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Alphonse Gerhardstein
Laufman and Gerhardstein
617 Vine Street, Suite 1409
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RE: Susan Samples v. Logan County Sheriff's Dept.
Case # 2:03CV847

Dear Mr. Gerhardstein,

These are my expert witness opinions on the above named case. These opinions are based upon my 26 years experience as a Family Physician and my 13 years of Correctional Health Care experience, my knowledge of Correctional Health Care standards through site surveys, as well as interaction with Correctional Health Care professionals in my role as President of the Society of Correctional Physicians and the American Correctional Health Services Association. I hold these opinions to a reasonable degree of medical certainty.

To formulate this opinion, I reviewed the following documents:

Documents from the Ohio Peace Office Training manuals, Section 6120: 1-8-09 of the Ohio Administrative Code of Minimum Standards for Full Services Jails, intake screening of Susan Samples at Logan County Jail and miscellaneous documents regarding training of officers, certificates and jail policies.

Depositions of:

1. Brent Samples
2. Corporal Guy Knight
3. Amy Oakley
4. Charles Wirick
5. Heather Maxwell-Boone
6. Francis Galyk
7. David Stockwell
8. Scott Costin
9. Brenda Shively

Interviews at the time of the incident of:

1. Beth Mathews
2. Charles Wirick
3. Deborah Kindle
4. Guy Knight
5. Heather Boone
6. Vera Holden

Susan Samples was a 42 year-old woman, who was arrested by Officer Francis Galyk in the early morning of September 17,2002 for disorderly conduct. Galyk had been dispatched to the Samples' residence, following a call by Brent Samples to the Sheriff's office. Upon arriving at the house, Officer Galyk was met by Mr. Samples who essentially told him that Mrs. Samples appeared to out of control and he was concerned. According to his report, Mr. Samples said Susan had a drinking problem and he was concerned for the welfare of himself and their children. After several attempts to quiet Mrs. Samples down, Officer Galyk finally arrested her and took her to the Logan County Jail.

The records indicate that they arrived at the jail at around 3:00 am but she wasn't booked in until 6:31 am. There was no specific explanation for this delay although there was speculation that the booking area might have been busy, or that she was too intoxicated to cooperate and they let her " sleep it off" for a few hours.

When Officer Galyk turned over custody of Mrs. Samples, he made a Xerox copy of his report and indicates in his deposition that he put multiple X's at the bottom to indicate to the jail staff that she was quite intoxicated. Review of Officer Galyk's deposition seems to suggest that at some later date, marks were made over his X's to try and hide them.

It appears that Officer Wirick booked Mrs. Samples although, in his deposition, he states that someone else may have finished her booking process.

Sometime in the morning around 9:00 am, Susan Samples was taken to court where she was sentenced to approximately 7 days in jail. She was returned to the jail and assigned an upper bunk in one of the female dorms. There appear to be no additional custody officer notes on her until the early hours of Sept. 18, 2002.

In the early hours of Sept. 18th, Corporal Knight, who was in the Control Center, received an intercom call from the inmates in Susan Samples' dorm, stating that a woman had fallen out of the upper bunk and struck her head on the floor. The records reviewed give estimates of the custody officer's response time, from 15 seconds to 5 minutes. Custody staff that entered the unit states they found a woman laying on the floor of the cellblock, partially on her side and bleeding from the head. Initial evaluation by Officer Boone indicated that she had a pulse but did not respond to command. Officer Wirick thought she was breathing, but that it was shallow. It appears that the majority of inmates and officers refer to a gurgling sound or abnormal breathing.

A call was made to Corporal Knight to summon the Rescue Squad. He placed this call after making a brief phone call to the on-call nurse. None of the officers attempted CPR, even though it appeared that Mrs. Samples' breathing was deteriorating or stopping and that her pulse was weak or nonexistent. When Fire Rescue arrived, which was about 22 to 23 minutes after the initial report of Susan Samples falling out bed, they found her to be in full code (not breathing and no heart beat). They called for backup and began CPR. Eventually, she was intubated and given defibrillation but to no avail. She was transported to the hospital where she was pronounced dead.

In reviewing these records, I find multiple instances of lack of care that constitute deliberate indifference to Mrs. Samples' serious medical needs. The first of these is the woefully inadequate intake screening on her booking into the Logan County Jail. She was obviously intoxicated and the staff was alerted to this via Officer Galyk's report, but nothing was done to assess her level of intoxication. More specifically, no questions were asked regarding her level of drinking or her duration of drinking. This is not in conformance with the Ohio Administrative Code of Minimum Standards for Full Service Jails, whose policies state that when doing an intake on an arrestee this type of information should be obtained. I attribute some of the blame for Mrs. Samples' demise on the failure of the Logan County Jail and it's staff, to follow these rules promulgated for full service jails [5120: 1-8-09] that are also reflective of the accepted Standard of Care in jails and prisons.

Second is the failure of the custody staff to follow up on Susan Samples when she returned from Court, as instructed by Corporal Knight when he finished his shift on the morning of September 18,2002. Had they done so, I believe that they would have seen the early indications of Alcohol Withdrawal Syndrome and been able to either

alert the nursing staff, or at least bring Susan Samples up to the booking area where she could have been monitored more closely.

Third, in reviewing the deposition of Dr. Scott Costin, it appears to me that he has very little knowledge of Alcohol Withdrawal Syndrome. He seems to indicate in his deposition that treating alcohol withdrawal with benzodiazepines only makes it more "tolerable" as opposed to being life saving. His responses also indicate that he does not recognize that untreated alcohol withdrawal can frequently be life threatening, nor does he seem to be knowledgeable that the majority of deaths related to alcohol withdrawal, occur in custody settings such as a jail. He mentions that he used Harrison's and Cecil's Manuals of Medicine, as well as the American Academy of Family Practice as his resources for practicing medicine. He has never joined a Correctional Health Care professional group or ever attended a Correctional Health Care conference, where issues of detox would have been a common theme. This lack of common knowledge of what is a significant life threatening illness in the correctional environment, where it occurs frequently, I consider to be deliberately indifferent to the serious medical needs of Susan Samples, as well as all inmates with serious alcohol problems booked into the Logan County Jail. I note that he acknowledges in his deposition, there are more individuals booked into the Logan County Jail with alcohol problems than are found in the general population. This indeed is most likely true, as alcoholics and those who are intoxicated are much more likely to run afoul of the law (as in Mrs. Samples' case) and be arrested.

This lack of knowledge and vigilance also allowed the nursing and custody staff to not be trained in recognizing Alcohol Withdrawal Syndrome as a potentially lethal entity and allow it to go unrecognized. Or to be recognized only after the individual was placed in housing and started to exhibit symptoms of withdrawal. In support of my opinions, I have attached a bibliography of articles on the lethality and treatment of Alcohol Withdrawal Syndrome, as well as the National Commission on Correctional Health Care Standards on Intoxication and Withdrawal dated in 1996. All of these texts should have been available to Dr. Costin, if he had chosen to learn more about Correctional Medicine.

One of the articles is a chapter from Clinical Practice in Correctional Medicine which discusses many of the issues that are dealt with in correctional setting that are different then those experienced in private practice. One of those differences relates to the frequency of alcohol and drug withdrawal in the correctional setting. This chapter, once again, emphasizes the lethality of untreated alcohol withdrawal.

According to Logan County Sheriff's Office, policy 72.75, Dr. Costin was to serve as the Medical Director of the jail. As such, he has the overall responsibility for health care in that jail which would include development or oversight of all medical and nursing policy and procedure, as well as writing or signing off on all standing orders. The records I reviewed appear to indicate that medical policies and procedures were actually written by custody and not medical/nursing staff, without input from Dr. Costin. Such actions, if accurate, would constitute deliberate indifference to the serious medical needs of the inmates of Logan County Jail, including Susan Samples.

Fourth, in reviewing Brenda Shively's deposition, it appears that the nurse sees individuals, who are identified as having possible alcohol withdrawal, when the nurse is on site. The custody staff does not appear to have been adequately trained to recognize Alcohol Withdrawal Syndrome. Therefore, even if there is a nurse on-call for such potential issues, if the custody staff can't recognize it, this would still constitute deliberate indifference to the serious medical needs of arrestees who either come into the facility or start to have problems during those hours a nurse is not on site (as was true in Susan Samples' case). Her deposition also indicates to me that she, too, does not have adequate knowledge of the lethality of Alcohol Withdrawal Syndrome. Such lack of knowledge in a jail setting, in my mind, constitutes deliberate indifference, as this is the setting where it most likely to occur and at the same time the person going through the withdrawal in unable to remedy the situation (i.e. drink some alcohol).

It haven't seen any evidence of education programs for the nursing or custody staff, not only in the lethality of alcohol withdrawal, but also no training in the CIWA-r scale recommended by the American Society of Addiction Medicine, the authors of "Clinical Practice in Correctional Medicine" and the articles in American Family Physician. Use of this scale, applies objectivity to monitoring the withdrawal process and allows someone to be safely detoxified. There is no evidence that this process was used and indeed, the detox protocols I reviewed are extremely vague to the point that I can't even tell if the nurse initiates them without seeing the patient.

If in fact, the nurses initiated the Detox process without physician contact, without a specific protocol and without the use of the CIWA-r scale, I consider that to be deliberate indifference to the serious medical needs of the inmate.

To this point, the records indicate to me deliberate indifference to the serious medical needs of Susan Samples by not doing a proper intake regarding alcohol consumption as put forth by the Ohio Administrative Code of Minimum Standards for Full Service Jails (Section 5120: 1-8-09). They failed to adequately re-evaluate Susan Samples as requested by Corporal Knight when he finished his shift. They lacked the training to evaluate someone going through potentially lethal alcohol withdrawal. Dr. Costin lacked the necessary training regarding alcohol withdrawal and failed to impart its importance to the nursing and custody staff at Logan County Jail and Nurse Shively failed to recognize the potential lethality of alcohol withdrawal and communicate that to her nursing staff via training and proper protocols.

It appears from the records, that Logan County Sheriff's Office policy 72.73, page 5, Section II, G, states that the physician will be on site three times a week. This is appropriate for a jail the size of Logan County and would meet the National Commission on Correctional Health Care standards were they to be accredited. However, the testimony I reviewed indicates to me that Dr. Costin was on site only once a week and that this was for about two hours, which were divided between the jail and the juvenile facility. The expectation appears to have been that, during this time, he would see all the sick call patients he needed to see, as well as any necessary physical exams. In my experience, performing all these services and providing quality care would be inconsistent in a jail setting. Several documents allude also to a quarterly report on utilization. This was not contained in any of the records I reviewed which might illuminate concerns about sick call flow.

Fifth, deliberate indifference is also seen in the custody staff's behavior once they were alerted to Susan Samples having fallen out of bed. Upon arriving at the scene, they assessed her for a pulse and breathing. Most of the testimony seems to indicate that she was not breathing normally, at best, making what sounded like agonal breath sounds and at worst, not breathing at all. In fact, in her testimony, Officer Boone states that she told Corporal Knight that she thought Mrs. Samples had stopped breathing. During that time, Officer Boone also checked Susan Samples' pulse and initially found a good pulse, but later before she leaves the scene, found it weakening. All of these signs are obvious indications that Susan Samples may be dying and in need of CPR. In spite of this, no CPR is started due to Officer Wirick's comment not to move her because of a possible head injury. In the face of someone dying due to lack of cardiopulmonary circulation, you don't let them die because you are afraid to move him/her. This to me indicates a lack of appropriate training of the Logan County Sheriff staff in regards to Emergency Care and CPR. Had the custody staff initiated CPR instead of waiting for the Rescue Squad, Susan Samples would more then likely than not, survived, as her head injuries were not that severe. Not initiating CPR to someone in cardiopulmonary arrest will usually assure his or her demise.

In summary, I believe Dr. Costin exhibited deliberate indifference to Susan Samples by not fulfilling his duties as Medical Director of the Logan County Jail. By not obtaining adequate knowledge of the lethality of Alcohol Withdrawal Syndrome, which is more common in the jail setting, and by not establishing polices and procedures that would assure adequate training of the nursing and custody staff in this syndrome or how to manage it when inmates began to show signs of it, also shows deliberate indifference. It also appears that he was not adhering to the policy of the Logan County Sheriff's Office with regard to the time spent on-site, nor fulfilling his duties in developing policies and procedures as outlined in the Ohio Administrative Codes of Minimum Standards for a Full Service Jail.

I believe Nurse Shively also demonstrated deliberate indifference to Susan Samples' serious medical needs by not being knowledgeable of the potential lethality of Alcohol Withdrawal Syndrome, not ensuring that her nursing staff and the custody staff were educated on how to recognize it and what to do once it was recognized.

I believe that Logan County and the Logan County Sheriff exhibited deliberate indifference to Susan Samples' serious medical need by not having an Intake Screen that was mandated by the Ohio Administrative Code of Minimum Standards for a Full Service Jail. If such an Intake Screen had been in place at the time of Susan Samples entry into their system, it would have revealed her to be at high risk for alcohol withdrawal and measures could have been taken to ensure closer observation and her safety. The lack of such a screen and attention to the arresting officers reports allowed someone with a serious medical condition to enter the system unknown.

The response of the custody officers to Susan Samples after she fell from the bunk bed ensured that she would not survive. At the time they reached her, she still had a heartbeat and possibly was still breathing. If CPR had been initiated at that time, there is a good possibility that she would have lived. However, the lack of oxygen to her brain from the time the officers entered the room until the time that Rescue arrived 22-23 minutes later, allowed her to expire. I regard this as deliberate indifference to her serious medical needs.

Lastly, I regard those actions and omissions of Dr. Costin and Nurse Shively stated above, to demonstrate deliberate indifference to Mrs. Samples' serious medical needs as well as demonstrating substandard care and medical negligence.

These opinions are based on my review of the records outlined at the beginning of this opinion letter. If additional records or information is made available in the future, I reserve the right to revise my opinion based on review of this new information.

Respectfully submitted,

Roderic Gottula MD

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