

1 IN THE COURT OF COMMON PLEAS

2 CUYAHOGA COUNTY, OH

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4  
5 JOHN T. MURRAY, As Administration  
6 of the Estate of Dale D. Dukeshire, Jr.  
7 deceased, et al,

8 Plaintiffs,

9 vs.

CV 18 905172

10 RITE AID OF OHIO, INC., and  
11 JAMES GALLAGHER, MD, et al.,

12 Defendants.

13 \*\*\*\*\*

14 The virtual deposition of ROBERT S.  
15 LITMAN, R.PH., C.PH., CGP, taken by the defendants  
16 under the Ohio Rules of Civil Procedure in the  
17 above-entitled action, pursuant to notice, before  
18 Kristina Guthrie, Professional Court Reporter, held  
19 via Zoom video conferencing, on Monday, November 9,  
20 2021, commencing at approximately 12:01 p.m.

21  
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Mrs. Dukeshire

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PROCEEDINGS

COURT REPORTER: We're here today for the deposition of Robert S. Litman, R.PH., C.PH., CGP in the Court of Common Pleas in Cuyahoga County, Ohio, in the matter of John T. Murray, et al. versus Rite Aid of Ohio, Inc., et al., being Civil Action No. CV 18 905172.

Today's date is November 8th of 2021, and the time on the monitor is 12:01.

My name is Kristy Guthrie and I'm a court reporter representing Realtime Reporters out of Charleston, West Virginia.

If counsel will please identify themselves and whom they represent, and I guess we'll start with the noticing attorney, please.

MS. WHITE-FARRELL: This is Tamela White-Farrell. I and John McManus are here on behalf of Rite Aid of Ohio, Inc.

MR. BECK: This is Chad Beck here on behalf of Dr. James Gallagher.

MR. ABRAMOWITZ: We have Mark Abramowitz and Christopher Stombaugh from DiCello Levitt Gusler on behalf of the plaintiffs and the Estate of Dukeshire, Ms. Dukeshire, as well --

1 MR. GRIFFIN: -- for Dr. Gallagher.

2 (Audio interference).

3 MR. ABRAMOWITZ: I'm sorry, Steven. My  
4 apology. I didn't mean to cut you off there. Sorry  
5 about that.

6 COURT REPORTER: Do we have someone else  
7 that needed to -- I believe.

8 WITNESS: I am Robert Litman, the expert  
9 witness, pharmacist.

10 COURT REPORTER: Great. Thank you. And I  
11 forgot to state, if anyone has an objection to me  
12 swearing in the witness remotely if they could say  
13 so at this time. Are there no objections? Thank  
14 you.

15 All right, I am going to put you under oath  
16 if you'll please raise your right hand.

17 ROBERT S. LITMAN, R.PH., C.PH., CGP,  
18 was called as a witness, pursuant to notice, and  
19 having been first duly sworn, testified as follows:

20 DIRECT EXAMINATION

21 BY MS. WHITE-FARRELL:

22 Q. Would you state your name for the record,  
23 please.

24 A. Robert Litman.

1 Q. And you are a pharmacist; true?

2 A. True.

3 Q. What is Ultimed Health Advisors, Inc.?

4 A. That is my company, my business company.

5 It's a consulting firm. We provide retail pharmacy

6 management services, long term care pharmacy,

7 nursing home consulting, and also, I also use it for

8 my legal consulting.

9 Q. What percent of the income of Ultimed  
10 Health Advisors is for legal consulting?

11 A. It's approximately 10 to 15 percent I would  
12 say. It's a rough estimate.

13 Q. Are you currently employed anywhere else as  
14 a pharmacist?

15 A. Yes.

16 Q. Where?

17 A. Well, under my company, Ultimed, I have

18 several long-term care nursing home accounts that I

19 service. Do you need the names of the homes? I can

20 relay the names of the homes. Coral Gables Nursing

21 and Rehab Center, Okeechobee Nursing and

22 Rehabilitation Center, Hampton Court Nursing and

23 Rehabilitation Center.

24 I also do independent consulting for a

1 fellow named Robert Rosenthal, Bobby Rosenthal, who  
2 was the former President of Florida Healthcare  
3 Association. He also has management contracts for  
4 long-term care facilities and I work with him, you  
5 know, doing troubled -- helping fix troubled homes.

6 Q. When was the last time you worked at a  
7 retail pharmacy?

8 A. I believe that was 2017.

9 Q. And what retail pharmacy was that?

10 A. It was Black and White Pharmacy. It's on  
11 Flagler Street in Miami.

12 Q. Do you have all of the -- you know, before  
13 I do that, Ultimed Health Advisors, Inc., where is  
14 it incorporated, in Florida?

15 A. Yes.

16 Q. Okay. Other than yourself, are there any  
17 other owners?

18 A. No.

19 Q. Do you have all of the information you need  
20 to render any opinion you would attempt to render in  
21 this matter?

22 A. Yes.

23 Q. Have you asked for any information that has  
24 not been provided to you?



1           A.     Not that I can think of off the top of my  
2 head.

3           Q.     Have you interviewed anyone from the  
4 Dukeshire family?

5           A.     No, I have not.

6           Q.     Have you interviewed anyone at all whether  
7 it be a party to this lawsuit or a colleague or a,  
8 for instance, a retail pharmacist, have you  
9 interviewed anyone at all for purposes of this case?

10                   MR. ABRAMOWITZ:  Objection, but you can  
11 answer.

12           A.     No, I haven't.

13           Q.     I sent to the court reporter this morning  
14 my Notice of Deposition.  Have you seen it before?

15           A.     Yes.

16           Q.     Have you brought with you your file?

17           A.     Yes.

18           Q.     Would you share with me what you brought?

19           A.     I brought a -- well, let me -- excuse me  
20 one second.  I brought these.  I don't know if you  
21 can see these records.  I brought -- these are  
22 mostly depositions that I have reviewed.  And I put  
23 all my bills and correspondence on a USB drive.

24           Q.     Okay.

1           A.     So they're not on paper. I have on a  
2 drive.

3           Q.     I will mark your bills and correspondence  
4 -- well, I'll mark the Notice of Deposition as  
5 Exhibit 1.

6                     DEPOSITION EXHIBIT NO. 1

7                     (Notice of Deposition was marked for  
8 identification purposes as Deposition  
9 Exhibit No. 1.)

10           I'll mark your bills and correspondence as  
11 Exhibit 2 and at a break, we will work with the  
12 court reporter to determine how to get those  
13 transmitted to her; okay?

14                     DEPOSITION EXHIBIT NO. 2

15                     (Bills and Correspondence were marked for  
16 identification purposes as Deposition  
17 Exhibit No. 2.)

18           MR. ABRAMOWITZ: Wait, we have to -- I need  
19 to enter an objection here. We believe there's some  
20 attorney-client privileged material inside of the  
21 bills. We are happy to provide a redacted version  
22 of them. We believe you are absolutely owed the  
23 numbers but any sort of detail about what was  
24 discussed between counsel and the experts witness

1 that are listed on those bills will be redact it.

2 Is that subject to us claiming our  
3 privilege on those matters? Is that okay?

4 MS. WHITE-FARRELL: I don't have any  
5 problem with that so long as the Goose/Gander role  
6 applies that the defendant can likewise redact  
7 anything that it contends is work product.

8 MR. ABRAMOWITZ: Well, of course. I mean,  
9 I believe those rules go both ways.

10 MS. WHITE-FARRELL: Yep. Okay. So at a  
11 break, let's talk about the housekeeping aspect of  
12 that rather than wasting time on the record; okay?

13 MR. ABRAMOWITZ: Fair enough.

14 BY MS. WHITE-FARRELL:

15 Q. On medical records, Doctor, on page 2 of  
16 your November -- on page 3 of your November 18,  
17 2020, report, you listed a number of medical  
18 records.

19 A. I'm trying to find that report. One  
20 second. What page was that? I'm sorry.

21 Q. Page 3.

22 A. All right. And the question again?

23 Q. Well, first, I was just orienting you, but  
24 the question is, is this a list of all of the

1 medical records for Mr. Dukeshire or Janet Dukeshire  
2 that you've received and reviewed in this case?

3 A. Yes.

4 Q. If you --

5 MR. ABRAMOWITZ: Object to the time of --

6 A. -- as of that time. I believe this is the  
7 US.

8 Q. Do you have any more medical records other  
9 than what are on this list?

10 A. To be -- I can't be sure at this point.  
11 There may have been some other materials I may have  
12 reviewed since I got, created this opinion letter  
13 but I would have to go through my files at home,  
14 because I prepared all of this prior to, you know,  
15 this, you know, when I submitted this report.

16 Q. Do you rely on any medical record whether  
17 they be listed in this report or otherwise as the  
18 basis of any opinion you would offer?

19 A. Yes. It's based on all of the records that  
20 I reviewed on this paper, yes.

21 Q. What about medical records that you have at  
22 home, is there any opinion that you have that you  
23 would rely upon any medical record that is not  
24 included in this list?

1           A.     There may be some files I've added since I  
2     created this document.  They were research documents  
3     that I, were checking from the other expert reports  
4     that I read trying to verify the data that was  
5     presented.  So I do have some other studies that  
6     I've put in my file.

7           Q.     My question is medical records.  Let's  
8     focus on medical records.

9           A.     Oh, medical records from the patient?  No.  
10    This is the complete list of medical records.

11          Q.     All right.  So that the record is clear,  
12    the list on page 3 of your report is the complete  
13    list of all medical records that you've reviewed?

14               MR. ABRAMOWITZ:  Objection, but you can  
15    answer.

16          A.     I believe so.  I believe that is the  
17    complete list.

18          Q.     And what are the studies that you have at  
19    home that you did not bring with you?

20          A.     Actually, I brought them with me here in  
21    paper but not on the hard drive.  They are -- one is  
22    from the chief medical examiner at North Carolina  
23    and it was the interpretation of toxicology results.

24          Q.     I'll mark that as Exhibit 3.

1 DEPOSITION EXHIBIT NO. 3  
2 (Interpretation of Toxicology Results,  
3 Chief Medical Examiner in North Carolina  
4 was marked for identification purposes as  
5 Deposition Exhibit No. 3.)

6 Q. All right. Any others?

7 A. The explanation of an overdose risk score.

8 Q. The explanation, the overdose risk score.  
9 I'll mark that as Exhibit 4.

10 DEPOSITION EXHIBIT NO. 4  
11 (Explanation of Overdose Risk Score was  
12 marked for identification purposes as  
13 Deposition Exhibit No. 4.)

14 A. A --

15 Q. -- morphine equivalent dosing, I'll mark as  
16 Exhibit 5.

17 DEPOSITION EXHIBIT NO. 5  
18 (Morphine Equivalent Dosing was marked for  
19 identification purposes as Deposition  
20 Exhibit No. 5.)

21 A. Right. This is from -- now, if you can see  
22 this, on this, our Experts Industry highlight,  
23 Insights.

24 Q. And that's Exhibit 5.

1 MR. ABRAMOWITZ: Hang on here one second,  
2 I'm sorry, Tammy. I know you're on a roll and I  
3 want to get things listed up so we can get this to  
4 you. So Exhibit 4 is explaining overdose risk.

5 WITNESS: That was 4.

6 MR. ABRAMOWITZ: And what's in 5?

7 MS. WHITE-FARRELL: 5 was the last one he  
8 held up which I think was the Morphine equivalence.

9 MR. ABRAMOWITZ: Thank you. I'm sorry,  
10 Tammy. I got some sticky notes now to keep track of  
11 this.

12 WITNESS: This one.

13 MS. WHITE-FARRELL: Exhibit 6 is the  
14 Pharmacokinetics and Pharmacodynamics of Carfentanil  
15 After Recreational Exposure, A Case Report.

16 DEPOSITION EXHIBIT NO. 6

17 (Pharmacokinetics and Pharmacodynamics of  
18 Carfentanil After Recreational Exposure, A  
19 Case Report was marked for identification  
20 purposes as Deposition Exhibit No. 6.)

21 MR. ABRAMOWITZ: All right.

22 A. And this was from Wolters Kluwer

23 Q. Wolters Kluwer, this is No. 7.

24 DEPOSITION EXHIBIT NO. 7

1 (Module 5 - Wolters Kluwer was marked for  
2 identification purposes as Deposition  
3 Exhibit No. 7.)

4 A. It's a module Addressing and assessing  
5 opiate use disorder.

6 Q. All right. No. 7, module 5.  
7 Any more independent research that you've  
8 done?

9 A. No. I believe that should cover  
10 everything.

11 Q. Have you consulted any trade journals or  
12 retail pharmacies concerning the filling of  
13 prescriptions one to two days before a prior  
14 prescription will expire?

15 A. No. I don't believe I have.

16 Q. Going back to the deposition notice,  
17 Exhibit 1, do you have any notes regarding this  
18 case?

19 A. Yes, I do.

20 Q. We'll make your notes the next exhibit  
21 which I believe is 8.

22 MS. WHITE-FARRELL: Am I right, Ms. Court  
23 Reporter?

24 COURT REPORTER: Correct.



1 DEPOSITION EXHIBIT NO. 8

2 (Notes of Robert S. Litman were marked for  
3 identification purposes as Deposition  
4 Exhibit No. 8.)

5 MR. ABRAMOWITZ: This is again subject to  
6 review for any attorney-client privilege work  
7 product information that might be inside of them  
8 which we would ask for a review before presenting.

9 WITNESS: All right. This is the report  
10 that I put together. It's a five-page report on the  
11 prescriptions from, based on the list I was  
12 provided.

13 MR. ABRAMOWITZ: Exactly. If it's a draft  
14 report, we're not going to be producing that.

15 WITNESS: What do you mean a draft report?

16 MR. ABRAMOWITZ: You used the term  
17 "report." Again, Tammy, I'm going to be speaking  
18 here. It's not to be insulting, use the term draft  
19 on a report.

20 WITNESS: I don't really -- I don't  
21 understand what you mean by draft. I mean, you  
22 asked for notes. This is notes.

23 MR. ABRAMOWITZ: Okay. I just want to make  
24 sure.

1 WITNESS: Didn't you ask me for notes,  
2 Tammy?

3 MS. WHITE-FARRELL: I did.

4 WITNESS: Yeah. These are the notes,  
5 right.

6 BY MR. WHITE-FARRELL:

7 Q. And what are those notes from? Were they  
8 from the patient profile or are they from  
9 prescriptions? Are they from medical records?  
10 What's the source of those notes?

11 A. Those are from Rite Aid's medical records.

12 Q. So the patient profile?

13 A. Yes.

14 Q. Okay. Did you match those notes with the  
15 Oarrs report?

16 A. I did from the reports that I had. I  
17 didn't have the complete reports, but what I did  
18 have I did match to some of the Oarrs statement.

19 Q. All right. And what are you saying to  
20 yourself on these notes that are Exhibit 8?

21 A. I was just merely noting the dates, the  
22 drugs dispensed, the prescriptions, the quantities,  
23 the date supplied, the number of days that that  
24 prescription should cover and then the doctor who

1 wrote it. And it goes from April 4, 2013, through  
2 August 21, 2017.

3 COURT REPORTER: May I ask --

4 MS. WHITE-FARRELL: Yes.

5 WITNESS: I'm sorry. I'm sorry. It goes  
6 through October 9, 2017.

7 COURT REPORTER: May I asked Oarrs data -  
8 O-r-r data?

9 MS. WHITE-FARRELL: O-a-r-r-s.

10 COURT REPORTER: Thank you.

11 WITNESS: Right.

12 BY MS. WHITE-FARRELL:

13 Q. What is it that you are communicating  
14 through these notes?

15 A. Well, I was doing these to assess the  
16 dispensing frequency, the retail status, when they  
17 would be filling scripts and to establish how long  
18 these prescriptions should be lasting on each  
19 dispensing and how often they were refilled or  
20 refilled early, or in many, in several cases, they  
21 may have been refilled a little late.

22 Q. On how many -- well, strike that.

23 Are you looking -- when you're using the  
24 words "refill," are you referring to C-IIs?

1           A.    I know.  I realize there's no refills in  
2 C-IIs.  They're all new prescriptions.

3           Q.    All right.

4           A.    So I've used the term refills.  It should  
5 be from one new prescription to the next new  
6 prescription.

7           Q.    So let's complete that thought.  For each  
8 of the prescriptions that Dale Dukeshire had for a  
9 C-II substance, he had to present a new  
10 prescription; didn't he?

11          A.    Yes.

12          Q.    And which meant there had to be a new  
13 original prescription; true?

14          A.    That's true.

15          Q.    Which meant that he had to see his provider  
16 in order to or have some direct communication with  
17 his provider in order to have that new prescription  
18 written?

19          A.    Yes.

20          Q.    Okay.  So where you have referred to early  
21 refill, what you're really referring to is  
22 presentation of a new prescription before an old one  
23 completely expired; right?

24          A.    Yes.  Correct.

1 Q. Do have you experience in, at any pharmacy  
2 in policies of refilling prescriptions or filling  
3 new prescriptions to prevent a patient from running  
4 out on the day that they are to expire?

5 MR. ABRAMOWITZ: Objection, but you can  
6 answer.

7 A. I'm not sure I understand that question.  
8 You're asking if I worked at a pharmacy where they  
9 had policies addressing that?

10 Q. Yes.

11 A. Yes, I have.

12 Q. And what is the purpose of a policy --  
13 let's take an anti-hypertensive, for instance. The  
14 patient that's on an anti-hypertensive, you do not  
15 want them to run out of that drug because you want  
16 them to keep a steady state of control of their  
17 blood pressure; right?

18 A. Yes. That's correct.

19 Q. Same way with an anti-diabetic medication;  
20 right?

21 A. Yes.

22 Q. And when patients are on chronic pain  
23 therapy, those patients require around the clock  
24 pain medication; true?

1 MR. ABRAMOWITZ: Objection, but you can  
2 answer.

3 A. Not necessarily.

4 Q. Don't they require the same steady state of  
5 maintenance of their medication as does someone who  
6 is on an anti-hypertensive or anti-diabetic  
7 medication?

8 MR. ABRAMOWITZ: Objection, but you can  
9 answer.

10 A. No. I don't believe so.

11 Q. Not chronic pain patients that are  
12 prescribed chronic opiate therapy. That's your  
13 testimony?

14 A. Yes.

15 Q. And why is it that you say that?

16 A. Because pain is very subjective and one day  
17 a patient may have worse pain than another day.  
18 There may be a weather influence on the pain. There  
19 may be a physical excursion that occurred that  
20 exacerbated the pain. Pain can change from moment  
21 to moment. It is not like a chronic diabetic  
22 condition in which blood sugar needs to be  
23 maintained between 90 and 120. It's nothing like  
24 that.

1           As I said, it's very subjective and some  
2 days a patient may not need any pain medication even  
3 if they have a chronic issue. Some days they may  
4 require a little bit more. It depends on the  
5 conditions. So chronic pain cannot be equated to a  
6 chronic disease state like diabetes or hypertension.

7           Q.    It depends on the individual patient;  
8 right?

9           A.    Yes.

10          Q.    And is it a positive thing for a pharmacist  
11 to have a personal relationship with a patient?

12          A.    Could you repeat that question?

13          Q.    Is it a positive occurrence for a  
14 pharmacist to have a personal relationship with a  
15 patient and know them?

16          A.    I believe that's a benefit to know your  
17 patients.

18          Q.    What information do you have about what  
19 Ms. Boroff and Ms. Shriver knew about Dale Dukeshire  
20 other than what you've read in their depositions?

21               MR. ABRAMOWITZ:  Objection, but you can  
22 answer.

23          A.    I only know from what I've read in their  
24 depositions.

1 Q. Have you actually read Ms. Boroff's  
2 deposition? It's not on your list.

3 A. I'm not sure. I believe -- yeah. I  
4 believe I have. I should have added it. Sorry.

5 Q. We'll get to your list in a minute.

6 A. Okay.

7 Q. You mentioned that you've worked at  
8 pharmacies that have policies with respect to fills  
9 of new prescriptions such as C-IIs and refills of  
10 expiring prescriptions. Do you remember that? You  
11 said you worked with pharmacies with policies in  
12 that regard?

13 MR. ABRAMOWITZ: Objection, but you can  
14 answer.

15 A. Yes, I remember.

16 Q. Under what policies have you worked with  
17 respect to either early fills or fills of a new  
18 prescription?

19 MR. ABRAMOWITZ: Just for clarity. What  
20 kind -- because we're dealing with two different  
21 types of drugs in the question. Which are you  
22 referencing? In terms of C-II versus non-C-II? I'm  
23 not a pharmacist so I (audio interference). I  
24 apologize.



1 MS. WHITE-FARRELL: However the way the  
2 witness wants to do it. I'll flow with it.

3 MR. ABRAMOWITZ: Thank you.

4 WITNESS: I'm sorry. Could you repeat the  
5 question?

6 BY MS. WHITE-FARRELL:

7 Q. Sure. I want to know about the policies  
8 that you've worked under.

9 A. Oh, okay. The policies, it depends. It  
10 varies from pharmacy to pharmacy. The pharmacies in  
11 which I have been a personal manager at, I have  
12 ensured that there would be a policy of no early  
13 refills on C-IIIs.

14 Q. Have you worked at -- so for purposes of  
15 this deposition, whenever a patient presents a new  
16 prescription for a C-II, you're calling that early  
17 refill?

18 MR. ABRAMOWITZ: Objection, but you can  
19 answer.

20 A. So you're saying any time they present a  
21 prescription, it's early? No. Well, I don't  
22 understand.

23 Q. That's what I didn't understand your  
24 answer. So what I'm trying to -- let's take the

1 C-IIIs first.

2 A. Right.

3 Q. When you say "no early refill," what do you  
4 mean by that?

5 A. I'm sorry. I used the term refill. We do  
6 not fill a new C-II prescription for people for the  
7 same medication if it arrives early, you know,  
8 earlier than the usage should be by based on the  
9 instructions in the original prescription.

10 Q. Now, you said that was at pharmacies at  
11 which you were a manager. Have you worked at  
12 pharmacies in which you were not the manager and the  
13 policy was different?

14 A. Not that I'm aware of. The pharmacies that  
15 I've worked at that I was not the manager were  
16 primarily through agencies, pharmacy agencies, and I  
17 was not there routinely and I did not have a chance  
18 to look at their policies and procedures.

19 So they may have had them but I did not  
20 have a chance to read them. The pharmacies that  
21 I've been the manager at, I've gone through the  
22 policy and procedure manuals.

23 Q. Is there any industry standard or protocol  
24 or published best practices from a trade association

1 that would adopt your personal practice versus that  
2 which Rite Aid had here which was a 48-hour rule?

3 MR. ABRAMOWITZ: Objection, but you can  
4 answer.

5 A. I'm sorry. Every time he objects, I forget  
6 the question. What was the question?

7 Q. Is there any written standard, trade  
8 organization policy, document, or thing you can  
9 refer me to that says your personal method of no  
10 fill except on the day of expiration is superior to  
11 a practice such as what Rite Aid had which was a  
12 48-hour rule?

13 MR. ABRAMOWITZ: Objection, but you can  
14 answer it.

15 Q. Again, every time you do that it throws me  
16 off. I'm sorry. I hate to ask you to repeat it. I  
17 know you're going to raise the objection again.

18 MR. ABRAMOWITZ: Before you say the  
19 question, for the record, I'm objecting. I  
20 apologize, Tammy, but I'm objecting now. Ask the  
21 question.

22 A. All right, I understand. You asked about  
23 trade journals that reflect my personal policy.

24 I have not, I'm not really familiar with

1 trade journals, although, there are many guidelines  
2 on dispensing narcotics that will reflect that what  
3 I call early refills or early requests for new  
4 prescriptions, I should say, where they would be  
5 considered a red flag of an opiate use disorder or  
6 drug seeking behavior.

7 And that's listed in publications such as  
8 the Pharmacist's Manual which is a DEA publication.  
9 It lists red flags and warnings that pharmacists  
10 should clear before filling C-II prescriptions.

11 Q. Is there any written standard that you can  
12 refer me to from any source that says that the  
13 standard of care in the industry is to only fill on  
14 the date that a prior C-II expires?

15 MR. ABRAMOWITZ: Objection, you can answer.

16 A. Not that I'm aware of. I feel I could  
17 probably do some research and find some policies  
18 that reflect that. But, again, the fact that early,  
19 seeking early new prescriptions, rather than use the  
20 term "refills", would be a red flag for pharmacists  
21 to have to clear before dispensing.

22 Q. I'll come back to that in a little while.  
23 How many times did Dale Dukeshire present with his  
24 controlled, his C-II prescription having expired?

1 In other words, not present either a day or two  
2 early or on the day of an expiration.

3 A. I'm sorry. The question that you're asking  
4 is how many times did he present it early?

5 Q. No. Did he present late meaning the  
6 prescription had expired and he's several days late.

7 A. Okay. Initially, in his therapy in 2013  
8 and 2014, he was pretty much on time. We did have a  
9 couple -- one, two, three, four -- I have five, six  
10 incidences in 2013 and '14 which he came for early  
11 fills.

12 There were, when we start getting into  
13 2016, his -- well, to me it became problematic and  
14 the problems were becoming obvious with his opiate  
15 use disorder.

16 In 2016, it was -- one, two, three -- in  
17 2016, there were about ten different instances he  
18 brought it in early, in the early part of the year.  
19 And then if you consider two days early, there were  
20 at least 22 incidences where he brought it early,  
21 two days.

22 And we have, I actually have one that he  
23 brought ten days early, one he brought eight days  
24 early, another six days early, another four days

1 early. So there's quite a few. I mean, he did have  
2 a total of 112 prescriptions filled in that four-  
3 year period and there were approximately 17  
4 different doctors writing narcotic prescriptions for  
5 him.

6 Q. I'll get to that in a little while.

7 My question was, did you tabulate and count  
8 the number of times that he actually presented  
9 prescriptions late meaning they had expired and he  
10 was coming after the fact to get a prescription  
11 filled.

12 A. I did document a few of them. I don't have  
13 -- I was really looking for early refills. As I  
14 said, in 2013 and 2014, he was pretty much on time  
15 with the exception of a handful of refills that he  
16 did come early. I did not document the late  
17 refills.

18 Q. Is Exhibit 8 --

19 A. -- '16 and '17. I don't believe there were  
20 any late refills.

21 Q. In Exhibit 8 which are just your notes, are  
22 there any other notes that you have regarding the  
23 case?

24 MR. ABRAMOWITZ: Objection, but you can

1 answer.

2 A. I may have some more notes at home. I'm  
3 not sure. I'd have to go through it. I tried to  
4 bring my whole file with me today and I did, I might  
5 have had some handwritten notes I left at home.

6 Q. If you'd pick up the pile that you held up  
7 at the very beginning, on the very back page it  
8 looked like there were some notes.

9 A. I may be have some notes for this.

10 MR. ABRAMOWITZ: Can we pull this apart now  
11 as well to get those exhibits together?

12 WITNESS: And I do have notes throughout  
13 my, you know, throughout myself.

14 MR. ABRAMOWITZ: I mean, there are various  
15 notes on some of these hand, on these printed things  
16 here.

17 MS. WHITE-FARRELL: On these depositions?

18 MR. ABRAMOWITZ: Some are depositions. I  
19 think maybe on a break, if it's okay with you,  
20 Tammy, at break we can maybe find a way to figure  
21 this out. I do not have a scanner. I have no cell  
22 coverage here. We just have Internet at the  
23 location we're at, so logistically we might need to  
24 figure something else, if that's okay.

1 MS. WHITE-FARRELL: Okay. We'll do that at  
2 a break.

3 BY MS. WHITE-FARRELL:

4 Q. What depositions -- if you would look at  
5 page 3 and 4 of your November 18, 2020, report and  
6 compare the depositions you have and tell me what  
7 depositions are not listed on that -- what  
8 depositions you have that are not listed on that  
9 list.

10 MR. ABRAMOWITZ: Aside from Boroff that  
11 we've already established?

12 MS, WHITE-FARRELL: Right.

13 COURT REPORTER: I'm sorry, could you  
14 repeat that objection or comment?

15 MR. ABRAMOWITZ: Aside from Boroff that  
16 we've already established.

17 COURT REPORTER: Thank you.

18 WITNESS: That's the only deposition that I  
19 believe I'm missing here. Again, I would want to  
20 check through my, you know, to see if there's any  
21 other records I have or on my drive but I believe  
22 this is everything that I've read except for the  
23 Emily Boroff deposition.

24 BY MS. WHITE-FARRELL:



1 Q. Now you're not a physician; right?

2 A. No, I am not.

3 Q. You're not here to talk about medical  
4 diagnoses or medical treatment. Is that true?

5 A. I am here to talk about pharmacy issues.

6 Q. All right. As far as cause of death, are  
7 you likewise deferring to a physician on causation  
8 and cause of death?

9 A. Well, I would really say on that that the  
10 coroner's report well documents the cause of death  
11 and my work, you know, reviewing notes says that  
12 it's very consistent with the coroner's report, that  
13 the cause of death is consistent based on my files.

14 Q. Okay. So other than the coroner's report,  
15 would you say anything else with respect to cause of  
16 death?

17 MR. ABRAMOWITZ: Other than rebuttal  
18 testimony for your expert witnesses?

19 MS. WHITE-FARRELL: Translate. I don't  
20 know what you're trying to coach him here on.

21 MR. ABRAMOWITZ: I'm not trying to coach  
22 him. I want to make sure we're clear here. Giving  
23 rebutting comments made by your experts is different  
24 than him giving an independent opinion. So I just

1 want to make sure we're clear that if whatever  
2 answer he gives here does not include the potential  
3 for rebutting whatever testimony experts might talk  
4 about related to pharmacological issues in his cause  
5 of death.

6 MS. WHITE-FARRELL: Okay. Now, I  
7 understand what you were saying.

8 MR. ABRAMOWITZ: My apologies.

9 BY MS. WHITE-FARRELL:

10 Q. The medical records that you have listed  
11 here, I'm trying to understand, since you are a  
12 pharmacist, what, if anything, is it from these  
13 medical records that you would base any opinion?

14 A. I'm sorry. I really don't understand the  
15 question.

16 Q. You're here to offer pharmacy opinions;  
17 right?

18 A. Yes.

19 Q. Is there any information that you gleaned  
20 from any of these medical records that supports any  
21 particular opinion that you have?

22 A. Well, are you talking about from the other  
23 depositions or from other expert reports?

24 Q. I'm talking about from the medical records.

1 You've listed Gallagher & Gallagher, Sandusky County  
2 EMS.

3 A. I have.

4 Q. Bellevue Hospital, Bethesda Care Center  
5 and a total of close to 20 medical records. I'd  
6 like to know, do you intend to point to any one  
7 particular medical record and say that it  
8 demonstrates X as it relates to any opinion you  
9 would offer?

10 A. No. I don't believe so.

11 Q. Okay. Did you gain anything from any of  
12 the medical records that you reviewed as it relates  
13 to the case?

14 A. I was -- I guess the medical records did  
15 provide me with information on Mr. Dukeshire's  
16 comorbidities and, you know, medical issues.

17 Q. Do you agree that from time to time  
18 Mr. Dukeshire had health problems for which he  
19 sought acute healthcare interventions such as at  
20 emergency departments?

21 MR. ABRAMOWITZ: Objection, but you can  
22 answer.

23 A. Yes. I saw that he did.

24 Q. Do you agree that he had chronic health

1 conditions including, for instance, a chronic wound  
2 on his buttocks and low back pain as in accordance  
3 with some of the medical records you reviewed?

4 A. Yes.

5 Q. When you talk about the 17 doctors from  
6 whom Mr. Dukeshire obtained prescriptions, which  
7 doctors in particular are you referencing?

8 A. I'm afraid I don't have their first names  
9 but I have last names. Dr. Diamond, Dr. Maderer,  
10 Dr. Huddleson, Dr. Laussane, Dr. Milner, Dr. Walsh,  
11 Dr. Vargos, Dr. John Smith -- I have the first name  
12 on that one -- Dr. Ronald Curl, Dr. George -- I  
13 can't read my writing -- Stepanek, Dr. Patricia  
14 Matu, James Huddleston. I think I mentioned him  
15 already. Dr. Jeffrey Dickenson. Those are some of  
16 the other doctors.

17 I have a few -- as you see, the extra  
18 doctors I put in blue and I highlighted it and I  
19 can't read a couple of the things I highlighted  
20 over.

21 Q. And you're referencing to Exhibit 8, your  
22 list of your, your yellow pad notes; right?

23 A. Yes.

24 Q. How many of these physicians, if you know,

1 wrote prescriptions for an acute episodic event such  
2 as a septic knee?

3 MR. ABRAMOWITZ: Objection, you can answer.

4 A. I don't know off the top of my head. There  
5 were various doctors. He went to emergency rooms,  
6 dentists, various doctors for various issues.

7 Q. Did you consider for any of your opinions,  
8 the clinical context in which Mr. Dukeshire saw any  
9 of these 17 physicians, and what I mean by that is  
10 was it an emergency medicine visit? Was it a septic  
11 knee? Was it his chronic ulcer on his bottom? Did  
12 you consider that at all with respect to any of  
13 those 17?

14 A. Yes, I did.

15 Q. And how did you factor that into your  
16 analysis?

17 A. Well, my analysis is actually just raw  
18 data. There was no factoring or figuring anything  
19 out. It was just literally transcribing the raw  
20 data and looking at the prescribing frequencies.

21 I did not take into account the causes of  
22 his acute treatments based on these other doctors  
23 but I'm not convinced that these other doctors were  
24 aware that he was being treated for, chronically for

1 pain.

2 Q. Do you know the converse that they did not  
3 know?

4 MR. ABRAMOWITZ: Objection, but you can  
5 answer.

6 A. No. I don't know what they knew or did not  
7 know.

8 Q. Do you agree that Mr. Dukeshire's death was  
9 investigated?

10 MR. ABRAMOWITZ: Objection, you can answer.

11 A. I can't, do not know.

12 Q. Okay. Do you agree that the Ohio Board  
13 Pharmacy has not issued any criticism of which you  
14 or anyone is aware of Rite Aid or any of its  
15 pharmacists arising out of Dale Dukeshire's death?

16 MR. ABRAMOWITZ: Objection, you can answer.

17 A. Not specifically, no.

18 Q. Generally, are you aware whether or not  
19 there's been any investigation, criticism, citation,  
20 disciplinary action or otherwise, issued against  
21 Emily Boroff or Ms. Shriver from the Ohio Board of  
22 Pharmacy arising out of Dale Dukeshire's death?

23 MR. ABRAMOWITZ: Objection, but you can  
24 answer.

1 A. Not to my knowledge.

2 Q. And likewise, the Ohio Board of Pharmacy  
3 regulates Rite Aid of Ohio; true?

4 A. I'm sorry. Could you repeat the question?

5 Q. The Ohio Board of Pharmacy also regulates  
6 the retail pharmacy known as Rite Aid of Ohio;  
7 doesn't it?

8 A. Yes, it does.

9 Q. Has the Ohio Board of Pharmacy taken any  
10 adverse action against Rite Aid of Ohio arising out  
11 of Dale Dukeshire's death?

12 MR. ABRAMOWITZ: Objection, you can answer.

13 A. Not that I'm aware of.

14 Q. Do you have any photographs in this case?

15 MR. ABRAMOWITZ: Objection, but you can  
16 answer.

17 A. No.

18 Q. Okay. The pile that you held up, are those  
19 all depositions with notes on them?

20 MR. ABRAMOWITZ: Objection, but you can  
21 answer.

22 A. Yes, they are. Almost all of them have  
23 notes.

24 Q. But they're all depositions?

1 A. Yes.

2 Q. Okay. The literature that we marked, I  
3 think they are Exhibits 3 through 7, is that all of  
4 the independent material, meaning non-medical  
5 record, non-deposition, that you have in this case?

6 MR. ABRAMOWITZ: Objection, but you can  
7 answer.

8 A. Yes, I believe so.

9 Q. Okay. Are there any text books, Internet  
10 search results, standards, or protocols of any kind  
11 that you've not identified here on the record that  
12 you would use for any purpose in this case?

13 MR. ABRAMOWITZ: Objection, as there's some  
14 purposes we can't know yet.

15 A. -- not that I'm aware of, no. (audio  
16 interference.)

17 Q. Do you have any written statements or  
18 affidavits from any witness regarding the case?

19 MR. ABRAMOWITZ: Objection, but you can  
20 answer.

21 A. Are you referring to expert reports?

22 Q. No. I'm talking about an affidavit or a  
23 statement from someone such as a fact witness that's  
24 not given a deposition.



1 A. No.

2 Q. Have you seen the expert reports from the  
3 Rite Aid witnesses?

4 A. I --

5 Q. Such as Dr. Weiner, Dr. Lucas,  
6 Dr. Dragovich?

7 A. Yes. I did review several of the doctors'  
8 reports.

9 Q. What, if any, disagreement do you have with  
10 Dr. Weiner's report?

11 MR. ABRAMOWITZ: Objection, but you can  
12 answer.

13 A. I don't know off the top of my head. I'd  
14 have to review that. I don't believe that was --

15 Q. Did you bring it with you?

16 A. It's on the thumb drive, electronically.

17 Q. Okay. But as you sit here today in  
18 answering the question, you can't identify any  
19 particular item with Dr. Weiner that you disagree  
20 with?

21 MR. ABRAMOWITZ: Objection. I don't think  
22 he's saying he can't -- you said identify  
23 everything. Your question --

24 MS. WHITE-FARRELL: -- I said anything.

1                   WITNESS: Not that I -- I would have to  
2 look at the report again and his summary to give  
3 that opinion.

4 BY MS. WHITE-FARRELL:

5           Q.    Going back to your report of November 18,  
6 2020, is this the only version of this document that  
7 exists?

8                   MR. ABRAMOWITZ: Objection. Any drafts are  
9 work product and under Ohio, they are not -- they  
10 are excluded from discovery.

11          A.    Well, I did make an earlier draft that I  
12 had to edit. Actually, I probably made several  
13 before I submitted it to Mr. Abramowitz. I usually  
14 have to review my own work and go through things and  
15 I add things as I do, so there were a couple of  
16 drafts that I did right before I submitted it to him  
17 before I submitted the original one.

18                   MR. ABRAMOWITZ: But do you have --

19          Q.    Since you wrote this in November of 2020 --  
20 is that when you wrote it, November of 2020?

21                   MR. ABRAMOWITZ: Objection; attorney-  
22 client. That's his attorney work product.

23          A.    Yes.

24          Q.    Have you had occasion to review the

1 documents since then?

2 A. I did look at some of the documents in the  
3 last 48 hours.

4 Q. Do you have any changes that you would make  
5 to this document?

6 A. There probably would be a few addendums I  
7 would have added but I think that the report is  
8 pretty complete as it is.

9 Q. What are the addendums you would add?

10 A. Well, it would be based on another expert's  
11 report, one of the medical doctors. Let me see  
12 which doctor that was. I don't have his data here.  
13 One of the expert reports, once of the physicians  
14 changed the Lucas County Coroner's report and added  
15 in his own therapeutic and toxic blood levels for  
16 carfentanil. Dr. McManus?

17 MR. ABRAMOWITZ: No, Lucas.

18 A. Lucas. Dr. Lucas, right, Dr. Lucas. And I  
19 would have made a comment on my report about his  
20 addition of a therapeutic or a toxic level that was  
21 not provided by the Ohio coroner.

22 Q. And what would that be?

23 A. Well, that he basically cherry picked the  
24 data and did not provide the entire report which

1 actually contradicted his therapeutic and toxic goal  
2 Range. It's -- the way he wrote it in his report it  
3 was misleading to believe that this data was  
4 accurate when it was in fact not accurate and he was  
5 kind of cherry picking the data.

6 Q. What data was that?

7 A. That was the data referring to the toxic  
8 therapeutic or toxic levels, blood levels, of  
9 carfentanil.

10 Q. And what do you contend was misleading  
11 about that?

12 A. Well, the initial report from the Lucas  
13 County Coroner's office did not have a listing for a  
14 therapeutic or a toxic level for that drug because  
15 they're really is none and he found an isolated  
16 study based on six patients and, which he took the  
17 lowest levels for toxicity and just inserted it in  
18 there as if it was a fact, in which case the actual  
19 mean, an average for the overdose levels was almost  
20 three or four times higher than what he indicated on  
21 his report.

22 Q. And that's based on the study that he  
23 relied upon.

24 A. Yes.

1 Q. Is that right?

2 A. Based on the study that he referenced.

3 Q. Okay. Any other addendum you would make to  
4 your report?

5 A. Not that I can think of at this time.

6 Q. Of the -- you've listed on page 1 of your  
7 report retail pharmacies where you've managed. Have  
8 you worked as a staff pharmacist at any retail  
9 pharmacy or have you always been a manager?

10 A. I have worked, as I mentioned earlier, I  
11 have worked agency. I have worked for two different  
12 agencies, Healthcare Consultants and Empire Pharmacy  
13 Consultant agencies where I was placed in a  
14 pharmacy, and I still get offers from them from time  
15 to time and I would work there as a staff  
16 pharmacist.

17 It was always on a per diem basis.  
18 Whenever I've worked in retail, I've pretty much  
19 always been the manager. I can't think of a time  
20 when I was a staff pharmacist.

21 Q. What do you mean on page 2 of your report  
22 where you say that you devote time to active  
23 clinical practice of pharmacy in retail pharmacies?

24 A. Okay. That means that I do clinical

1 practice and work in retail pharmacies.

2 Q. Well, you then have the word "or." You say  
3 you do clinical practice of pharmacy in retail  
4 pharmacies and long-term care facilities or pharmacy  
5 instruction, so I don't understand what you --

6 A. -- that should be "and." And pharmacy  
7 instruction at accredited schools. I teach clinical  
8 rotations. So the students are sent to me by the  
9 different universities and are kind of like an  
10 entourage.

11 They follow me around as I work and I do  
12 stop to lecture and teach throughout the day as for  
13 evaluating charts or seeing patients or even going  
14 through pharmacy shelves if we're at a retail  
15 setting. I may just, you know, go through the  
16 shelves and talk to them about different therapies  
17 and drugs and things like that.

18 So it shouldn't be "or," it should be  
19 "and."

20 Q. All right. And what do you mean here when  
21 you say that you have reviewed well over 150,000  
22 medical charts?

23 A. That's part of my job. That's what I do  
24 for, you know, in the nursing homes. I review the

1 patient's medical charts, the drug regimen. They're  
2 called drug regimen reviews. We review the  
3 medication therapies, we look at the labs, we look  
4 at physician orders, we look at ancillary notes.  
5 Basically, we look at the whole chart.

6 Q. And that's in the long-term care context;  
7 right?

8 A. Well, it's long-term care. I've also done  
9 it for the agency, for healthcare administration in  
10 which I would review patients for the Medicaid  
11 Waiver program, and these were mostly patients  
12 residing in ICFMRs, intermediate care facilities for  
13 the mentally retarded, and so I would do chart  
14 reviews for them as well.

15 That was a separate type of work I did.  
16 I've done so much in pharmacy it's hard to keep  
17 track of everything. I've been doing this for over  
18 40 years.

19 Q. But you've not reviewed 150,000 charts as a  
20 retail pharmacist?

21 A. No. But I filled well over 500,000  
22 prescriptions as a retail pharmacist. It's probably  
23 close to a million at this point.

24 Q. Okay. A retail pharmacist does not obtain

1 a medical chart and review a medical chart in the  
2 ordinary course and scope of their practice; right?

3 A. Well, not in a medical chart but they do  
4 review medical profiles and drug regimens for  
5 patients. So when I do the chart in the nursing  
6 homes we do the whole chart. When we're doing it in  
7 the retail setting, we're just looking at the  
8 medications and doing a review of medications. So I  
9 would call that a drug regimen review.

10 Q. Now, you are familiar with the DUR process;  
11 right?

12 A. Yes, I am.

13 Q. And I take it from your report you have no  
14 criticism of the DUR process that any pharmacist  
15 followed here?

16 MR. ABRAMOWITZ: Objection, you can answer.

17 A. I honestly had trouble determining how they  
18 measured their DURs at this pharmacy. There was no  
19 documentation or indication that there was any  
20 pharmacist interventions that would arise from doing  
21 a DUR.

22 Q. So you have no criticism of any DUR process  
23 that was or was not followed; true?

24 A. Well, I didn't see a process. I didn't see



1 a DUR process being followed at all.

2 Q. Do you -- are you going to --

3 A. -- to me, that's problematic.

4 Q. Are you going to come to the trial of this  
5 matter and say that Ms. Boroff, Ms. Shriver, or any  
6 pharmacist deviated from a standard of care with  
7 respect to a DUR process and Dale Dukeshire?

8 A. Yeah. I'd be willing to testify that they  
9 lacked the DUR process.

10 Q. And what specifically did they lack?

11 MR. ABRAMOWITZ: Objection, but you can  
12 answer.

13 A. Well, I didn't see any consulting. They  
14 basically glossed over several glaring red flags  
15 that were very problematic and are well documented  
16 and outlined in the DEA's pharmacist manual.

17 They basically, in my opinion, were just  
18 taking each individual prescription as it came in  
19 and filled it as quickly as possible without any  
20 clinical intervention or DUR processing being, you  
21 know, being done.

22 Q. What is your basis to say there was no  
23 consulting? That you see no documentation of  
24 consulting?

1 MR. ABRAMOWITZ: Objection, but you can  
2 answer.

3 A. Yes. I saw no indication, no records of  
4 consulting. The fact that the prescriptions were  
5 being filled early consistently, especially in 2016  
6 and '17 without any interventions, documentation,  
7 that there was no pharmacist logs or communication  
8 logs or anything that would provide any information  
9 for anybody, you know, assessing his prescriptions.

10 Q. Do you know of any particular conversations  
11 that any Rite Aid pharmacist had with Dale Dukeshire  
12 in his lifetime?

13 MR. ABRAMOWITZ: Objection but you can  
14 answer.

15 A. I believe there was in one of the  
16 depositions I read, there may have been a  
17 communication at one time during the four-year  
18 period that I noted.

19 MR. ABRAMOWITZ: And Tammy, are we getting  
20 -- it's been about an hour.

21 MS. WHITE-FARRELL: Sure. You want to take  
22 a break?

23 MR. ABRAMOWITZ: If it's okay. If it's a  
24 good time for you now or if you want to --

1 MS. WHITE-FARRELL: Yeah, that's fine.

2 MR. ABRAMOWITZ: Great.

3 MS. WHITE-FARRELL: Okay.

4 MR. ABRAMOWITZ: Thank you.

5 (Short break in proceedings.).

6 BY MS. WHITE-FARRELL.

7 Q. We'll start where we left off and it's  
8 about the documentation of consulting or no  
9 documentation of consulting.

10 Do you agree that conversations happened  
11 between pharmacists and their patients and even  
12 family members that do not recorded?

13 A. Yes. There are conversations that are not  
14 recorded.

15 Q. And do you agree that a patient has the  
16 right to refuse counseling?

17 A. Yes. A patient does have a right to either  
18 accept or refuse counseling, but in my opinion there  
19 are circumstances in which the pharmacist should  
20 offer counseling even if it's unsolicited.

21 Q. Do you have any factual basis to say that  
22 Dale Dukeshire did not understand the addictive  
23 nature of opiates?

24 MR. ABRAMOWITZ: Objection, but you can

1 answer.

2 A. I'm sorry. Could you rephrase that?

3 Q. Do you have any factual basis to say that  
4 Dale Dukeshire in his lifetime did not understand  
5 the addictive nature of opiates?

6 MR. ABRAMOWITZ: Objection, you can answer.

7 A. No. I don't have any documentation of  
8 that.

9 Q. In your report you do not mention the DUR  
10 therapy or DUR processes; do you?

11 MR. ABRAMOWITZ: Objection, but you can  
12 answer.

13 A. I would have to look through my report  
14 again, but I don't recall if I mentioned DURs in my  
15 report.

16 Q. Look at your report and tell me if there's  
17 anything that you refer to that relates to the new  
18 opinion that you've offered today regarding the DUR  
19 process.

20 A. I don't see anything that I mentioned  
21 specifically using the terms DUR, but several of the  
22 issues that evolved in the DUR process are mentioned  
23 in my report.

24 Q. And which are those?

1           A.     Things talking about accessing the Oarrs  
2 prior to dispensing narcotics. That's part of the  
3 DUR process. The corresponding duty that is  
4 mentioned in my report is part of the DUR process.  
5 So although it's not listed as under DUR, those are  
6 aspects of the DUR process that the Rite Aid  
7 pharmacists failed to do.

8           Q.     Are there any other new opinions that are  
9 not in your report that you would attempt to offer  
10 at trial?

11          A.     The only opinion that I can think of at  
12 this time would be the coroner's report alteration  
13 done by the defense expert.

14          Q.     And that's by the pharmacologist Dr. Lucas;  
15 right?

16          A.     Yes.

17          Q.     But you're not a pharmacologist; are you?

18          A.     No. I'm a clinical pharmacist and retail  
19 pharmacist.

20          Q.     And you're not a toxicologist; are you?

21          A.     No. I'm not a toxicologist by trade.

22          Q.     What qualifies you then to say that  
23 Dr. Lucas is wrong?

24                 MR. ABRAMOWITZ: Objection, but you can

1 answer.

2 A. I know how to read a study and I looked at  
3 the data that he took, the study that he took his  
4 data from and he selectively cherry picked the data  
5 that would benefit him or his, you know, his  
6 employers rather than the actual data, the complete  
7 set of data which indicated something completely  
8 different.

9 I don't have to be a pharmacologist to be  
10 able to realize that he did not provide all the data  
11 that was in his report.

12 Q. Do you agree that carfentanil is a C-I,  
13 it's an illegal substance?

14 A. I'm not sure of the status of carfentanil  
15 in this country right now if it's a C-I or C-II. I  
16 know that there is a brand named drug called Wildnil  
17 which is Carfentanil. It's used in zoological  
18 practices, veterinary practices for sedation of  
19 large animals like rhinos, elephants, hippos things  
20 like that. They would use it, I believe, with  
21 horses.

22 So I'm not sure what the schedule status of  
23 carfentanil at this time, since I know that in the  
24 past it has been used as a C-II in veterinary

1 practicing.

2 Q. Do you agree that there's no legitimate  
3 medical purpose for the use carfentanil in humans?

4 A. Yes. I would agree with that.

5 Q. Exhibit 8 were notes. That's based upon  
6 the patient profile as I understand it, your yellow  
7 notes?

8 A. Oh. My yellow notes. Which exhibit was  
9 it?

10 MR. ABRAMOWITZ: Note Exhibits 8 list down  
11 here are records, exhibit 8 notice of the  
12 deposition.

13 (Inaudible.)

14 MS. WHITE-FARRELL: No. 8.

15 MR. ABRAMOWITZ: My apologies, Tammy. Is  
16 it Exhibit 8.

17 WITNESS: Yes, I have it.

18 BY MS. WHITE-FARRELL:

19 Q. I just want to make sure I understand. You  
20 have not gone back to the medical record for any of  
21 those acute fills or prescriptions to determine what  
22 the health care problem was relating to the reason  
23 that the patient got acute fills; right?

24 MR. ABRAMOWITZ: Objection, but you can

1 answer.

2 A. Not necessarily. In several of the -- I  
3 believe in several of the records that I may have  
4 reviewed there may have been indications why he was  
5 going to the dentist or the emergency room.

6 Q. Have you matched those up to the patient  
7 profile into your chart that you created as Exhibit  
8 8?

9 A. No. I don't believe that I have.

10 Q. Do you agree that Mr. Dukeshire's Oarrs  
11 report was, in fact, accessed by the Rite Aid  
12 pharmacist?

13 MR. BRAHMOISM: Objection, but you can  
14 answer.

15 A. I believe they may have looked at the Oarrs  
16 report on one or two occasions, that I'm aware of.  
17 But according to their own depositions I believe  
18 Ms. Shriver in her deposition said that she if she  
19 knows a patient she doesn't have to look it up, if  
20 she knows who it is and she's comfortable she  
21 doesn't bother accessing it.

22 So I don't believe that there was access to  
23 the Oarrs reports on every prescription that was  
24 presented to that pharmacy.



1 Q. You're not here to tell the jury that it's  
2 the standard of care to check the Oarrs report for  
3 every prescription presented; are you?

4 MR. ABRAMOWITZ: Objection. Are we talking  
5 about C-I or C-II? I'm sorry.

6 Q. It would be C-II.

7 MR. ABRAMOWITZ: Okay. Thank you.

8 A. Yes. I am here to say that the pharmacists  
9 should be checking the Oarrs report on every C-II  
10 prescription.

11 Q. Is there any writing, standard,  
12 publication, or document that you can point me to  
13 that supports that proposition?

14 MR. ABRAMOWITZ: Objection, but you can  
15 answer.

16 A. I don't know the documents off the top of  
17 my head, specifically, but I would believe that the  
18 pharmacist manual, you know, a document produced by  
19 the DEA may have that information in there. The  
20 Board of Pharmacy records from Ohio may have  
21 something, although I have not seen it myself  
22 directly or have not looked it up but it may be in  
23 those records. I'm not familiar with that so I  
24 don't know.

1           Q.    Have you looked it up from any source that  
2 you can point me to that would say that the standard  
3 of care requires a pharmacist to check an Oarrs  
4 report with each knew C-II prescription that is  
5 presented?

6           A.    Off the top of my head, no. I can't come  
7 up with any documents that would confirm that;  
8 although there maybe some out there that I'm not  
9 aware of or that I have not reviewed thoroughly.

10          Q.    What is the Acugenasis team,  
11 a-c-u-g-e-n-a-s-i-s team?

12          A.    The Acugenasis team is a group of  
13 researchers at the Imperial College of London that  
14 are doing drug studies and studies on  
15 chemotherapeutics and I had done some work in the  
16 biomechanical engineering field with a professor  
17 named James Moore who runs that team.

18               And he asked me if I would work with some  
19 of his Ph.D. students and the Acugenasis team on  
20 development of these testing apparatus for  
21 determining skin cancers.

22          Q.    Does that have any role or relationship to  
23 outpatient pharmacy practice?

24          A.    Not yet. I mean, the goal of them was to

1 produce this test they were doing. It was a topical  
2 test and they wanted to get it into retail  
3 pharmacies and wanted to know how pharmacists would  
4 interact with the patient on both the recommendation  
5 and evaluation of these tests.

6 And so I was their consultant in it from  
7 the retail pharmacy field and give them an idea of  
8 where this could be placed, whether OTC status,  
9 prescriptions status, how pharmacists would interact  
10 in interpreting the results and how to get  
11 physicians involved in this process as well.

12 Q. I think you told me you last worked in a  
13 retail pharmacy in 2017. Is that right?

14 A. Yes. That's right.

15 Q. Was that full time? Part time? Per diem?  
16 What basis was that?

17 A. I believe that was the Black and White  
18 pharmacy and I was the pharmacy manager there for a  
19 short time. I was there, I believe, working two  
20 days a week, one week and three days a week the  
21 other week. Every other week I'd be working two or  
22 three days.

23 Q. Did you have to exercise your independent  
24 pharmacist judgement from time to time in filling

1 prescriptions when you worked last as a retail  
2 pharmacists?

3 A. Yes.

4 Q. Do you agree that in the everyday practice  
5 of pharmacy a retail pharmacist must exercise his or  
6 her pharmacist judgement?

7 A. Absolutely.

8 Q. Have you ever offered the opinion that you  
9 offer here today anywhere else that a C-II can only  
10 be filled on the day that it expires or a day after  
11 that?

12 A. You're asking if I have testified as this  
13 before?

14 Q. Have you ever offered that opinion anywhere  
15 before?

16 MR. ABRAMOWITZ: Objection, but you can  
17 answer.

18 A. No. I don't believe I've been asked that  
19 before.

20 Q. Going to your report, page four --

21 A. Okay.

22 Q. -- what is it from the Social Security  
23 Administration records that you would rely upon;  
24 anything?

1 A. Not that I can think of right now.

2 Q. Would you rely upon anything from the  
3 Freemont and Sandusky police departments?

4 A. I don't recall the exact records but  
5 perhaps it would play into my opinion.

6 Q. And how?

7 A. Well, if there was a history of DUIs, any  
8 type of, you know, drug-related, you know, events  
9 that may have occurred, you know, that he was in  
10 trouble with the police, anything like that.

11 Q. Was Rite Aid or any of its pharmacists ever  
12 put on notice that Dale Dukeshire had any DUIs?

13 MR. ABRAMOWITZ: Objection, you can answer.

14 A. Not that I'm aware of.

15 Q. Was Rite Aid or any of its pharmacists ever  
16 on notice that Dale Dukeshire had any drug related  
17 instances or events happen in his life?

18 MR. ABRAMOWITZ: Objection, you can answer.

19 A. Not that I'm aware of.

20 Q. Back to your report, there's a list of  
21 legal documents, discovery responses. Tell me what  
22 you would rely upon, if anything, from any of those  
23 discovery responses.

24 MR. ABRAMOWITZ: Objection, but you can

1 answer.

2 A. I honestly would have to look at them  
3 again. I mean, I'm sure that there's information  
4 from responses to Rite Aid as to their policies and  
5 procedures, on their training a pharmacist, and  
6 dispensing of narcotics and C-II drugs and things  
7 like that.

8 Q. What do you understand Rite Aid's training  
9 to be of its pharmacists with respect to C-II drugs?

10 MR. ABRAMOWITZ: Objection, but you can  
11 answer.

12 A. From my opinion, it's virtually nothing.  
13 The pharmacists, as I, that I read their depositions  
14 said that they had no training. One of them I  
15 believe said they had no training. The other might  
16 have watched a video, one video or something like  
17 that. I don't recall exactly. But the training, if  
18 there was any at all, it was minimal.

19 Q. And what training do you contend should  
20 have occurred?

21 MR. ABRAMOWITZ: Objection. You can answer  
22 it if you can.

23 A. Well, I believe that the pharmacists need  
24 to at least sign off that they've reviewed the DEA's

1 document, the pharmacists manual, that they have at  
2 least reviewed Rite Aid's policies and procedures on  
3 dispensing of C-II drugs, that they really need to  
4 do -- I mean at least, you know, in Florida, we have  
5 to do continuing education on a yearly basis  
6 addressing narcotics and C-II dispensing and opiate  
7 dispensing.

8           They should require specialty courses in  
9 that and training in that. There's quite a bit. I  
10 mean, pharmacists can always be learning more.  
11 There's always more we need to know.

12           And the environment changes, you know. In  
13 the last ten years or so it's become a major  
14 problem. Prior to this they were not a major  
15 problem. So, you know, things change and policies  
16 have to develop to address those changes in the  
17 community.

18           Q. Are you familiar with the continuing  
19 education that the State of Ohio required of  
20 pharmacists prior to Dale Dukeshire's death as it  
21 relates to controlled substances?

22           MR. ABRAMOWITZ: Objection, but you can  
23 answer.

24           A. I believe that they do require a course in

1 opiate use disorder or something similar to that for  
2 their continuing education.

3 Q. Do you have any basis to say that  
4 Ms. Boroff and Ms. Shriver or any Rite Aid  
5 pharmacist was not in compliance with the required  
6 continuing education on opiate dependance?

7 MR. ABRAMOWITZ: Objection, but you can  
8 answer.

9 A. Well, I'm sure that they were compliant  
10 with the regulations to do the continued education  
11 to renew their license. That does not mean that  
12 they were well educated and informed in the, the  
13 risk of dispensing opiates, the MMEs, assessment of  
14 MMEs for dispensing of opiates and other issues that  
15 may deal with the red flags and clearing red flags  
16 prior to dispensing opiates.

17 Q. Isn't the MME for opiates a physician  
18 responsibility?

19 MR. ABRAMOWITZ: Objection, but you can  
20 answer.

21 A. Yes. It is a physicians responsibility as  
22 well as a pharmacist's responsibility.

23 Q. What source, document, publication,  
24 regulation, can you refer me to that MME calculation



1 is a pharmacist's obligation?

2 A. I don't have it in front of me, but there  
3 is a record that I reviewed that I can provide to  
4 you that mentions pharmacists, intervention, and  
5 accessing MMEs.

6 Q. If you would and we'll make that Exhibit 9.

7 DEPOSITION EXHIBIT NO. 9

8 (Record Concerning MMEs was marked for  
9 identification purposes as Deposition  
10 Exhibit No. 9.)

11 MR. ABRAMOWITZ: Can you write that down so  
12 I can dig out that file?

13 WITNESS: It's about pharmacists (audio  
14 interference, speaking inaudibly.)

15 BY MS. WHITE-FARRELL:

16 Q. You mentioned the pharmacist manual, you've  
17 mentioned that several times. Where is this  
18 publication? Is it online? Is it hard copy? Where  
19 do we get a copy of it?

20 A. You can find it easily online. You can  
21 also request a copy from the DEA. They will send  
22 you one, and most likely they'll refer you to their  
23 website and tell you to download it.

24 Q. And the DEA pharmacist manual provides

1 specific guidance with respect to the filling of  
2 opiate prescriptions. Is that true?

3 A. Yes, it is.

4 Q. Those are guidelines not standards of care.  
5 Isn't that true?

6 MR. ABRAMOWITZ: Objection, but you can  
7 answer if you can.

8 A. I wouldn't be able to answer that question  
9 without actually looking at the document. I don't  
10 have it in front of me right now.

11 Q. Turning to the next page of your report, do  
12 you agree with Rite Aid's statement in their policy  
13 that you quote in block quotes at the middle of page  
14 5 that begins with the phrase "Rite Aid acknowledges  
15 that misuse and abuse of prescription drugs is a  
16 growing national epidemic?"

17 A. Do I agree with the statement?

18 Q. Yes.

19 A. Well, in some ways I do agree with it. I  
20 mean, they have developed certain procedures and I  
21 think a lot of them are based on the pharmacists  
22 manual; however, you know, they say that procedures  
23 for assisting validation and dispensing the  
24 substances however they don't add that there's any

1 checks or balances as to whether the pharmacists  
2 have reviewed this, have they, you know, have they  
3 utilized it or is it mandatory or is this optional  
4 for the pharmacists.

5           There's nothing that says it's a  
6 regulation. They just say we acknowledge that  
7 there's an abusive of drugs and in order to address  
8 this we have set up procedures. But, you know, the  
9 procedures obviously have been failing because their  
10 policies have allowed for, you know, basically a  
11 violation or ignoring of red flags.

12           Their pharmacists have ignored many red  
13 flags. It's hard to -- I mean, I agree with the  
14 state that they acknowledge that there's a problem  
15 but I question whether that they really done a lot  
16 to really prevent abuse or diversion.

17           Q. And that's because in this case you contend  
18 red flags were ignored?

19           A. Yes.

20           Q. Is there any specific written procedure of  
21 Rite Aid that, of which you have criticism?

22           MR. ABRAMOWITZ: Objection.

23           A. I don't have the policies in front of me so  
24 I wouldn't be able to determine that right at this

1 point. And I could in the future look through  
2 specifically at all their policies and can point out  
3 failings and things like that, I'm sure.

4 Q. Well, you've been involved in this case for  
5 how long?

6 MR. ABRAMOWITZ: Objection. It was the  
7 work of the attorney work product as to when we  
8 retained services or when we started he reviewing  
9 matters for us. I mean, generally, you can -- I  
10 mean the cases he's been on since the beginning as  
11 he -- certificate of merit -- (audio interference)  
12 -- we're not letting him share anything beyond that.

13 Q. So, you've known of this case for at least  
14 two years. Is that correct?

15 A. Yes.

16 Q. And through the present day, have you  
17 formulated any criticism of any written policy or  
18 procedure published by Rite Aid?

19 MR. ABRAMOWITZ: Objection, but you can  
20 answer.

21 A. Again, I would have to have that in front  
22 of me to look at it to make, to determine that. I  
23 do have objections with the way the pharmacists who  
24 were filling Dale Dukeshire's prescriptions. I have

1 issues with that. I would have to look at their  
2 specific policies again.

3 And again, I've looked at these records, as  
4 you said, it's been a couple of years. It's nothing  
5 I look at every day for the last two years. It's  
6 something I looked at two years ago and then I  
7 looked at it again a few days ago. So it's been a  
8 long period of time between, you know, the time I  
9 initially looked at and now.

10 Q. In the time that you have spent in  
11 reviewing materials in this case, have you  
12 formulated any opinion critical of any written  
13 document published by Rite Aid?

14 MR. ABRAMOWITZ: Other than what's in his  
15 report?

16 MS. WHITE-FARRELL: Any written document --  
17 there's no criticism of a written document in his  
18 report, so if there is point it out to me.

19 MR. ABRAMOWITZ: I mean, the first heading  
20 is Rite Aid designed a blind spot, that would be a  
21 culmination of the procedures he's pointing at. I  
22 just want to make sure, in these pages -- there's a  
23 lot of policy and procedures out there beyond what  
24 are applicable and what's been provided in this

1 case.

2 I'm just trying, I guess, maybe if you  
3 rephrase it maybe I would be very helpful.

4 MS. WHITE-FARRELL: I'll do it one more  
5 time, because this is about the fifth time I've  
6 asked the question.

7 BY MS. WHITE-FARRELL:

8 Q. Is there any particular written policy or  
9 procedure by Rite Aid that as of this date you have  
10 formed any opinion critical of?

11 A. Well, I believe that their 48-hour,  
12 allowing 48-hour overlap of C-II prescriptions to be  
13 filled, I am critical of that policy.

14 Q. Any other?

15 A. That's the only written policy that I can  
16 answer that at this time.

17 Q. So let's go to the six steps that are  
18 listed in your report. You agree that for each C-II  
19 prescription that was presented to Rite Aid it was a  
20 valid prescription?

21 MR. ABRAMOWITZ: Objection, you can answer.

22 A. You're asking me if every prescription was  
23 a valid prescription presented to Rite Aid?

24 Q. Every original C-II prescription.

1           A.    I can't answer that because I don't know if  
2 they were valid based on, they may have been valid  
3 based on a physician, a licensed physician writing  
4 it and it may have been valid based on a physician  
5 with a patient relationship.

6                   But it may not have been valid if there was  
7 not a legitimate medical purpose for the use of  
8 these drugs.

9           Q.    And what did you undertake, if anything,  
10 prior to today's deposition to determine whether or  
11 not any of the prescriptions presented were not for  
12 legitimate medical purpose?

13                   Did you undertake any activity?

14           A.    Other than reviewing the records provided,  
15 no.

16           Q.    Did you identify from any medical record or  
17 records provided that any prescription that was  
18 presented to Rite Aid was not for a legitimate  
19 medical purpose?

20                   MR. ABRAMOWITZ:  Objection.  Are you overly  
21 broad but you can answer.

22           A.    Well, I realize that he had chronic  
23 conditions that were treated by Dr. Gallagher;  
24 however, there were other physicians that he would

1 seek out that would write narcotics and those may  
2 not have been for a legitimate medical purpose;  
3 although, the physicians may have been duped into  
4 thinking they were.

5 Q. And so my question is simply, do you have  
6 any factual basis to say that Rite Aid was on notice  
7 that any particular prescription was not for a  
8 legitimate medical purpose?

9 MR. ABRAMOWITZ: Objection.

10 A. Well, as far as I know Rite Aid did not  
11 validate many of the prescriptions, so there would  
12 not be any record of that.

13 Q. Do you know from any source that Rite Aid  
14 was on notice that any of the prescriptions were not  
15 for a legitimate medical purpose?

16 MR. ABRAMOWITZ: Objection, you can answer.

17 A. Not that I know of.

18 Q. Each time a C-II original prescription was  
19 presented, steps 1 through 6 were completed by Rite  
20 Aid. Were they not?

21 MR. ABRAMOWITZ: Objection, over broad.  
22 Answer if you can.

23 A. No. I don't believe they did.

24 Q. Which one of the step or steps was not



1 completed? And I'd like to know when.

2 A. Well, just -- I would say that the  
3 validation of the prescription, to validate a  
4 prescription from, and I'm going to say this for any  
5 of the other 12 doctors other than Dr. Gallagher was  
6 writing for narcotics, that those prescriptions  
7 should all be validated when the physicians call,  
8 informed that they were receiving, you know, routine  
9 opiate prescriptions from a, not a pain management  
10 doctor.

11 So the pharmacists failed to validate each  
12 of these other extra-when I say "extra" I mean other  
13 than Dr. Gallagher prescriptions, and using  
14 professional judgement, whether to dispense or not  
15 dispense a prescription and report suspicious  
16 activity such as seeking early refills, coming to  
17 the pharmacy and saying I lost my prescription,  
18 somebody stole my prescription I need another one,  
19 that type of thing.

20 Those are suspicious activities and  
21 behaviors that I believe the Rite Aid pharmacists  
22 did not pursue to follow up on.

23 Q. I know it's your opinion that it was a  
24 suspicious activity that Mr. Dukeshire presented new

1 prescriptions 48-hours before an old one expired;  
2 right? That's your opinion.

3 A. Yes. And some of them more than 48 hours.  
4 Some of them were, you know, 72 hours, some of them  
5 were even longer. I mean, there was a variety. And  
6 as time went on from 2015, '16, '17, the numbers and  
7 the shortened refills -- I shouldn't say refills --  
8 shortened presentation of new prescriptions became  
9 more frequent and more often.

10 Q. How many, if any, new refills -- well,  
11 strike that.

12 Did Dale Dukeshire ever present claiming  
13 that his prescription was stolen, lost, or destroyed  
14 and it was actually, and a new prescription was  
15 actually obtained and filled?

16 MR. ABRAMOWITZ: Objection, you can answer  
17 if you can.

18 A. Not to my knowledge.

19 Q. What is your comment regarding the Nexgen  
20 system that's on the next page of your report. I'm  
21 not sure I understand what you're trying to  
22 communicate there.

23 MR. ABRAMOWITZ: For the record we're on  
24 page 6 of his report, 7. We're on page 6 you're

1   referencing?

2           Q.    Let me count them here.  It would be six,  
3   where you talk about, at the top of the page, where  
4   you talk about the Nexgen system.

5           MR. ABRAMOWITZ:  Thank you for that.

6           WITNESS:  I'm sorry can you repeat the  
7   question for this?

8   BY MS. WHITE-FARRELL:

9           Q.    Yeah.  I'm trying to understand what you're  
10   trying to communicate in that first paragraph.

11          A.    I was just saying that there seems to be a  
12   gap in the Nexgen system.  There's basically a hole  
13   in that they allow for a 48-hour early presentation  
14   of new C-II prescription without flagging it, that  
15   they find that to be acceptable.

16               Where in my opinion, that is a problem with  
17   the, it's an inherent systematic problem with the  
18   Rite Aid computer system, that they should be  
19   flagging these as red flags when they come in, you  
20   know, less than, you know, 24 hours, you know,  
21   before acceptable refill status is obtained.

22          Q.    If other similar situated retail pharmacies  
23   like Walgreens and Giant Eagle have a policy that  
24   permits a 48 or 72 hour fill, would you have the

1 same opinion critical of those?

2 MR. ABRAMOWITZ: Objection. Are you  
3 referencing the opioid MBL and the settlements that  
4 were recently achieved in Ohio based on some of  
5 those specific pharmacies, you know, in requesting  
6 to exit the litigation based on their policies and  
7 practice and how it hurt the community?

8 Q. No. It's just a simple question. What  
9 about the witness, not a dialog about the MDL. I'm  
10 sure you need me to repeat the question given that  
11 objection?

12 A. Yes. I do. I'm sorry.

13 Q. My question is, if other similarly situated  
14 retail pharmacies such as Walgreens, Giant Eagle,  
15 Kroger, Walmart have fill policies that would allow  
16 for 48 or even 72 hours of fill before a prior C-II  
17 expires, would you likewise be critical of them?

18 MR. ABRAMOWITZ: Objection.

19 A. Yes, I would.

20 Q. Okay. Do you know of anybody that agrees  
21 with you?

22 MR. ABRAMOWITZ: Objection, but you can  
23 answer.

24 A. Well, I haven't presented this opinion to

1 my colleagues or anything like that; although, when  
2 I do train my students I do specifically spend an  
3 afternoon discussing opiate prescriptions,  
4 verification of opiate prescriptions, and so I do  
5 teach that in my pharmacy rotations, that they you  
6 have to go above and beyond the policies of the  
7 pharmacy you're working at.

8 Q. For an individual pharmacists, that's what  
9 you teach?

10 A. Yes.

11 Q. Is there a text book or a publication that  
12 you rely upon for that statement or is it a personal  
13 practice?

14 MR. ABRAMOWITZ: Objection, but you can  
15 answer.

16 A. It is my personal practice; although, I do  
17 provide my students with a copy of the pharmacists  
18 manual, and we review that, you know, during the  
19 afternoon course. We'll take a break from doing  
20 charts and we'll talk about the pharmacist's manual  
21 or go through the different red flags are and how to  
22 clear a red flags and that type of thing.

23 Q. Now, in the next paragraph on page 6 you  
24 say that Mr. Dukeshire was dispensed 112 narcotic

1 prescriptions.

2 A. Yes.

3 Q. I don't understand your statement then, on  
4 average were dispensed 144 days early.

5 How do you come up with an average of 144?

6 A. That was based on the 100 -- that was based  
7 on what I consider early fillings in that four-year  
8 period of those 112 prescriptions. If I added up  
9 the days that were filled early it turned out, in  
10 that four-year period, it was 144 days early.

11 Q. So that's really a sum, not an average?

12 A. Yes. Yes. I would agree with that.

13 Q. Did you calculate what the average was,  
14 meaning was it one day? Two days? Zero days? Did  
15 you calculate it?

16 MR. ABRAMOWITZ: Objection, but you can  
17 answer.

18 A. I did calculate that out and I'm afraid I  
19 don't have that document with me, but I can provide  
20 it for you later.

21 Q. Yes. And we'll make that Exhibit 10.

22 DEPOSITION EXHIBIT NO. 10

23 (Calculation of Days Early was marked for  
24 identification purposes as Deposition

1 Exhibit No. 10.)

2 A. Okay.

3 MR. ABRAMOWITZ: Again, subject to or  
4 review for attorney-client privilege in that  
5 exhibit.

6 And just so we're clear, Tammy, that is the  
7 document with the calculation of the average?

8 MS. WHITE-FARRELL: Yes.

9 MR. ABRAMOWITZ: Thank you.

10 Have you worked in pharmacies where  
11 pharmacist's write notes on the back of the original  
12 prescription?

13 A. I have in the past, yes.

14 Q. And was that the custom and practice at  
15 that particular, those particular pharmacies?

16 A. Well, that was the practice at the  
17 pharmacies that I worked at probably in the 1980's  
18 and '90s. More recently, the pharmacies that I  
19 worked at may have pharmacist's log books or  
20 communication logs, which whenever I've managed a  
21 pharmacy I always send install a pharmacist's  
22 communication log book.

23 So rather than look at the Post-it notes on  
24 past prescriptions it will all be in one area so

1 pharmacists can look and see what another pharmacist  
2 has been doing if they don't happen to be on shift  
3 at the same time.

4 Q. Do you know of any particular instance with  
5 respect to Mr. Dukeshire where pharmacists wrote a  
6 note on the back of the prescription that did not  
7 get communicated to another pharmacist at a later  
8 time if they needed it?

9 MR. ABRAMOWITZ: Objection, over board and  
10 you can answer.

11 A. Well, I wouldn't know specifically whether,  
12 you know, the pharmacist was reading the other  
13 pharmacist's communications. But I know the system  
14 was set up so that it was difficult and that if you  
15 needed to look at past prescription you had to go  
16 into the back files, the whole hard copy files, and  
17 look back to see it.

18 There was no one central place where you  
19 can make notes from one pharmacist to another. So  
20 it was very difficult and it would be time consuming  
21 to have to go back through those files without  
22 having a centralized area where you would just refer  
23 to a communication log or a computer note when, you  
24 know, when you bring up that patient's profile.



1 Q. Can you name one instance where a  
2 pharmacist had information on the back of one of  
3 Dale Dukeshire's original prescriptions that did not  
4 get appropriately communicated to another  
5 pharmacist?

6 MR. ABRAMOWITZ: Objection. Over broad.  
7 You can answer if you can.

8 A. I can't answer that specifically.

9 Q. What are the red flags that you contend  
10 were overlooked in this case?

11 A. Well, there's several hard red flags to me  
12 and then some subtle red flags, but the hard red  
13 flags would be the, you know, the increasing, as  
14 time went on the increasing desire for him to fill  
15 new prescriptions early, that's a red flag, seeking  
16 early refills.

17 The other really hard red flag is what we  
18 call doctor shopping, where a patient goes to an  
19 emergency -- he's getting chronic pain meds from a  
20 pain medication doctor like Dr. Gallagher but then  
21 they're also going to emergency rooms, they're going  
22 to dentists, they're going to other doctors,  
23 orthopedists, to seek out prescriptions for other  
24 narcotics because their pain management doctors are

1 not giving them enough drugs.

2 Q. Any other red flags that you contend were  
3 overlooked in this case?

4 A. Well, those are the two big red flags. But  
5 the fact that the patients, I mean, the pharmacists  
6 did not talk with the patients about coming in and  
7 seeking early fills of their prescriptions, that  
8 there was virtually no counseling, that the patient,  
9 you know, was perhaps overusing his medication.

10 There's no questioning that I had seen, no  
11 documentation on that. I'm sure there were other  
12 things that I'm not remembering at this point. But  
13 I think those two red flags, the two hard flags  
14 would definitely have to be cleared, the ones I  
15 mentioned before about doctor shopping and early  
16 refills, early fills.

17 Q. I want to make sure I have the number of  
18 physicians that you -- I, early in the deposition I  
19 thought you said there were 17 physicians but in  
20 your report you say 12. Which one is it?

21 A. It's both. There were 17 from the onset of  
22 the Rite Aid prescriptions. But once he started  
23 seeing Dr. Gallagher at that point there were only  
24 12 other physicians other than Dr. Gallagher, once

1 he started becoming a patient of Dr. Gallagher's.

2 Prior to that there were five other doctors that he  
3 sought medications from.

4 Q. Okay. Now, I got it.

5 MS. WHITE-FARRELL: We've been going about  
6 another hour and I've had to much to water drink so  
7 I need to take a break.

8 MR. ABRAMOWITZ: I'm with you. I got you.

9 MS. WHITE-FARRELL: All right. Let's take  
10 another break.

11 (Short break in proceedings.)

12 BY MS. WHITE-FARRELL:

13 Q. Doctor, I don't which page of your report  
14 is, you say Both pharmacists who were deposed claim  
15 a lack of knowledge as to narcotic drugs such as  
16 other opiates.

17 What are you saying by that in your report?

18 A. That was based on the information I read in  
19 their depositions. I was actually pretty shocked to  
20 find out that one of the pharmacists did not know  
21 that what heroin was, which is, you know, pretty  
22 much explained in every continuing education on  
23 opiate use disorder.

24 The required courses from boards of

1 pharmacy I'll mention it, and the pharmacists didn't  
2 know what it was. To me it seemed she had a  
3 complete lack of knowledge of opiates. And then  
4 that actually brings to mind another red flag that I  
5 forgot to mention, was the assessment of morphine  
6 milli equivalents in dispensing of drugs and looking  
7 at the risks involved in patients taking high MMEs.

8 As you mentioned earlier you said that's  
9 what doctors do. What I said pharmacists do it,  
10 too. And when we look at it we could, I don't know  
11 if you're familiar with what MMEs are, but an MME is  
12 a morphine milli equivalent and it gives you a risk  
13 factor based on your MME cut, daily MME count.

14 So an MME of 50 is generally a warning.  
15 When you get to an MME of 90 it may become a red  
16 flag that the patient's taking very high doses and  
17 has a very high risk of overdose death.

18 So this is when a pharmacists vigilance  
19 needs to go up when they do an assessment of MMEs on  
20 their patients. By 2016, Mr. Dukeshire was  
21 receiving approximately 135 MMEs every day of  
22 opiates, which is in the very high risk range.

23 That would actually would, should trigger  
24 another red flag for the pharmacist to do more due

1 diligence in clarifying the scripts, counseling the  
2 patient, and actually warning the patient of the  
3 dangers of high MMEs on a daily basis.

4 Q. When did you come up with the MME red flag  
5 opinion?

6 MR. ABRAMOWITZ: Objection, attorney-client  
7 work product, but for that objection you can  
8 answer.

9 A. Well, throughout the case I thought about  
10 MMEs but I didn't really apply it to this case  
11 probably until within the last few weeks.

12 Q. And what was it that caused you to apply it  
13 to this case in the last few weeks?

14 MR. ABRAMOWITZ: Objection, but you can  
15 answer.

16 A. It was just, you know, I was contacted  
17 again by the attorneys after a long period of time  
18 that we hadn't talked and I wanted to refresh myself  
19 so I was looking through some different files. I  
20 reviewed the pharmacist's manual and things like  
21 that again.

22 And the issue of MMEs came up in some of  
23 the literature I read. So I said, let me go back  
24 and take a look and calculate how many MMEs

1 Dukeshire was taking on a daily basis. And when I  
2 did that I realized he was taking an extremely high  
3 MME count.

4 So I didn't put in my report initially that  
5 I did, you know, a year or so ago but, you know,  
6 it's something that I would add as an adjunctive or  
7 addendum to it as far as a red flag.

8 Q. Is there a particular writing or source or  
9 guideline that you can refer me to as to what MME  
10 would have been acceptable non-red flag range for a  
11 chronic pain patient such as Dale Dukeshire?

12 MR. ABRAMOWITZ: Objection, but you can  
13 answer.

14 A. I wouldn't know specifically that, you  
15 know, met all of the criteria of your question. But  
16 one of the documents I gave you, you know, that we  
17 have in the exhibits that details MMEs and the  
18 importance of assessment of MMEs.

19 Q. What is heroin?

20 MR. ABRAMOWITZ: Objection, you can answer.

21 A. It is a synthetic opiate. It's called  
22 diacetylmorphine. It's a stronger opiate than say,  
23 then morphine itself.

24 Q. Is it a C-I?

1           A.     In the United States it's a C-I. In various  
2 other countries like Europe it's a C-II.

3           Q.     For any opinion that you have, do you rely  
4 upon any Ohio statute or regulation?

5                   MR. ABRAMOWITZ:  Objection, but you can  
6 answer if you can.

7           A.     That's a good question.  I think -- I don't  
8 know the Ohio standards and regulations by heart.  I  
9 would have to go through them, but I think they  
10 would be similar to the general federal regulations  
11 on assessments of, you know, narcotic dispensing.

12          Q.     As you sit here today, is it a correct  
13 statement that you cannot point me to any Ohio  
14 regulation or statute that you contend was not met?

15                   MR. ABRAMOWITZ:  Objection, but you can  
16 answer.

17          A.     Not off the top of my head.  But I'm sure  
18 that if I had the Board of Pharmacy regulations in  
19 front of me I could find a listing of regulations  
20 and red flags that would have, that would pertain to  
21 what you're asking, but I personally don't have that  
22 knowledge memorized.

23          Q.     At any time have you undertaken to look at  
24 the Ohio statute or regulations to determine if any

1 was not complied with in this case?

2 MR. ABRAMOWITZ: Objection, but you can  
3 answer.

4 A. I don't recall if I looked at specifically  
5 at that Ohio regs. I may have. I believe I was  
6 looking at the federal regulations, and whenever  
7 there's conflicting regulations being state and  
8 federal, the strictness of the two are to be  
9 followed.

10 Q. So I think the answer to my question is no.  
11 Is that right?

12 MR. ABRAMOWITZ: Objection.

13 A. It's, I don't remember. I may have looked  
14 at the Ohio Board of Pharmacy regulations.

15 Q. As you sit here today, can you recall  
16 identifying anyone that was not met?

17 MR. ABRAMOWITZ: Objection; asked and  
18 answered but you can answer.

19 A. Not off the top of my head. Again, I would  
20 have to look at a regulations.

21 Q. What claimed lack of understanding about  
22 narcotic prescriptions do you claim the pharmacists  
23 had here?

24 A. The lack of understanding? You know --



1 Q. You say --

2 MR. ABRAMOWITZ: Wait, he's answering.

3 A. Ho ahead. I'm sorry.

4 Q. You say in your report, "The claimed lack  
5 of understanding about narcotic prescriptions, if  
6 true, would also be a violation of Rite Aid's e  
7 training and supervision of their pharmacists."

8 So I'm trying to understand what claimed  
9 lack of understanding about narcotic prescriptions  
10 existed.

11 A. Well, according to the depositions of the  
12 pharmacists that I read, as I mentioned, they didn't  
13 know what heroin was, they didn't due, calculate  
14 MMEs, and I don't believe they were asked about it  
15 so I don't know their knowledge about it but I did  
16 not see anything in the record that showed they  
17 address that or looked at the MMEs on the patients.

18 The fact that they were filling the drugs  
19 without calling doctors, when multiple doctors are  
20 writing scripts they weren't calling doctors, when  
21 patients were coming in with, when a patient,  
22 Mr. Dukeshire was coming in several days early for  
23 new prescriptions there were not calls to doctors.

24 It was pretty much, you know, they were

1 isolating every prescription as it came in as one  
2 prescription and we'll just fill that one  
3 prescription without looking at the whole big  
4 picture of how many scrips he's been getting, how  
5 frequently he's seen coming for early fills.

6           They didn't bother -- in my knowledge I saw  
7 no record of them calling these other 12 doctors to  
8 let them know that the patient was receiving  
9 narcotics from other physicians. All these things  
10 accumulate to my assessment that they have a lack of  
11 understanding about narcotic prescriptions and the  
12 potential harm that could be caused by things such  
13 as early fills and multiple physicians prescribing.

14       Q.   How much of your current work load is  
15 consumed by expert witness work?

16       A.   It varies from month to month. I would say  
17 last month zero. This month about 15 percent of my  
18 work. Many months I do no expert witness work. The  
19 expert witness work tends to come in waves where  
20 you'll get a case and do a lot of work for a week or  
21 so and then it sits idle for a year or two.

22           And that's pretty much what happened with  
23 this case as well. And so I don't do expert witness  
24 work all the time. I do pharmacy work all the time.

1 Q. How many active cases do you have right  
2 now?

3 A. Five, maybe six that are active. I'm not  
4 actually sure. I actually spoke to a lawyer last  
5 week who wanted to refer me a case and I asked him,  
6 you know, I said something about, well, we did good  
7 on the other case that you did.

8 And he says that case is still active. And  
9 that was six years ago. And I didn't even know the  
10 case was still active. I thought it had already  
11 settled. So that's why I said five and then I would  
12 change it to six because I wanted to add that case.

13 I haven't been in contact with the lawyer  
14 for six years but he considers it still an active  
15 case.

16 Q. What percentage of your case work is for  
17 the plaintiff versus for the defense?

18 A. I would say it's about 50/50.

19 Q. What do you charge for record review?

20 A. Well, do you want to know what I charged  
21 for this case? Because I've changed my fees last  
22 year and I'm still basing this case on previous  
23 billing. So do you want my current or do you want  
24 the one that's on this case?

1 Q. Both.

2 A. Okay. On this case I charged \$300 an hour  
3 for record reviews, \$400 an hour for depositions and  
4 trial testimony. That was old fees.

5 My new fees are, let me get this straight.  
6 \$350 an hour for reviews and \$500 for depositions  
7 and trial testimony. So I raised my rates a little  
8 bit about a year ago.

9 Q. Okay. Have you ever been qualified to  
10 testify at trial by a court?

11 A. Have I ever testified at trial by court?  
12 Yes.

13 Q. How many occasions?

14 A. I believe there were four trial  
15 testimonies.

16 Q. Have you ever testified in Ohio at trial?

17 A. No, not at trial. I have worked on another  
18 Ohio case.

19 Q. Do you know of any evidence in this case  
20 that by filling a prescription up to two days early  
21 from when a prior C-II prescription expired that  
22 Rite Aid was on notice that Dale Dukeshire was  
23 abusing any of his medicines?

24 MR. ABRAMOWITZ: Objection, but you can

1 answer.

2 A. Can you repeat the first part of the  
3 question?

4 Q. Sure. Do you have evidence that by  
5 allowing the 48-hour time period to apply that Rite  
6 Aid was on actual notice that Dale Dukeshire was  
7 abusing any of his prescriptions?

8 A. I can't answer that. I don't know what  
9 Rite Aid knew or did not know based on that.

10 Q. Do you have any knowledge from any source  
11 that Rite Aid was on notice that Dale Dukeshire was  
12 not taking his meds appropriately?

13 MR. ABRAMOWITZ: Objection, but you can  
14 answer.

15 A. Not that I know from their records.

16 Q. From any source?

17 MR. ABRAMOWITZ: Objection, but you can  
18 answer.

19 A. Well, when you look at any source there was  
20 deposition of a nurse practitioner that had spoken  
21 to Dr. Gallagher, I believe, talked to Dale  
22 Dukeshire's family, that showed concern that he may  
23 -- according to her the family told her he crushing  
24 and snorting medication, that he was buying pills on

1 street and that type of thing. So there was some  
2 knowledge from a nurse practitioner who tried to  
3 intervene.

4 Q. But my question was, was Rite Aid ever on  
5 notice that Mr. Dukeshire was not taking his  
6 medicines appropriately?

7 MR. ABRAMOWITZ: Objection, but you can  
8 answer.

9 A. Not that I know of.

10 Q. Do you have any evidence that Rite Aid was  
11 ever on notice that Mr. Dukeshire was taking street  
12 drugs?

13 MR. ABRAMOWITZ: Objection, but you can  
14 answer.

15 A. Not that I noticed in the records.

16 Q. From any source, was Rite Aid on notice  
17 that he was taking street drugs?

18 A. Not that I know of.

19 Q. Do you agree that's it's not in the  
20 pharmacist's scope of practice to say whether or not  
21 a patient's pain is legitimate?

22 MR. ABRAMOWITZ: Objection, but you can  
23 answer.

24 A. That's not the pharmacist's duty; although,

1 a pharmacist does have to have confidence that there  
2 is a legitimate medical reason for each prescription  
3 that's being dispensed.

4 Q. Was the 12 physicians that wrote episodic  
5 scripts, did each of those physicians just write one  
6 script?

7 A. I'd have to look at the records.

8 MR. ABRAMOWITZ: Objection, but you can  
9 answer.

10 A. There were a couple of physicians that  
11 wrote the scripts a couple times. Dr. Stephanie  
12 George wrote two prescriptions, and James Huddleston  
13 wrote two prescriptions, and Robert Cook also wrote  
14 two prescriptions.

15 So there were several, there were three  
16 doctors that wrote multiple scripts, two scrips for  
17 him, in addition to the, you know, the other 108  
18 from Dr. Gallagher, whatever, over 100 from  
19 Dr. Gallagher.

20 Q. Looking at my notes here. Give me a few  
21 minutes.

22 A. Sure.

23 Q. Do you agree that pharmacists do not and  
24 cannot render medical opinions?

1 MR. ABRAMOWITZ: Objection, but you can  
2 answer.

3 A. Yes. I understand that.

4 Q. And pharmacists cannot and do not render  
5 medical diagnoses?

6 MR. ABRAMOWITZ: Objection, but you can  
7 answer.

8 A. Yes. We do not render though; although, we  
9 do have to document them in many cases.

10 Q. When you -- for the record, you are unaware  
11 of any specific conversation that any of the  
12 pharmacists had with Dale Dukeshire or with  
13 Mrs. Dukeshire; true?

14 MR. ABRAMOWITZ: Objection.

15 A. Only from what I've read in the  
16 depositions.

17 Q. Okay. The universe what you know about  
18 those conversations, if any, are in the depositions?

19 A. That is correct.

20 Q. Let me check with Mr. McManus. We may be  
21 about done, so let's take just a five minute, a  
22 quick break.

23 (Short break in Proceedings.)

24 BY MS. WHITE-FARRELL:



1 Q. Mr. Litman, have we discussed all of the  
2 opinions with will attempt to offer in this case?

3 A. I believe you've covered most of my  
4 opinions; although, specifically, my summary, you  
5 know, and how I look at the whole thing has not been  
6 isolated. Everything has been kind of thrown into  
7 that one report.

8 Q. What do you mean by that?

9 A. I mean that, you know, going into the  
10 dispensing patterns of this pharmacy, when I look at  
11 the dispensing volume of prescriptions that they're  
12 processing, you know, between 200 and 300 a day in a  
13 12-hour period, allowing two to three minutes per  
14 prescription, it seemed to me that, you know, that  
15 Rite Aid was, you know, kind of woefully blind as to  
16 clearing red flags because it would interfere with  
17 their dispensing of prescriptions.

18 They literally had, the pharmacists  
19 literally had two to two and half, maybe three  
20 minutes to process a prescription and that includes  
21 verifying it, calling physicians, insuring that it's  
22 not too soon, you know, all these different factors  
23 that are involved.

24 And their system was kind of set up for

1 failure because the weren't checking. They didn't  
2 give their pharmacists enough time to process things  
3 properly and as well as not really verifying that  
4 the pharmacist were well trained and well versed in,  
5 you know, opiate use disorders and dispensing of  
6 opioid products, clearing red flags.

7 It seems like there was just a whole, you  
8 know -- I guess it's all summarized in my report.  
9 But I guess we just didn't discuss it today, some of  
10 the details that were in my report.

11 That's why I said when you asked if there's  
12 anything else, I think there were other things in my  
13 report that were not brought to light in our  
14 discussion today.

15 Q. Anything else that I've not brought to  
16 light other than what you just mentioned?

17 A. Not that I can think of off the top of my  
18 head, but I think that those were very important key  
19 points.

20 Q. Can you take a moment and look at your  
21 report and double check for me?

22 A. Okay.

23 About the flags, standard of care, the  
24 violation of standard of care and not informing

1 other physicians along with primaries that he's  
2 seeing other doctors. That's important to discuss  
3 that. (Reading to himself, inaudible.)

4 One statistic I listed in the report that  
5 we didn't bring up is that, you know, when you keep  
6 isolating these new prescriptions and say, it's an  
7 isolated script, they were filling it two days  
8 early, there not a problem in that, but when you  
9 look at the pattern of that over a period of time  
10 like we did this four-year period of time we came to  
11 a summary of early fills over that period of time of  
12 144 days.

13 And that doesn't even include the one day  
14 early refills. That -- I didn't even include those.  
15 If we included those it would be even more. So  
16 Mr. Dukeshire probably -- they basically dispensed  
17 an extra five months worth of medications to this  
18 patient. So there was no control on his usage, no  
19 monitoring of him being in compliance with a  
20 physicians guidelines for using these drugs.

21 And that was in my report that was not  
22 discussed today. Let's go on -- I think we've  
23 covered most of my opinions that are listed in the  
24 report.

1 Q. Well, look at your report and tell me if  
2 there's any that we have not because -- and the  
3 question is broader than that because you gave me  
4 two extra opinions today, a DUR opinion and a MME  
5 opinion.

6 MR. ABRAMOWITZ: Objection, but you can  
7 answer.

8 A. Okay. I think aside from those other two  
9 opinions that I've added that we have my opinions in  
10 the report.

11 Q. All right. Have you likewise, have you  
12 shared with me the basis for your opinions, meaning  
13 where the things that you rely upon for the opinions  
14 you would attempt to offer?

15 A. Well, I mentioned the pharmacist manual,

16 MR. ABRAMOWITZ: I'm sorry. Objection.

17 A. The pharmacist manual and I rely on my 40  
18 years of experience as a pharmacist, my 35 years of  
19 experience a pharmacy professor in providing solid,  
20 sound, ethical pharmaceutical care to my patients.

21 Q. Anything else?

22 MR. ABRAMOWITZ: Objection, but you can  
23 answer.

24 A. I think that's the summary of where I

1 developed my opinions.

2 MS. WHITE-FARRELL: Those are all my  
3 questions. Thank you.

4 MR. BECK: This is Chad Beck. I don't have  
5 any questions for the witness.

6 MR. ABRAMOWITZ: I might have few -- well I  
7 have just one question to clarify here.

8 EXAMINATION

9 BY MR. ABRAMOWITZ:

10 Q. Mr. Litman, about thirty minutes or so  
11 Tammy used the term, "was Rite Aid on notice."

12 How did you take that term to mean? Can  
13 you just explain to us what your understanding is?

14 A. She asked if they were on notice, I assume  
15 a third-party entity had contacted Rite Aid, like  
16 the DEA or the Board of Pharmacy contacted them and,  
17 you know, and said that they were flagged or, you  
18 know, having an issue with the dispensing of  
19 narcotics.

20 That's what you meant right, Tammy?

21 EXAMINATION

22 BY MS. WHITE-FARRELL:

23 Q. I meant notice from any source.

24 A. Okay. I assumed that you meant a third-

1 party source.

2 I mean, they really, you know, should have  
3 been on notice themselves based on the, based on the  
4 filling patterns.

5 Q. On notice of what?

6 MR. ABRAMOWITZ: That, for the record,  
7 we'll hand the question over to Tammy, just so it's  
8 cleared for the record.

9 A. I'm sorry. Repeat the question again?

10 Q. On notice of what.

11 A. On notice that their, that Mr. Dukeshire  
12 had an opiate use disorder, that he was consistently  
13 requiring early fills of his C-II prescriptions,  
14 that I guess it looks like a blindness on Rite Aid's  
15 part to not want to intercede and just got the  
16 scripts filled.

17 I think their motivation was to fill, sell  
18 drugs, and they weren't really looking out for the  
19 safety or well being of the patients or community.  
20 They just wanted to make their sales. So that's how  
21 I feel that, you know, they should have put  
22 themselves on notice.

23 But when you said it I thought you were  
24 referring to another regulatory agency putting them

1 on notice for, you know, either somebody reported  
2 something to the DEA or the Board of Pharmacy about  
3 that pharmacy.

4 MS. WHITE-FARRELL: All right. Those are  
5 all my questions.

6 Do you want to read and sign, Mark?

7 MR. ABRAMOWITZ: Yes, please. I'm sorry --

8 MS. WHITE-FARRELL: Mark, are you sending  
9 these exhibits to me and then me to the court  
10 reporter or are you sending them to the court  
11 reporter directly?

12 MR. ABRAMOWITZ: I'm happy to send them  
13 both to you at the exact same time if you'd like it,  
14 and include Chad or Stephen on that as well.  
15 Whatever ever you guys like, copy everybody at the  
16 same time.

17 (Short discussion off the record.)

18 COURT REPORTER: And I guess Mr. Beck do  
19 you want to order a copy on the doctor's behalf  
20 since there's several of you on here?

21 MR. BECK: Yes, ma'am.

22 (Having chosen to read and sign, the  
23 deposition concluded at 2:50 p.m.)

24

ERRATA SHEET

I, ROBERT A. LITMAN, do hereby certify that  
the foregoing is a true and correct transcript of my  
deposition with the exception of the following  
corrections:

PAGE	LINE	CORRECTION
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\_\_\_\_\_  
Deponents's Signature

State of \_\_\_\_\_,  
County of \_\_\_\_\_,

Sworn to before me,

\_\_\_\_\_,  
Notary Public, this \_\_\_\_\_ day of \_\_\_\_\_,  
2021.

\_\_\_\_\_  
Notary Public



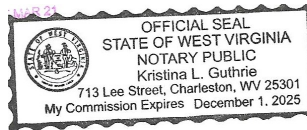
1 STATE OF WEST VIRGINIA

2 COUNTY OF KANAWHA, to wit:

3 I, Kristina Guthrie, Professional Reporter  
4 and Notary Public within and for the County and  
5 State aforesaid, duly commissioned and qualified, do  
6 hereby certify that the foregoing proceedings were  
7 duly transcribed by me from stenographic notes taken  
8 in the foregoing proceedings to the best of my skill  
9 and ability.

10 I do further certify that the said  
11 proceedings were correctly taken by me in shorthand  
12 notes, and that the same were accurately written out  
13 in full and reduced to typewriting by means of  
14 computer-aided transcription.

15 Given under my hand this 15th day of  
16 November, 2021.



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Kristina Guthrie, Professional  
Reporter and Notary Public

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