AFFIDAVIT OF JONATHAN M. GIFTOS, MD, AAHIVS

New York, NY

Qualifications and Background

My name is Dr. Jonathan M. Giftos and I am a general internist, addiction medicine specialist and correctional health expert. My Curriculum Vitae is attached. I am board certified in internal medicine and addiction medicine. I am currently the Medical Director of Addiction Medicine & Drug User Health at Project Renewal and a Clinical Assistant Professor in the Department of Medicine at Albert Einstein College of Medicine. I was previously the Clinical Director of Substance Use Treatment for NYC Health & Hospitals, Division of Correctional Health Services at Rikers Island. In that capacity, I was responsible for the clinical and administrative oversight of all diversion, harm reduction, treatment and reentry services for incarcerated patients with substance use disorders. I also served as the medical director of the Key Extended Entry Program (KEEP) on Rikers Island, the nation's oldest and largest jail-based opioid treatment program that provided withdrawal management, and methadone and buprenorphine maintenance treatment to incarcerated patients with opioid use disorder. I have overseen the care of thousands of incarcerated patients with opioid use disorder, and I am called upon locally and nationally to provide clinical guidance and technical assistance to jurisdictions looking to improve the care of incarcerated patients with opioid use disorder. I was retained by Anthony Carr on behalf of the plaintiff in December 2020 to act as Expert Witness regarding Case No.: 20-CV-447-JL.

Facts and/or Data Considered

I have reviewed the records and discovery materials in this case, including Plaintiff's Complaint and Amended Complaint, Plaintiff's Hillsborough County of Corrections records, medical records from Elliot, the death certificate, the autopsy report, the discovery responses from the parties, the parties' document productions, deposition transcripts of the witnesses who have been deposed, the documents obtained by Plaintiff pre-suit, the HCDOC and AIMG agreement, Manchester PD report, the affidavit of Michael Differ, and the reports of Nurse Luethy and Dr. Thomas Andrew.

Opinions

I hold the following opinions to a reasonable degree of medical and scientific certainty based on my review of the records and materials and my education, training, and experiences:

1. The risks related to opioid withdrawal are well known in the correctional setting

Substance use disorder (SUD) is the clinical term for a problematic relationship with illicit drugs or alcohol. SUD are generally defined by an escalating use of the substance, a loss of control, cravings, continued use despite negative consequences, the development of a tolerance to the effects of the substance, and a physical dependence such that abrupt discontinuation of the substance leads to a withdrawal syndrome.

Opioid use disorder (OUD) is a specific type of SUD marked by a problematic relationship with opioids - a class of substances that can include certain prescription pain medications, heroin or, as we are now seeing, heroin contaminated by illicit fentanyl - a potent and dangerous synthetic opioid that has been associated with a dramatic increase fatal overdoses over the past several years. People can ingest opioids orally, intranasally (sniffing), or intravenously (injection).

OUD is associated with substantial health risks. Such risks include dangerous withdrawal symptoms, fatal overdose, infection from shared injection equipment, social isolation, and increased exposure to arrest or incarceration.

SUD - and OUD in particular - are highly prevalent in correctional settings, and incarceration itself can exacerbate some of the health risks noted above. The two most substantial harms of incarceration for person with OUD are 1) untreated withdrawal symptoms (arrest and incarceration is associated with an acute disruption in one's access to opioids), leading to substantial morbidity and occasional mortality, and 2) fatal drug overdose - the risk of which is most pronounced during the first few days of reentry to the community. Careful assessment, monitoring, and treatment with medications like methadone and buprenorphine can all but eliminate these risks. In fact, in my 3+ years overseeing the care of incarcerated patients with OUD at Rikers Island, we had zero instances of withdrawal related mortality, despite admitting and caring for 3,000+ such patients each year.

The National Commission on Correctional Health Care (NCCHC) 2014 Standards (J-G-07) on Intoxication and Withdrawal emphasized the need for careful assessment, monitoring, and treatment of opioid use disorder in correctional settings. Key elements of these standards include a clear protocol for the assessment, monitoring, and management of withdrawal that is approved by the responsible physician. Within that protocol, individuals should be housed in a safe location that allows for effective monitoring. Individuals experiencing withdrawal should be monitored by qualified health professionals trained in the assessment of withdrawal and its complications, and able to deliver appropriate treatments. There should be a mechanism for identifying complications that should require transfer to a higher level of care, such as a hospital. The NCCHC specifically notes in its standards that withdrawal management must be done under the supervision of a physician. And ideally, medication such as methadone and buprenorphine should be available to both manage withdrawal symptoms, and to be offered as part of maintenance regimens for ongoing care.

In addition to the NCCHC quality standards, the American Correctional Association (ACA) released a resolution in 2017 calling for all correctional institutions to institute the above best practices for the screening, assessment, monitoring and treatment of OUD. This resolution acknowledges the substantial morbidity and mortality experienced by incarcerated people with OUD, and the role good policy and practice can play in mitigating those harms.

In summary, although rare - death is a known risk of untreated opioids withdrawal, and such deaths have been known to occur in correctional settings due to insufficient access to medical care. Deaths related to opioid withdrawal are easily and entirely preventable so long as access to medical care is not denied.

2. AIMG "created" a system of care that was incapable of keeping inmates like Mr. Sacco safe from serious harm

AIMG took on a broad range of duties in its agreement with Hillsborough County that positioned them as the facility's health care authority. These responsibilities include, but are not limited to, policy development, ongoing nursing education, and supervision of continuous quality improvement. It is clear from the testimony of PA Schweiger and Dr. Braga that they did not perform many of these duties. These failures created a system of care that was incapable of keeping Mr. Sacco safe from harm.

Such failures are summarized below:

1) The contract says they'll provide a minimum of 12 hours of service on site at the jail per week. They seemed to provide 3-5 hours of care on-site per week. A limited on-site clinical presence renders them unavailable more often than not. They could not have possibly taken on their broad obligations to HCDOC inmates in good faith given their other professional obligations.

2) The contract says AIMG will contribute to the review and revision of the facility's health care policies and procedures and will recommend changes consistent with "evolving standards of care and professional requirements". PA Schweiger and Dr. Braga have testified that they did not do that, nor did they ever consider doing that. For example, the policy describing care for people with opioid withdrawal is grossly inadequate, dangerous, and not aligned with current standards of care, yet they made no attempt to update this policy the two times they renewed it before Mr. Sacco's death.

    a) The contract also says they will deliver care in accordance with NCCHC/ACA standards. As stated above, the NCCHC standards for the treatment of opioid withdrawal call for protocols that are approved by the responsible physician, are current, and that are consistent with nationally accepted treatment guidelines. Specifically, they also call for the use of validated withdrawal assessments (eg,

Clinical Opioid Withdrawal Scale, COWS), and the rapid transfer of patients experiencing severe withdrawal to licensed acute care facilities. The AIMG policy toward the treatment of opioid withdrawal does not use validated withdrawal assessments, and is not consistent with nationally accepted treatment guidelines. Significantly, the AIMG policy toward the treatment of opioid withdrawal also bypasses the requirement of being conducted under the supervision of a physician through the use of the vague, outdated and dangerous standing orders. HCDOC protocol also doesn't clearly state when to initiate withdrawal management; there is no communication with the physician/PA to authorize treatment, despite the use of standing physician orders; and the protocol does not use medications that can effectively treat withdrawal. Additionally, the protocol does not clearly state when a patient should be transferred to a higher level of care. AIMG essentially signed off on a protocol that cannot ensure the safety of people experiencing opioid withdrawal without putting any thought into it.

3) The contract says that AIMG will oversee the facility's quality assurance program. There does not seem to be a quality assurance program in place, insofar as clinical care is concerned, and Dr. Braga has testified that he does not think that this was his responsibility. The absence of a quality assurance process creates a culture of limited accountability, and a system that cannot identify where and how it needs to improve. There does not appear to have been any type of effort to understand the systemic factors that led to Mr. Sacco's death or define a plan to improve on those factors.

4) The contract says AIMG will provide in-service training to facility staff, including nurses, a minimum of twice annually. They have not done this. This creates a staff of poorly trained nurses who are not able to effectively implement protocols, or escalate situations when clinically indicated.

    a) Specifically, with regard to the opioid withdrawal protocol, there is no evidence that AIMG trained facility nurses in how to perform withdrawal assessments, when to initiate the detox protocol, or when to call a provider or further escalate care.

5) The contract says AIMG will reasonably document all medical services. They do not attempt to do this. This creates a system of poor and unreliable documentation.

Ultimately, the failure of AIMG to recommend and authorize a clear, evidence-based policy toward the treatment of incarcerated patients with opioid withdrawal, and instead perpetuating an opaque and antiquated policy that nurses weren't even trained or capable of safely administering, led to grossly insufficient oversight of the clinical care of at-risk patients. Here, more

specifically, it led to no oversight at all and ultimate denial of appropriate medical care for Mr. Sacco.

3. Mr. Sacco's death could have been avoided if the nurses were not deprived of training and supervision

Given that people are incarcerated 24/7 at HCDOC, and given that AIMG and its PA Schweiger and Dr. Braga are only on-site ~5 hours per week, AIMGs ability to deliver and maintain medical care to HCDOC requires careful collaboration and coordination with on-site clinical nursing and administrative staff. And if AIMG staff are not on-site at the facility, the on-site staff must have appropriate training in the clinical protocols, and on when and how to appropriately contact off-site providers.

Additionally, the opioid withdrawal policy at HCDOC involves the use of standing medical orders authorized by AIMG. A treatment plan that involves the initiation of standing medical orders relies on the assessments of on-site clinical staff, and a clear understanding of the various decision-points along the way. Given AIMG's role as the authorizing provider of this protocol, AIMG has the added duty of training and supervising nurses in the safe and accurate administration of the protocol.

My review of the opioid withdrawal protocol, and my review of the nurse and AIMG testimony, leads me to believe that the nurses were deprived of adequate training. The various witnesses who have been deposed in this case have each given different testimony as to what it is they look for when assessing withdrawal symptoms and what distinguishes mild from moderate from severe withdrawal. There has also been conflicting testimony as to whether HCDOC used COWS or any other similar validated withdrawal assessment tool. While it has become clear to me that HCDOC did not use any type of validated withdrawal assessment tool in the time frame when Mr. Sacco was incarcerated, this confusion and inconsistency is an obvious and foreseeable result of AIMG making no efforts to supervise and train the nursing staff. See Nurse Luethy report for additional details, but LPNs do not receive any specialized training in the diagnosis or treatment of opioid use disorder, and their scope of practice generally limits their ability to make independent clinical assessments. In my opinion, it is inappropriate and reckless for AIMG to assume that the nurses would know from their training how to assess for opioid dependence, when to initiate the detox protocol, how to monitor for worsening withdrawal symptoms, and when to notify a provider or escalate care, without making any effort to confirm that the nurses in fact had such knowledge or training. Had AIMG made meaningful effort to train and supervise the HCDOC nursing staff, Mr. Sacco's death could have been easily avoided because they would have known that it was obvious to call a provider or send him to the hospital.

4. **Nicholas Sacco exhibited signs and symptoms of severe withdrawal by Saturday May 18, 2019, and they continued through Tuesday May 21, 2019 when he was admitted to Elliot Hospital**

Patients who use opioids (either pain medication, or illicit opioids like heroin or fentanyl) on a daily basis often develop "tolerance" to the effect of the medication. That is to say, the patient will require a higher amount of the opioid to obtain the same effect (either pain relief, or euphoria). This tolerance is the result of important physiologic changes, many at the level of the opioid receptor, that occur in the setting of chronic opioid use. It is not uncommon for a person with an opioid use disorder to start with a few oxycodone 5 mg tablets, or a ½ bag of heroin per day, and to eventually take 200-300 mg of oxycodone daily, or use 20-30 bags of heroin daily as their tolerance to the opioids develops.

Along with tolerance, regular opioid use leads to the development of physical dependence. That is to say, the body regulates itself around the daily opioid use such that the abrupt discontinuation of opioid use results in a withdrawal syndrome. This withdrawal syndrome is marked by dysphoria, pain, anxiety, sweating, nausea, vomiting and diarrhea, the latter of which puts them at high risk of severe dehydration and its attendant complications. The intensity of the withdrawal syndrome is influenced by a variety of factors, including the duration of opioid use, the type of opioid used, and the quantity of opioid used. It also varies depending on the time that has elapsed since last opioid use, with the syndrome starting with mild symptoms and in many cases progressing to moderate or severe withdrawal symptoms if left untreated. Many people with opioid use disorder live in a chronic state of mild to moderate withdrawal that drives continued opioid use to relieve these symptoms.

Opioid withdrawal generally starts 6-12 hours since last use, peaking in intensity in 1-3 days, and then symptoms slowly subside. This timeline can vary by opioid, with methadone and fentanyl notable for a more protracted withdrawal course.

Evaluating a patient at risk of withdrawal starts with a thorough medical evaluation that includes a substance use history and a urine toxicology screen. A history of daily opioid analgesic or heroin use suggests almost certain risk of opioid withdrawal if access to opioids is disrupted (as is often the case with arrest and incarceration). Such patients would then have their withdrawal state assessed with a validated withdrawal assessment tool, such as the Clinical Opiate Withdrawal Scale (COWS) or the Objective Opiate Withdrawal Scale (OOWS).

The COWS explores eleven domains, and includes subjective and objective elements. For each question, the severity of the answer corresponds to a number. After completing the assessment, the numbers for each domain are added together to provide a resulting "COWS score". A score of 5-12 is considered mild withdrawal; 13-24 moderate withdrawal; 25-36 moderately severe withdrawal; and > 36 severe withdrawal. While each patient may present slightly differently, the

symptom profile tends to be fairly similar from patient to patient. Some symptoms present earlier in the withdrawal timeline, but the major difference between mild, moderate and severe withdrawal is not the presence of symptoms, but the severity of those symptoms - and the physiologic derangements and distress that they represent.

For example, a few domains measured in the COWS include pulse (or heart rate), restlessness, GI upset, bone pain, tremors, and anxiety. Mild withdrawal may present as a slightly elevated HR (81-100), a reported difficulty sitting still (but still able to do so), stomach cramps, mild diffuse discomfort, a slight tremor, and a reported irritability or anxiousness. If allowed to progress without treatment, severe withdrawal may present as severely elevated HR (> 120), the inability to sit still for more than a few seconds, multiple episodes of diarrhea or vomiting, the rubbing of bones or muscles due to discomfort, a gross muscle tremor, and anxiety or irritability that prevents the person from engaging further in the assessment.

Withdrawal symptoms can be effectively treated with opioid medications like methadone and buprenorphine, or, in cases where these medications are not available, the alpha-2 receptor agonist clonidine. If started early, these medications can prevent the progression of withdrawal symptoms, and alleviate the symptoms that already exist. Methadone and buprenorphine can be slowly tapered if that is the patient's preference. However, the best long-term outcomes for opioid disorder treatment are seen in patients who do not taper the medication, but who start and slowly increase the medication as part of a maintenance regimen. Regardless of the long-term treatment plan, the COWS allows you to assess and track withdrawal symptoms as they respond to treatment.

Case specific comments:

- Mr. Sacco reported using 5 grams of heroin daily (2 grams in the Differ affidavit). Heroin packaging and distribution can vary regionally, but it is generally assumed that one gram of heroin is the equivalent to approximately 20 bags of heroin (or 2 bundles of heroin). So Mr. Sacco may have been using 40-100 bags of heroin daily. This reflects an extremely high tolerance to the effect of opioids that resulted from his chronic opioid use disorder. This clinical information, coupled with his prior history of detention at HCDOC where he experienced opioid withdrawal, would suggest to any clinician that he is at extremely high risk of severe opioid withdrawal if not provided appropriate medical care.

- There were several signs documented on the detox flowsheet concerning for progressive withdrawal where it should have been obvious to escalate to the medical provider, which would have led to urgent medical treatment. Most concerning was the HR > 120 and the progressive development of restlessness, agitation, nausea and vomiting. It's hard to conclusively state the level of withdrawal, as the nurses did not use a validated withdrawal assessment tool such as the COWS (nor were they trained to), but the clinical

history (5 gram heroin daily use; with last use on 5/16/19), the markedly elevated HR and the associated symptoms all suggest progressive withdrawal that has become severe. And while nurses cannot be expected to diagnose or treat opioid withdrawal, this progression of symptoms and unstable vitals should have at least prompted even a poorly trained LPN to call the physician authorizing the withdrawal management.

- There were multiple requests by Mr. Sacco to be brought to the hospital for medical treatment. Notably, on 5/18 Nurse Gustafson notes that he shared that he was withdrawing from heroin and that he asked to go to the hospital. His HR at this time was noted to be 114 sitting (128 standing). The detox protocol was started at this time (2 days after admission, and which essentially involved monitoring), yet there was no documented communication with the treating physician regarding the markedly elevated heart rate or the request for medical treatment by Mr. Sacco.

- Nurse Gustafson noted in the early morning of 5/19 that he had developed restlessness and leg cramps, both signs of worsening withdrawal symptoms. His HR around that time remained > 120. Nurse Gustafson returned the morning of 5/20, and she documented additional withdrawal symptoms - now including weakness, consistent with Differ's account - and his HR remained markedly elevated (114). It is very likely that Mr. Sacco was already experiencing severe opioid withdrawal that was progressive on 5/18, 5/19 and 5/20.

- Nurse Malo notes a HR of 120 and 125 on 5/19, and during her second check she notes new restlessness, nausea and vomiting. These findings should have been concerning for progressive opioid withdrawal that was likely severe. She also documented her note just below Nurse Gustafson's note regarding his evolving symptoms and his request for hospitalization.

- Cellmate Differ notes in his affidavit that on 5/20 Mr. Sacco was lightheaded and was having a hard time standing on two feet. He also notes that Mr. Sacco collapsed on the evening of 5/20. He notified corrections officers, but there is no nursing note discussing the incident or the follow-up.

- Nurse Bancroft's nursing note on 5/21 at 00:32 does not mention the above noted collapse, and the detox flowsheet does not mention weakness, which calls into question the integrity of the entire assessment.

- On 5/21 nurses were notified by cellmate (presumably Differ) that Mr. Sacco was in "rough shape". Mr. Sacco crawled to the doorway, was noted to be lethargic, and he was witnessed vomiting green bile. His vital signs were markedly abnormal, with a BP 90/56 and a pulse 52). Noted here is marked hypotension (low blood pressure) and a low pulse.

He eventually became non-responsive. It's hard to say with clinical certainty what was happening, but a likely explanation is that he became so dehydrated over the three previous days that he developed kidney and/or liver failure, and the attendant electrolyte abnormalities caused his heart to stop. When Mr. Sacco was assessed by Nurse Bancroft on 5/21 at 00:32 it should have been obvious to her that he needed immediate medical treatment.

- Of note, Mr. Sacco did not request to be hospitalized after his two previous attempts were denied. This should not be interpreted to mean that Mr. Sacco's condition was improving, or that he didn't remain at grave risk of serious harm. In my experience, it is not uncommon to give up on attempts to advocate for oneself in a correctional setting if you feel that the people you have access to (corrections officers or nurses, in this case) are ignoring your concerns. It is also not uncommon for people with addiction to believe that they are not worthy of compassionate care. Being told that your suffering is normal (as noted in several nursing notes), and that you do not need medical treatment, can reinforce the belief that you do not deserve more than you are receiving.

In summary, there was clear evidence available to nurses that Mr. Sacco had a history of extensive opioid use (2-5 grams daily), and that he was at high risk of severe opioid withdrawal if not provided timely medical care. He also demonstrated to nurses on numerous occasions the signs and symptoms of a progressive withdrawal syndrome that was likely severe, as noted by his markedly elevated heart rate, and evolving restlessness, nausea, and vomiting. Nurses were aware of his abnormal vitals, his progressive withdrawal symptoms, his request to be hospitalized and his suffering, but they did not contact the providers or send him to the hospital.

5. **Nurses Gustafson, Malo, and Bancroft ignored the obvious risk of harm posed to Mr. Sacco**

Despite the many shortcomings on behalf of AIMG, the nurses had clear evidence of a patient experiencing a progressive withdrawal syndrome with many alarming symptoms as noted above. There was also evidence of substantial suffering that was essentially ignored. While they didn't have clear instructions on how to implement an appropriate intervention at HCDOC, these nurses had two appropriate options at their disposal. First, the nurses should have notified the authorizing physician that the patient was experiencing symptoms consistent with severe withdrawal. I have never worked in a clinical setting in which such abnormal vital signs (HR > 120) would not be presented to the supervising physician for review. Second, absent guidance from the supervising physician, the nurses should have requested that the patient be brought to a licensed medical facility for further assessment and medical treatment.

The standing order at HCDOC for the treatment of withdrawal was a "Vistaril taper". As noted, this is not the appropriate treatment for opioid withdrawal. That being said, the internal policy

calls for nurses to initiate this standing order if "indicated by signs or symptoms". Mr. Sacco had a clear history of opioid dependence (using 40-100 bags of heroin daily) that was acknowledged by nursing (see nursing note on 5/18/19 at 21:20), with a last use date of 5/16/2019, and he was demonstrating clear signs of withdrawal on 5/18, 5/19 and 5/20 (elevated HR, restlessness, nausea and vomiting), yet the nurses at no point initiated the standing orders that were available to them, let alone discuss the case with the authorizing physician, or advocate for transfer to a facility that could provide appropriate medical treatment. Additionally, Dr. Braga testified that IV hydration is available at HCDOC, yet none of the nurses seemed to be aware of this intervention, nor is it mentioned in any policies or procedures.

In summary, standard of care would dictate that staff assess Mr. Sacco for risk of opioid withdrawal on arrival to the jail, measure and monitor his withdrawal symptoms with a validated tool such as the COWS, offer medication treatment with methadone, buprenorphine or clonidine (under the direction of the authorizing physician), coordinate with physician to monitor treatment response, and have in place a clear protocol for transferring patients who are not responding to treatment to a higher level of care to ensure their safety. This standard of care was essentially completely ignored. The internal protocol, as inadequate as it may be, dictated that nurses should initiate the standing order for Vistaril if indicated by signs and symptoms of withdrawal. And in his deposition, Schweiger states he expects to be called when patients "appear ill, were significantly tachycardic, hypotensive. . . or just generally did not appear to be well" (32: 22-33: 2), and nurses suggested the same in their depositions. Every symptom PA Schweiger lists here was true from Saturday 5/18 through Tuesday 5/21 yet no one contacted a provider, or initiated the standing order. And in their depositions, all of the nurses defended the bulk of their inaction, further evidencing that the failure to act was deliberate.

There are several examples of nurse inaction in the face of concerning signs and symptoms.

- In response to Sacco's two pleas to be brought to the hospital or given medication, Nurse Gustafson says that no meds are given on the 3rd shift. This is not true.

- Gustafson testified in her deposition that staff are advised to call a provider after two complaints from a detainee that did not result in a resolution of his complaints. Nurse Malo admits the same. Mr. Sacco twice complained to Gustafson to either be brought to the hospital or given medication.

- All nurses identify weakness as a reason to take action by notifying a provider. Nurse Gustafson charted new weakness on 5/20, yet did nothing.

- Mr. Sacco's cellmate testified that he witnessed Mr. Sacco collapse the evening of 5/20/2019. He was found nonresponsive several hours later. Ms. Bancroft's nursing assessment at 00:32 on 5/21/2019 absolutely should have noted weakness, and she

absolutely should have known to notify the provider.

- Nurse Malo admitted in her deposition that Mr. Sacco's symptoms worsened between the prior assessment by a different nurse and her assessment on 5/19. Not only did Mr. Sacco have signs and symptoms of severe withdrawal, they were actually worsening. This should have prompted communication with the supervising physician for guidance, yet no communication was made.

- Nurse Malo testified that she would have called the provider if you could "put a cup under their chin and fill it with sweat". It's important to note that sweating is only one of eleven symptoms assessed in the COWS. Not everyone manifests every withdrawal symptom the same, and so it's important to use a validated tool that comprehensively measures symptoms in order to make treatment decisions. The absence of profuse sweating, in a patient otherwise exhibiting multiple other signs of severe withdrawal, is not a reason for inaction. In addition, there are indications that Mr. Sacco was in fact sweating profusely.

- Nurse Gustafson noted multiple times in her deposition that Mr. Sacco's symptoms could have been associated with anxiety. While it's true that some medical symptoms, such as chest pain, may be associated with anxiety, we never make that determination without further assessment. And an LPN should never be attributing a symptom to a diagnosis, as this is clearly outside their scope of practice. An elevated HR, restlessness, and weakness in the context of a detox protocol should never be solely attributed to anxiety, and a provider should have been aware of the progression of these symptoms.

The nurses' inactions had deadly consequences. It is my opinion that if Nurse Bancroft called for Mr. Sacco to be brought to a hospital at 0032 on 5/21/19 he would still be alive. Likewise had any of the other nurses contacted a provider, initiated IV hydration therapy, or contacted emergency services, it is my opinion that Mr. Sacco would still be alive. If I had been the provider and any of the nurses contacted me about Mr. Sacco between Saturday 5/18 and Tuesday 5/21, it would have been obvious to me to transfer Sacco to a hospital for further medical care.

No medical treatment was provided to Mr. Sacco, despite clear evidence of need, and he was simply provided a cup to facilitate oral rehydration. The only explanation I have for this treatment is that the suffering and neglect are by design. Unfortunately there are many in correctional health who still think that opioid withdrawal is not fatal, and that the suffering facilitates behavior change. There is no evidence that this is true, and there is clear evidence that is harmful. In this case, it is my view that the permitted suffering, and failure to provide appropriate medical care led to Mr. Sacco's death.

I'd like to address the comment by Dr. Braga in his deposition (Page 18) that the medications that nurses offer under his standing order as part of the detox protocol - the Vistaril taper - are "just for comfort measures" and that they are "not a cure". First, it's important to note that withdrawal management itself is not a "cure" for opioid use disorder. That is to say, a patient with an opioid use disorder who has received appropriate withdrawal management may continue to have cravings and may quickly return to opioid use without further treatment. For this reason, withdrawal management alone is not recommended as the only treatment for opioid use disorder. But good withdrawal management, with careful assessment and monitoring, the use of appropriate medications, and clear escalation pathways if symptoms are not responding to treatment, does virtually eliminate (or cure) the risk of death from opioid withdrawal. This is essential to the process of continuing further treatment and recovery. Describing the interventions as simple "comfort measures", as Dr. Braga does on Page 18, dramatically underappreciates the importance of effective withdrawal management.

I'd like to share a clinical story that may explain why this process is so important. I managed the opioid treatment program at Rikers Island from 2016-2020. We cared for thousands of patients per year who entered the jail with an opioid use disorder, and who required withdrawal management. All patients who entered the jail-system were seen by a physician or PA within 24 hours, immediately assessed for risk of withdrawal, and offered methadone or buprenorphine for management of withdrawal. Virtually all patients who started methadone or buprenorphine had near complete relief of the most severe withdrawal symptoms within hours. The majority of our patients then elected to titrate their medications up to what we would consider maintenance doses. This process is meant to further eliminate any lingering withdrawal symptoms or cravings, and to provide blockade against the effect of any additional illicit opioids they may take.

Any patient who did not have resolution of withdrawal symptoms could come to the clinic to see a provider. On one occasion, I saw a patient who continued to feel extremely weak, nauseated and with an elevated HR 48 hours into his withdrawal management. Knowing that this was highly unusual, I drew labs and he was found to be in kidney failure. We sent him to the hospital and he was found to have infective endocarditis - a bacterial infection on his heart valve - that required immediate surgical treatment to prevent further destruction to his heart, or death. The point here is that physician oversight of the withdrawal process is critical to ensure not only that effective treatments are started, but also that failure to respond to treatment gets appropriately assessed. The vast majority of people entering a jail in opioid withdrawal who do not receive treatment will not feel well because they are withdrawing from opioids, but there are other reasons people may have these symptoms, and it is wildly irresponsible to leave nurses, most of whom were LPNs, in the position of monitoring those symptoms without clear oversight and support.

6. I disagree with Dr. Braga's opinions and testimony about Sacco's cause of death

The medical examiner determined that Mr. Sacco died of complications of opioid withdrawal. Dr. Braga testifies that he disagrees with this assessment, though he does not have an alternative explanation. He cites that Mr. Sacco's vital signs as noted on the nursing flow sheet are not consistent with dehydration, and therefore he could not have been dehydrated sufficiently enough to cause the complications that may lead to death.

It's hard to argue that this death wasn't due to the complications of opioid withdrawal. Reading the chart is like watching a train wreck happen in slow motion, with no interventions offered to prevent the outcome. Mr. Sacco had a clear history of 40+ bag/day heroin use, with last use on 5/16, and the period from 5/18-5/21 represented the peak window during which opioid withdrawal occurs. Nurses documented progressive worsening symptoms of withdrawal that included elevated HR (with HR > 120 for several days), nausea, vomiting, restlessness and eventually weakness. Mr. Sacco's cellmate, Mr. Differ, noted that he did not witness Mr. Sacco consume any food, and noted that he could not tolerate fluids by mouth from 5/18 to 5/20. Eventually, Mr. Sacco became so weak that he could not stand, with a collapse witnessed by Mr. Differ on 5/20.

Dr. Braga largely bases his opinion on the fact that Mr. Sacco did not have orthostatic hypotension - that is to say, his blood pressure did not drop substantially when he was moved from lying to standing - as evidence that he was not that dehydrated. I disagree with this assertion. First, the nursing assessment by Ms. Bancroft on 5/21 (shortly after Mr. Differ noted Mr. Sacco's collapse, and a few hours before his death) did not note weakness as a symptom, which calls into question the integrity of the evaluation. Can we be sure she really made him stand for the assessment? Secondly, orthostatic vitals involve taking the blood pressure after lying down for 5 minutes. The person is then asked to stand, and the blood pressure is repeated after 1 and 3 minutes. An sBP drop by more than 20, a dBP drop by more than 10, or dizziness is considered abnormal. The charted vitals note BP (sitting) and BP (standing), but this is not how orthostatic vitals are measured. Sitting approximates standing, and so comparing these two positions is less helpful. And there is no assessment of dizziness. Third, Mr. Sacco was a young, otherwise healthy man who likely could tolerate dehydration better than, say, an older patient. He might have been able to preserve his blood pressure longer than expected, despite substantial dehydration. Eventually, though, vomiting and diarrhea without the ability to replenish fluids can lead to profound dehydration, hypernatremia (an electrolyte imbalance), and heart failure. Before his death, he was found to be extremely hypotensive (90/50) with a slow heart rate. This low blood pressure and slow heart rate may have led to further underperfusion of his organs, the development of kidney failure, worsening electrolyte abnormalities, and eventually a fatal arrhythmia of his heart. While the dying mechanism is complex - the body becomes increasingly dysregulated, and organs start to fail in ways that are hard to track - it's hard to say that this death was due to anything other than severe, progressive and untreated opioid withdrawal.

Jonathan M. Giftos

State of New York)
) ss
County of New York)

On the 8th day of November in the year 2021, before me, the undersigned notary public, personally appeared Jonathan M. Giftos, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Notary Public

SUZANNE E. KAISER
Notary Public, State of New York
No. 02KA6012935
Qualified in New York County
Commission Expires 9/8/2022