excluded
☐ Pregnant or had a baby within the last month	
☐ History of unexplained stillborn infant, recurrent spontaneous abortion (3 or more), premature birth with toxemia or growth restricted infant	Recurrent fetal loss is associated with antiphospholipid antibody syndrome, procoagulant platelet microparticles and some inherited thrombophilias such as Factor V Leiden. There have been reports of both heritable and acquired thrombophilias being associated with preeclampsia, intrauterine growth restriction (IUGR), and abruption. However, these associations are not consistently reported with hereditary thrombophilias[46]
Add 2 POINTS for each of the following criteria:	Criteria interpretation for the health-care provider
☐ Age 61-74 years	
☐ Current or past malignancies (excluding skin cancer but including melanoma)	Whether the cancer diagnosis is remote or recent the patient will receive a score of 2. This is because patients with a remote history of cancer are always at risk of occult metastasis, which would increase their risk of thrombosis. Every incidence of cancer is considered separately and scored accordingly. For example, a patient who has a remote history of breast cancer and is recently diagnosed with uterine cancer would receive a score of 4 (2 points for each episode of cancer). For the purpose of this document, Ductal Carcinoma in situ (DCIS) would also receive a score of 2 as there is always the potential of an invasive cancer. Myelodysplastic syndrome (MDS) would be scored as 2 points only if the disease requires chemotherapy treatment. The patient would also receive an additional point for the chemotherapy treatment

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Add 2 POINTS for each of the following criteria:	Criteria interpretation for the health-care provider
☐ Planned major surgery lasting longer than 45 minutes (including laparoscopic and arthroscopic)	Do not add to the "5" for total hip or knee replacement surgery. One additional point should be added if the surgery lasts longer than 2 hours, including anesthesia time. See "Other risk factors (1 point each)"
☐ Nonremovable plaster cast or mold that prevents leg movement within last month	The intent of this risk factor is to capture any limitation in leg mobility which would interfere with calf muscle pumping action such as a leg brace or cast. Patients using crutches who are nonweight bearing on one leg would also be included. The use of an assistive device for stability, such as a walker, would not meet the criteria if the patient is using their calf muscles
☐ Tube in blood vessel in neck or chest that delivers blood or medicine directly to the heart within the last month (eg, central venous access, PICC line, port)	
☐ Confined to bed for 72 hours or more (unable to ambulate continuously 30 feet).	"Confined to bed" is confusing terminology and should be referred to as impaired mobility. The patient is unable to ambulate continuously 30 feet. This would also apply to any patient who is unable to ambulate using both leg muscles. For example, a patient who requires crutches and is nonweight bearing would be considered as restricted mobility even though they can ambulate 30 feet. Patients who are using a cane or walker for stability are not included in this group if they are using their calf muscles for ambulation[45]

Add 3 POINTS for each of the following criteria:	Criteria interpretation for the health-care provider
☐ Age 75 or over	
☐ History of blood clots, either deep vein thrombosis (DVT) or pulmonary embolism (PE). This also includes history of superficial venous thrombosis (SVT).	Arterial blood clots are *not* included in the scoring. A CVA due to a paradoxical embolus (eg, PFO) would be given 3 points; however, a DVT must be documented by an objective measure in this case. Each episode of a DVT or PE is captured as a separate event for scoring. For example, a patient with a medical history of DVT in 2014 and PE in 2015 would be given a cumulative score of 6. However, PE and DVT events that occur simultaneously would be scored as 3 points. SVT must be captured and scored a 3 here as well[47]
☐ Family history of blood clots	Family history should include first-degree relatives (sibling, son/daughter, parent, grandparent), second-degree relatives (maternal half-sibling, paternal half-sibling, niece/nephew), and third-degree relatives (cousin). Younger age of first venous thromboembolism (VTE) and male relative increase the risk[39]
☐ Personal or family history of positive blood test indicating an increased risk of blood clotting (eg, genetic or acquired thrombophilia)	A patient will receive a score of 3 points for each genetic thrombophilia marker. If a family member has a proven genetic marker the patient will receive a score of 3 unless it has been confirmed that the patient does not have this genetic marker. Genetic (inherited) factors: Factor V Leiden/activated protein C resistance, antithrombin III deficiency, protein C & S deficiency, dysfibrinogenemia, 20210A prothrombin mutation. Acquired factors: lupus anticoagulant, antiphospholipid antibodies, myeloproliferative disorders (including thrombocytosis), disorders of plasminogen and plasmin activation, heparin-induced thrombocytopenia, hyperviscosity syndromes, and homocysteinemia.[48] HIV infection is an acquired thrombophilia[49]

Add 5 POINTS for each of the following criteria that apply NOW OR WITHIN THE PAST MONTH:	Criteria interpretation for the health-care provider
☐ Elective hip or knee joint replacement surgery	5 points are given for each surgical procedure; therefore, patients having staged or bilateral arthroplasty surgery are to be scored as 10 points
☐ Broken hip, pelvis, or leg	Fractures requiring surgical repair would receive 5 points for the fracture and will also be assessed additional points depending on the type of surgery. Patients undergoing an ORIF would be given 2 points for "surgery over 45 minutes." Patients requiring a hemiarthroplasty would receive 5 points "for elective hip replacement surgery." For example, a patient with a fractured ankle undergoing an ORIF would receive a score of 7, 5 points for the fracture and 2 points for the surgical repair. An additional 2 points would be added if a cast or brace is applied

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Add 5 POINTS for each of the following criteria that apply NOW OR WITHIN THE PAST MONTH:	Criteria interpretation for the health-care provider
☐ Serious trauma (eg, multiple broken bones due to a fall or car accident)	Now or within the past month
☐ Spinal cord injury resulting in paralysis	Now or within the past month
☐ Experienced a stroke	Now or within the past month

Abbreviations: CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; CVA, cerebral vascular accident; IV, intravenous; ORIF, open reduction internal fixation; PFO, patent foramen ovale; VTE, venous thromboembolism.

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