

ELECTRONICALLY FILED

NO. 18-CI-005283

JEFFERSON CIRCUIT COURT
DIVISION FOUR (4)
JUDGE CHARLES L. CUNNINGHAM

CASONYA SLONE Individually and as
Administrator of the Estate of BRENT SLONE;
and CASONYA SLONE, as Mother and
Next Friend of CELECIA SLONE, a Minor

PLAINTIFFS

v.

PLAINTIFFS' EXPERT DISCLOSURE

COMMONWEALTH PAIN ASSOCIATES, PLLC
d/b/a/ COMMONWEALTH PAIN AND SPINE;
STEPHEN KYLE YOUNG, M.D.; and
JAMES JACKSON, M.D.

DEFENDANTS

* * * * *

Comes the Plaintiff, by and through counsel, and in compliance with the Court's
Pretrial Order, Plaintiff expects to call the following expert witness, who is expected to
render the opinions set forth below:

Marc P. Orlando, M.D.
4744 Maxwell Drive
Mason, OH 45040

Dr. Orlando has reviewed the following materials:

- Medical records from Commonwealth Pain and Spine Associates, PLLC, Kindred Hospital, The Cove at La Jolla, Baptist Hospital, Integrated Healthcare, Norton Brownsboro Hospital, and Scripps Health
- Pharmacy records from Kroger, Save Rite and Walgreens
- Pre-2017 medical records from Dr. Joseph Green, Dr. Preethi Ananthakrishnan, VNA Home Health, Baptist Health Wound Care, Bluegrass Pain Consultants, Dr. Bruce Wolf, MD2U Advanced Care, Hardin Memorial Hospital, Norton Wound Treatment & Hyperbaric Medicine Center, and Sharp Grossmont.
- Kentucky Medical Examiner file
- Depositions of Cheyenne Day, Rita Greenwood, Dr. Stephen Young, Dr. James Jackson, Barbara Lemmons, Judith Miller, Casonya Slone, and Billy Slone
- Complaint filed September 11, 2018
- Plaintiff's Responses and Supplemental Responses to Defendant's First Set of Interrogatories and Requests for Production of Documents
- Death Certificate

- Text messages and call log from Brent Slone's cellular telephone
- 201 KAR 9-260
- Summary of Controlled Substance Regulations, Kentucky Medical Association, copyright 2013

Dr. Orlando is prepared to testify Commonwealth Pain & Spine Associates, PLLC ("Commonwealth"), through its employees, fell below the standard of care in their care and treatment of Brent Slone. Specifically, Dr. Orlando is of the opinion it was below the standard of care not to have a policy on tapering opioids or on bridging narcotics when a patient runs out of medication. Brent's exceptionally high MDE should not have been abruptly reduced by 50% following his return from California to the Defendant's practice. The records lack any timelines or rationale for such a significant deviation from the previous medication dosage. It appears Commonwealth employees made a mistake in copying a prior note from one visit to the next, which led to a drastic reduction in Brent's narcotic pain medication. It appears the Defendants failed to follow the 2016 CDC Guidelines, or any other guidelines, which discussing tapering narcotics by no more than a 10 to 30 percent maximum taper reduction at a time. It does not appear the health care professionals at Commonwealth considered the documentation from The Cove at La Jolla in deciding to reduce Brent's pain medication by >50%. Defendants should have incorporated a taper decision tool similar to the Pain Management Opioid Taper Decision Tool published by the United States Department of Veterans Affairs.

It further appears Defendants deviated from the standard of care by not having a patient termination policy which should include providing the non-compliant patient with a 30-day refill at the last dosage, the option for inpatient admission, or the option of outpatient detoxification by Commonwealth. The failure of the Defendants to adequately train its staff regarding MME/MDE was also below the standard of care and caused or

contributed to the improper medication reduction. Finally, it also appears Commonwealth fell below the standard of care in failing to follow its own Treatment and Prescription Agreement which indicates Commonwealth will attempt a “safe discontinuation of opioid medications” if a patient violates their agreement. Contrary to the stated “safe discontinuation,” Commonwealth abruptly refused to provide any additional medication or treatment and failed to even allow Mr. Slone to see a healthcare provider.

The Defendants care and treatment of Brent Slone parted from the standard of care in such a way as to be reckless and was a substantial factor in causing Mr. Slone’s breakthrough pain, which caused him to take his own life.

Respectfully submitted,

/s/ Hans G. Poppe

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CERTIFICATE OF SERVICE

It is hereby certified that on January 20, 2020 the foregoing was filed through the Court's Efiling System, which will provide electronic notice, and served electronically to the following:

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/s/ Hans G. Poppe

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