Forensic Pharmacist Report in a Coumadin Death Case

James O'Donnell

THIS ARTICLE, AS part of the Forensic Pharmacist issue, presents a series of reports of opinions, case summary, citations to standards of practice, and pharmacy rules and regulations, as applied and utilized in a forensic evaluation by this author in a death caused by a Coumadin dispensing error; Cogentin had been prescribed. An interesting part of the case was the deception by the defendant pharmacist, who denied knowledge of the error when the death was investigated by the hospital treating the patient as well as by the Board of Pharmacy investigators.

The case is made interesting further because, in Pennsylvania, the state in which the error occurred and the suit was brought, experts must express complete reports, and depositions of experts are, by custom, not taken. All of the experts' opinions must be fully expressed in reports, or they will be precluded in trial.

Because Coumadin errors are the most frequent cause of lawsuits against pharmacists, any practicing pharmacist is a potential defendant in such a lawsuit, as well as a potential expert witness, who, analyzing the facts and testimony in the case, will be called upon to offer expert opinions.

The case, incidentally, was settled shortly before trial, following a ruling by the trial Judge that allowed the plaintiff's attorneys to introduce a punitive damages claim against the pharmacy corporation operating the community pharmacy in which the error occurred. Because a confidentiality agreement was entered, the names of the plaintiff, the prescribing physician (who was sued by the Pharmacy), the name of the pharmacy company, and the names of the defendant pharmacist and other pharmacists employed by and who testified in the litigation have been deleted and identified only by position.

James O'Donnell, PharmD, MS, Assistant Professor of Pharmacology, Rush Medical College, Chicago, IL. President, Pharmaconsultant Inc., 1935 S. Plum Grove Rd., PMB 255, Palatine, IL 60067.

July 8, 1999

PLAINTIFF'S ATTORNEY

RE: DECEDENT VS. CONFIDENTIAL DEFENDANT PHARMACY

Mr. ATTORNEY

I, James O'Donnell, earned Bachelor's and Doctorate degrees in Pharmacy from the Universities of Illinois and Michigan, respectively, and earned a Master's degree in Clinical Nutrition from the Rush University. I completed a residency in Clinical Pharmacy at the University of Illinois Research Hospitals. I currently hold the rank of Assistant Professor of Pharmacology at the Rush Medical College. I have served as a consultant to the Drug Enforcement Administration, Illinois Department of Public Health, and several pharmacy companies. I have managed and supervised pharmacies and pharmacists, written and updated Policy and

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Procedure manuals, written, published and consulted on the Standard of Care of Pharmacists. I am the Editor-in-Chief of the *Journal of Pharmacy Practice*. I am a Diplomate of the American Board of Clinical Pharmacology, and a fellow in the American College of Nutrition, and member of several professional societies. A copy of my Curriculum Vita is attached.

I have consulted and testified in such issues in dozens of states, including Pennsylvania, New Jersey, Florida, Illinois, Indiana, Michigan, Ohio, California, Nevada, New Mexico, Texas, Alabama, Mississippi, Georgia, North Carolina, South Carolina, Missouri, and New Jersey, to name a few. I have been qualified and allowed to testify in Court as a pharmacist in Federal and State courts, and have consulted in all 50 states, the District of Columbia, Puerto Rico, Canada, Bermuda, Ireland, and South Africa.

Any reference to CONFIDENTIAL DEFENDANT PHARMACY in this report refers to the defendant CONFIDENTIAL DEFENDANT PHARMACY Corporation and CONFIDENTIAL DEFENDANT PHARMACY of Pennsylvania, Inc.

I reviewed the following materials in this matter. (Underlined text indicates bases for opinions, *italicized text is direct citation for sources*):

1. Medical records of Mrs. Decedent
2. Depositions and Hearing Testimony
   a. Hospital Risk Manager
      After Decedent's admission at the Community Memorial Hospital, Ms. Risk Manager informed Mr. Defendant Pharmacist on October 7, 1994, sufficient information to trace the actual prescription without disclosing the patient's name. Mr. Defendant Pharmacist's testimony is in direct opposition to the testimony of Ms. Risk Manager. The Pharmacy Technician remembers receiving the telephone call. Page 9, "I placed a call to the phone number that was on the bottle. A person answered the phone and I told him that I needed to speak to a pharmacist, and I was transferred to someone who did identify himself as Defendant Pharmacist. I told him, without giving our patient's name, what had happened or what we believed had happened, the wrong pills were in this bottle and that was thought to be the cause of her cerebral bleed. I did give him some information that he could go back and check. I don't have specific recollection, but it was something like the date on the bottle and how many pills were missing so that he might have been able to backtrack and figure out when it was filled and who got those pills that day. He told me that he would check the shelf, make sure that there was no mis—I guess—filing or storing on the shelf, that one thing wasn't where the other thing should be, and he was going to follow up on that". . . . There was no follow up from CONFIDENTIAL DEFENDANT PHARMACY.

   b. Pharmacy Technician
      Ms. Pharmacy Technician describes inappropriate dispensing techniques in her deposition. No training, no manuals, remembers Risk Manager's Call. Telephone prescription not directly entered in the computer, not discarded in the trash. Taught the NDC check system. (*If this NDC check system had been used, error would have been discovered; therefore, it was not used.*) Filled new Rx from the computer label, not the prescription, sometimes (the pharmacist) looked inside (the prescription vials) to check the contents. Sometimes I just bagged (the Rx). We checked each other (Technician checking Pharmacist). Never knew about Dr. Defendant Physician's call, remembers the call from Hospital which was transferred to the pharmacist.

c. Ms. Pharmacy Supervisor R.Ph., CONFIDENTIAL DEFENDANT PHARMACY testified that

the CONFIDENTIAL DEFENDANT PHARMACY Pharmacy Manual had no "professional guides," the new manual does not discuss how to fill the prescription. (My own review of CONFIDENTIAL DEFENDANT PHARMACY manuals contradicts this testimony.)

there was no prior technician manual in existence,

no job description for a technician,

15 prescriptions an hour is "light volume"

It was not likely that an error occurred in the drugstore (The Decedent error)

She had no knowledge of the Hospital Risk manager's call

It would be standard of practice to "look at the pills" if someone else (a technician) filled the prescription (contradicts Defendant Pharmacist and supports O'Donnell)

NDC verification up to individual pharmacist; not an enforced company policy

Would immediately reduce telephone prescription to writing and retain as the "hard copy" in the prescription file. This "reduction" would not be discarded in the trash. State Law, "reduce to writing."

d. Defendant Pharmacist, the CONFIDENTIAL DEFENDANT PHARMACY Pharmacist who filled Ms. Decedent's prescriptions

Testimony at State Board Hearing, page 420, ". . . quite certain he did not mistakenly dispense Coumadin in place of Cogentin. I don't make mistakes." I don't physically inspect the pills. He doesn't recall being asked anything by Dr. Defendant Physician. Told Corporate Director of Pharmacy about the State Board investigation (page 129), but not the Risk Manager's call (page 156). Did not look at the medicine in the filled vial. Possible that he didn't check Pharmacy Technician every time (page 175). *The facts of this case, the discrepancies of testimony of the parties and witnesses, the evidence of obstruction of the State board investigation, the discovery of the Coumadin tablets in the Cogentin vial, and the careless method of pharmacy practice, lead me to opine that Mr. Defendant Pharmacist and his Pharmacy Technician did in fact, MAKE A MISTAKE, and dispense the wrong drug, which resulted in Mrs. Decedent's death. The same factors lead me to the conclusion that CONFIDENTIAL DEFENDANT PHARMACY employees concealed a dispensing error before and after Decedent's death.*

e. Mrs. Decedent's son

Mr. Decedent testified there was no Coumadin prescribed for his parents, and that the only prescriptions that his parents purchased were from the CONFIDENTIAL DEFENDANT PHARMACY, to the best of his knowledge.

f. Defendant Physician MD

Dr. Defendant Physician testified that on October 5, 1994, he called CONFIDENTIAL DEFENDANT PHARMACY (the Pharmacist), "I talked to the pharmacist, went through all of her medications to make sure she wasn't on some anticoagulant drug. She was on meds from me, one of which was a drug called Cogentin, ... She was on another medicine too but none of these meds, except the Ibuprofen, could have accounted for abnormal bruising and these prothrombin time prolongations and PTT prolongations, and I was puzzled by this. So after I went through the meds with the pharmacist and ascertained there was no drug that could

cause this except possibly the Ibuprofen, I did call a hematologist. . . . He asked specifically, you sure she's not on Coumadin. . . . I've checked with the pharmacist so we had no evidence that any Coumadin was involved . . . we stopped the Ibuprofen and he advised putting her on Mephyton, 20 mg a day, five mg four times a day for 48 hours . . . (pp. 10–12).

. . . I called the pharmacist and asked for the list of any meds she had had and specifically asked if she had ever been on Coumadin by any doctor. Is there any record that she received Coumadin in the last—anytime in her records and the answer was no. . . . (page 18).

(Page 21) Somebody called and told me that they had found Coumadin in one of the vial containers that she had and it was in a bottle labeled Cogentin.

At this occasion of Dr. Defendant Physician's call, Mr. Defendant Pharmacist would have known that there was a concern about Coumadin inadvertent use, and the treatment (Mephyton) to reverse Coumadin toxicity. A confirmation that Mrs. Decedent was receiving Cogentin, recently re-prescribed with a new prescription number should have precipitated a check of the California files, which would lead to a discovery of the "missing" prescription, and also a potential suggestion that a "look-alike" error had occurred, prompting a check of the tablets in the Decedent's prescriptions vial. One can reasonably conclude that the critical prescription order was disposed of or concealed intentionally.

3. Literature and Trade Publications

   O'Donnell James T. Status of Standards of Practice in Pharmacy. *Journal of Pharmacy Practice,* Vol. 1, No. 1, August (1988): pp. 11–23.

   Kalman SH and Schlegel JF. Standards of Practice for the Profession of Pharmacy. *American Pharmacy,* Vol NS 19, No. 3, March (1979) 133: pp. 22–35.

4. Report of Dr. Savard

5. Title 35, P.S. 780-112 Consolidated Statutes, Controlled Substances Act, Pennsylvania

6. Title 63 P.S. 385-387, Professions and Occupations, Pharmacy Act 390-1, specifically 63 P.S. & 390-5(9)(i)

   Willfully deceiving or attempting to deceive the State Board of Pharmacy or its agents with respect to any material matter under investigation by the board;

   and 63 P.S. & 390-5 (11)

   has acted in such a manner as to present an immediate and clear danger to the public health or safety.

   and 63 P.S. & 390-5 (12)

   Is guilty of incompetence, gross negligence or other malpractice, or the departure from, or failure to conform to, the standards of acceptable and prevailing pharmacy practice, in which case actual injury need not be established.

7. Pennsylvania Administrative code, Title 49. Professional and Vocational Standards, part I. Department of State, Subpart A. Professional and Occupational Affairs, Chapter 43A. Commissioner of Professional and Occupational Affairs, Schedule of Civil Penalties, Guidelines for Imposition of Civil Penalties, and Procedures for Appeal-Statement of Policy & 43a.9, State Board of Pharmacy

27.12 Practice of Pharmacy

(A) It shall be unlawful for a person not licensed as a pharmacist, under the act, to engage or allow another to engage in the practice of Pharmacy, including the preparing, compounding, dispensing, selling or distributing at retail to a person a drug, except a pharmacy intern or other authorized per-

sonnel under the immediate personal supervision of a pharmacist, who may assist the pharmacist with the preparation of other than Schedule II controlled substances and except personnel engaged in clerical functions, provided that: (2) After the prescription has been prepared, a licensed pharmacist shall thoroughly inspect the prepared prescription to verify the accuracy of the preparation, dosage, and number of allowable refills. (Mr. Defendant Pharmacist testified that the clerk/intern (technician) might be the person who last inspected the prescription. He also testified that he did not visually inspect the "pills" in the bottle, which, in my opinion, would be interpreted as a lack of a thorough inspection.)

8. Riff v. Morgan Pharmacy (508 A.2d 1247 Pa. Super 1986)
9. CONFIDENTIAL DEFENDANT PHARMACY Pharmacy managers manual DW-1 3/12/99
10. Pleadings, interrogatories, exhibits to depositions.
11. Pennsylvania Pharmacy Board Hearing testimony and investigative files.
12. Documents Produced by Plaintiffs' (Exhibits A–T listing attached).

CASE SUMMARY

This case involves a prescription for Cogentin, a prescription to relieve Mrs. Decedent's Parkinson disorder, which was discovered to contain Coumadin, a blood thinner–anticoagulant. Mrs. Decedent presented to her physician, Dr. Defendant Physician, on October 5, 1994, with bruising. Dr. Defendant Physician called Mr. Defendant Pharmacist and asked what medications she was taking. Mr. Defendant Pharmacist failed to tell Dr. Defendant Physician that there was a problem with Mrs. Decedent's prescription. She was hospitalized two days later and developed brain and systemic bleeding, resulting in her death some 10 days later. At the hospital, the caregivers discovered Coumadin tablets in the Cogentin bottle. Ms. Risk Manager, the hospital Risk Manager, called Mr. Defendant Pharmacist and advised him of the error, the date the prescription was filled, and that he needed to check on his procedures.

Subsequent investigation by the Board of Pharmacy of Mr. Defendant Pharmacist and his CONFIDENTIAL DEFENDANT PHARMACY Drugstore resulted in a subject prescription "missing" from the file, a claim that his policy was to throw out the telephone note, and a description, in my opinion, of a rather unprofessional and unsupervised use of a technician.

OPINIONS

In my opinion, Defendant Pharmacist, assisted by Pharmacy Technician, at the CONFIDENTIAL DEFENDANT PHARMACY, negligently dispensed the prescription for Cogentin with Coumadin, resulting in the suffering and death of Mrs. Decedent. In my opinion, Mr. Defendant Pharmacist, in several acts and omissions, negligently and deliberately violated the Pennsylvania Pharmacy Practice Act, departed from the Standard of Care of a reasonable and prudent pharmacist, and attempted to cover up his error when the error was investigated by the Pharmacy Board. Mr. Defendant Pharmacist, and thus the CONFIDENTIAL DEFENDANT PHARMACY Pharmacy Corporation, his employer, were grossly negligent in the following acts and omissions:

1. Negligently dispensed Coumadin when Cogentin was ordered. The Coumadin was found in a prescription vial labeled Cogentin, the number of tablets missing was consistent with a once daily use since 9/7/94, the toxicology reports and analysis confirmed that Cogentin was not detected in the bottle, the circumstances of the testimony, and other items mentioned herein provide strong bases for this opinion.

2. Negligently allowed an untrained and thus incompetent technician, Pharmacy Technician, to perform final checks on prescriptions, in direct violation of the Pennsylvania Pharmacy Act.
3. Deliberately destroyed the telephone prescription, in violation of the Law and the Standard, and hid the copy of the filed prescription from the State Board investigators. Failed to investigate dispensation error when contacted by Hospital; withheld knowledge and facts from State Board investigators.
4. Failed to perform a thorough inspection of the finished prescription, i.e., "look at the pills," in violation of the Law and the Standard. Failed to utilize an NDC check in verifying the accuracy of the prescription. Failed to have a Quality Assurance review of filled prescriptions. Failed to follow up on inquiries from the hospital and the physician regarding the Decedent incident. Failure to communicate with the Pharmacy Supervisor. Failure of the Pharmacy supervisor to adequately supervise the pharmacy.
5. Failed to have a Quality Assurance program in place (CONFIDENTIAL DEFENDANT PHARMACY Corp.). CONFIDENTIAL DEFENDANT PHARMACY failed to establish any institutional controls on the dispensing of prescriptions. CONFIDENTIAL DEFENDANT PHARMACY made no effort to ensure that there was any updated procedure for the Defendant Pharmacist to learn, and it did not have a policy and procedure handbook on how to fill prescriptions for their pharmacists and their technicians (Testimony of Pharmacy Supervisor). A reasonable Quality Assurance program to check on the accuracy of prescription filling would be to examine all newly filled prescriptions on a subsequent shift or following day to match the written prescription with the computer record. Such a common QA program is common to the industry, is not new to chain drugstores, and is in common current use in chain drugstores during the 1990s.
6. Failed to properly supervise and train employees. (CONFIDENTIAL DEFENDANT PHARMACY Corp.)
   Untrained, no training manuals
7. Failed to have an adequate Policy and Procedure manual in place (CONFIDENTIAL DEFENDANT PHARMACY)
   No training manuals for technicians or for pharmacists describing safe methods for filling prescriptions.
8. Aside from negligence, the deliberate and/or reckless acts of Mr. Defendant Pharmacist constitute a careless, reckless, willful, and wanton disregard for the safety of the public, including Mrs. Decedent. Mr. Defendant Pharmacist's acts and behavior in regard to the "missing" prescription were totally irresponsible and breached fundamental duties of care and diligence and led to Mrs. Decedent's death.
9. The negligent supervision and training of CONFIDENTIAL DEFENDANT PHARMACY of their pharmacies, pharmacists, and technicians, constitutes a violation of the standard of care of a reasonable and prudent pharmacy company and a reckless, careless, willful, and wanton disregard for the safety of the public, including Mrs. Decedent. CONFIDENTIAL DEFENDANT PHARMACY was tolerant of unsafe dispensing practice; this tolerance demonstrates negligent management, which, considering the risk associated with prescription errors, that is, serious injury or death, demonstrates a careless disregard for safety.

All the opinions herein are within a reasonable degree of professional certainty.

This completes my report.

Very truly yours,

James O'Donnell, PharmD, MS
Diplomate—American Board of Clinical Pharmacology
Registered Pharmacist—Illinois 51 27990

August 30, 1999

RE: Decedent v. CONFIDENTIAL DEFENDANT PHARMACY Corporation and CONFIDENTIAL DEFENDANT PHARMACY of Pennsylvania Inc.

SUPPLEMENTAL REPORT

Mr. Attorney:

Since preparing my expert report of July 8, 1999, I have reviewed the following additional materials in this matter:

1. Report of Dr. Jones
2. Reports of Dr. Smith, plaintiff's additional Pharmacy expert (initial and supplemental)
3. Report of Mr. Galen, defendant's pharmacy expert
4. Report of Dr. Medica, defendant's medical expert
5. Depositions of Inspectors Friday and Ides, Homicide Detective Holmes, and Ms. McFadden
6. Defendant CONFIDENTIAL DEFENDANT PHARMACY of Pennsylvania, Inc.'s Response and Objections to Plaintiffs' Second Request for Production of Documents (including post-occurrence CONFIDENTIAL DEFENDANT PHARMACY University Pharmacy Manual)
7. Affidavit of former Commonwealth Attorney Foran, August 25, 1999.

I agree with and adopt the opinions and conclusions of Dr. Medica, and incorporate them into my opinions. I agree with and adopt the opinions and conclusions of Dr. Jones. I agree with Attorney Foran that the "prescription" produced was probably a regenerated copy, and that the missing prescription was most suspicious. The written copy of the prescription is used to check the computer entry at the time of filling, for quality assurance review on the next shift or the next day, and at subsequent times when there is a question of what was ordered and what was filled. Even Supervisor Pharmacist testified that the law was to reduce the telephone order to writing, and file the telephone prescription. Discarding of the written record is a violation of the law and a deviation from the standard of care. Deliberate destruction of the prescription is willful and wanton obstruction of the investigative process. It is a violation of the Pharmacy Practice Act of Pennsylvania. It is no wonder the investigators and prosecutors were suspicious!

I disagree with the opinions and conclusions of Mr. Galen and some of the opinions of Dr. Medica.

GALEN'S REPORT

Pharmacist Galen opines that while unwritten, the policies and procedures for filling prescriptions by Defendant Pharmacist and CONFIDENTIAL DEFENDANT PHARMACY were adequate, a 3 point system, and need not be written. It is clear from examination of the testimony of the Defendant Pharmacist, Pharmacy Technician, and the Pharmacy Supervisor that there were clear violations of Pennsylvania prescription practices (disposal of the telephoned prescription, no visual inspection of the contents of the prescription vial filled by a technician, occasional non-checking of prescriptions). Mr. Galen has elected not to comment/challenge these previously stated opinions, therefore, I assume that he agrees with my previous report. As to his opinion that the policies and procedures need not be in writing (i.e., professional prescription filling policies), in my opinion, he is fundamentally wrong. Even in a system with a few outlets (stores, units, satellites), it is imperative for a written manual with accurate and complete directions and guidelines for new and old employees alike to assure that employees are informed of and have access to written policies guiding their practice. This does not preclude the assumption by the employer that the licensed employee is competent. It is additional, and standard of care of a reasonable and prudent company operating multiple outlets to provide written policies and

procedures, and then to provide quality assurance mechanisms and supervision to ensure that the safe policies are followed. This clearly is not the case in this CONFIDENTIAL DEFENDANT PHARMACY / Decedent case.

Review of the depositions of Friday, Ides, Detective Holmes, and McFadden provide additional proof that Defendant Pharmacist was aware of the prescription error when the inspectors came to the pharmacy, and that he failed to identify a problem with the prescription (unable to find) when Dr. Defendant Physician inquired two days before Mrs. Decedent's death. This is additional proof that Defendant Pharmacist's deliberate deception, misleading and untruthful testimony, and reckless disregard for the life of Mrs. Decedent was a proximate cause of her death. Had Dr. Defendant Physician known she was taking Coumadin on October 5th, her life could have been saved.

MEDICA'S REPORT

Regarding Dr. Medica, his analytical detective skills are flawed. He states that:

> Mrs. Decedent died because she took 5 mg Coumadin tablets which had been substituted for 0.5 mg Cogentin tablets. Traces of Coumadin were found in the medication vial. A residue consistent with Cogentin was present. This suggests that substitution took place after leaving the pharmacy. . . . It is not believable that the pharmacy would put Cogentin in a vial, remove the Cogentin, and then place Coumadin in the vial. *Hence the presence of Cogentin in the vial* would prove that the substitution occurred after leaving the pharmacy.

My reading of the DrugScan report and the testimony of the chemist/analyst leads to the conclusion that there was no Cogentin found, period! I am stunned by Dr. Medica's conclusion! The presence of a tablet filler cannot be extrapolated to proof the presence of Cogentin. Further, where would the Decedent have obtained the Coumadin, precisely 69 tablets, representing 31 days use since the (negligent) dispensation by CONFIDENTIAL DEFENDANT PHARMACY Defendant Pharmacist, other than from Defendant Pharmacist? No additional Cogentin 0.5 mg was found anywhere in the home! Having filled tens of thousands of prescriptions in my career as a pharmacist, I can state with certainty that almost any colored tablet will leave a "white" residue on the interior of the prescription vial. This residue is by contact and electrostatic charges, and "tapping" the vial will definitely **NOT** eliminate any traces of the original contents from the vial. Only thorough and repeat rinsing will completely remove traces of prior tablet contents, so as to test "negative" by way of Gas Chromatographic/Mass Spectrophotometry. Dr. Medica's opinions that there was never Coumadin in the vials is wrong; the opinions, report, and testimony of the chemist at DrugScan, in my opinion, provide conclusive evidence of the presence of Coumadin and the absence of Cogentin in the tested vial.

SUMMARY

Having read these new materials and reports, my opinions are strengthened and broadened that Defendant Pharmacist acted negligently in dispensing Coumadin for Cogentin, and willfully, recklessly, and wantonly attempted to cover up his error, which compounded the injury and removed any opportunity to effectively reverse the overdose of Coumadin which caused Mrs. Decedent's death. I remain convinced that the CONFIDENTIAL DEFENDANT PHARMACY company departed from the standard of care of a reasonable and prudent pharmacy company, and this departure was reckless and exhibited a conscious disregard for the safety of the public in failure to provide adequate policies and procedures and institutional controls and quality assurance programs for its pharmacists and drugstores. CONFIDENTIAL DEFENDANT PHARMACY's departure is proximately related to Mrs. Decedent's death.

All of the opinions stated herein are held

with reasonable pharmaceutical and pharmacological certainty.

Very truly yours,

James O'Donnell, PharmD, MS
Diplomate—American Board of Clinical Pharmacology
Registered Pharmacist—Illinois 51 27990

October 7, 1999

RE: Decedent v. CONFIDENTIAL DEFENDANT PHARMACY Corporation and CONFIDENTIAL DEFENDANT PHARMACY of Pennsylvania Inc.

SECOND SUPPLEMENTAL REPORT

Mr. Attorney:

Since preparing my expert report of July 8, 1999 and supplemental report on August 30, 1999, I have reviewed Dr. Smith's 9/28/99 Supplemental report as well as copies of prescriptions on file in the CONFIDENTIAL DEFENDANT PHARMACY.

I concur with Dr. Smith's conclusions regarding the inconsistency of Defendant Pharmacist's prescription recording practices. There is direct contradiction to Defendant Pharmacist's testimony that he either enters the information directly into the computer, or writes the information on a scratch sheet, enters the information in the computer, and then discards the handwritten note, and uses the computer generated label/tab as the filling document and the subsequent permanent prescription record.

The Pennsylvania Pharmacy Law, the Standard of Practice, Pharmacists Investigator Friday, Pharmacy Supervisor, Corporate Pharmacy Director, Smith, and myself all describe "reducing the prescription to writing," which is clearly evident in these prescription copies gathered by Dr. Smith.

This is clear evidence that Defendant Pharmacist was totally untruthful in his testimony, and additional evidence of his malicious efforts to conceal his error, the combination of the error and the concealment the proximate cause of Mrs. Decedent's death.

Further, this is clear evidence that the prescription copy attempted to be introduced by counsel for CONFIDENTIAL DEFENDANT PHARMACY at the Board Hearing was probably a regenerated copy, thus a misleading and fraudulent representation by CONFIDENTIAL DEFENDANT PHARMACY counsel to the Board of Pharmacy. Certainly, Ms. Pharmacy Supervisor, an experienced pharmacist and Defendant Pharmacist's supervisor, must have known that he was untruthful, and should not have been complicit in this conspiracy, suggesting that she found the prescription that was attempted to be introduced at the Hearing.

Having read these new materials and report, my opinions are strengthened and broadened that Defendant Pharmacist acted negligently in dispensing Coumadin for Cogentin, and willfully, recklessly, and wantonly attempted to cover up his error, which compounded the injury and removed any opportunity to effectively reverse the overdose of Coumadin which caused Mrs. Decedent's death. I remain convinced that the CONFIDENTIAL DEFENDANT PHARMACY company departed from the standard of care of a reasonable and prudent pharmacy company and this departure was reckless and exhibited a conscious disregard for the safety of the public in failure to provide adequate policies and procedures and institutional controls and quality assurance programs for its pharmacists and drugstores. CONFIDENTIAL DEFENDANT PHARMACY's departure is proximately related to Mrs. Decedent's death.

All of the opinions stated herein are held with reasonable pharmaceutical and pharmacological certainty.

Very truly yours,

James O'Donnell, PharmD, MS
Diplomate—American Board of Clinical Pharmacology
Registered Pharmacist—Illinois 51 27990

October 13, 1999

RE: Decedent v. CONFIDENTIAL DEFENDANT PHARMACY Corporation and CONFIDENTIAL DEFENDANT PHARMACY of Pennsylvania Inc.

THIRD SUPPLEMENTAL REPORT

Mr. Attorney:

Since preparing my expert report of July 8, 1999 and two supplemental reports, I have reviewed Dr. Smith's 10/11/99 Supplemental Report III which describes the prescription vial and Coumadin contents examined by Dr. Smith in your office.

I concur with Dr. Smith's conclusions and opinions as expressed in her report.

The size of the prescription vial is too large for 100 Cogentin; Coumadin was found. This is additional evidence supporting my opinion that Mr. Defendant Pharmacist erroneously filled the Cogentin prescription with Coumadin.

All of the opinions stated herein are held with reasonable pharmaceutical and pharmacological certainty.

Very truly yours,

James O'Donnell, PharmD, MS
Diplomate—American Board of Clinical Pharmacology
Registered Pharmacist—Illinois 51 27990