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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

DARRYL DUNSMORE, ANDREE ANDRADE, ERNEST ARCHULETA, JAMES CLARK, ANTHONY EDWARDS, REANNA LEVY, JOSUE LOPEZ, CHRISTOPHER NORWOOD, JESSE OLIVARES, GUSTAVO SEPULVEDA, MICHAEL TAYLOR, and LAURA ZOERNER, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

SAN DIEGO COUNTY SHERIFF'S DEPARTMENT, COUNTY OF SAN DIEGO, SAN DIEGO COUNTY PROBATION DEPARTMENT, and DOES 1 to 20, inclusive,

Defendants.

Case No. 3:20-cv-00406-AJB-DDL

**DECLARATION OF PABLO STEWART IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION TO LIMIT ADMINISTRATIVE SEPARATION FOR CLASS MEMBERS WITH SERIOUS MENTAL ILLNESS**

Judge: Hon. Anthony J. Battaglia

Date: November 20, 2025
Time: 2:00 p.m.
Crtrm.: 4A

**Redacted**

I, Pablo Stewart, M.D., declare:

1. I am a board-certified Psychiatrist and Clinical Professor at the University of Hawaii, John A. Burns School of Medicine, and have extensive background and experience in the provision of mental health care in detention settings. My curriculum vitae is attached hereto as **Exhibit A**. I have more than 35 years of experience in correctional mental health care, including serving as the court's expert in class action cases challenging the provision of mental health care to incarcerated people. I have served as amicus curiae for the First Circuit on the issue of solitary confinement in *Cintron v. Bibeault*, No. 22-1716 (May 10, 2023). I make this declaration in support of Plaintiffs' Motion for Preliminary Injunction to Limit Administrative Separation for Class Members with Serious Mental Illness.

2. I have been asked to provide my opinion regarding the policies and practices of the County of San Diego, the San Diego County Sheriff's Office ("SDSO"), and their agents as they relate to the provision of mental health care to incarcerated people in the San Diego County Jail (the "Jail"). To that end, I inspected three of San Diego's jail facilities in February 2024: San Diego Central Jail ("Central"), George Bailey Detention Facility ("George Bailey"), and Las Colinas Detention and Reentry Facility ("Las Colinas"). During my inspections, I spoke to numerous individuals with serious mental illness in the Administrative Separation units at the three facilities. The Administrative Separation units at Vista Detention Facility ("Vista") appear to follow a similar practice to the other three jails I inspected, at least as described in the declarations I received.

3. I also reviewed numerous documents regarding the provision of mental health care in the San Diego jails, including SDSO policies and procedures and medical records of *Dunsmore* class members. I then prepared a Rule 26(a) report that I am informed and believe was served on August 21, 2024 as well as a rebuttal report that I am informed and believe was served on October 31, 2024. These reports have been previously filed in connection with Plaintiffs' Opposition to

Defendants' Motion for Partial Summary Judgment and can be found at Dkt. No. 937-5, Ex. 1 and 937-5, Ex. 2. I incorporate them here by reference. I also submitted a declaration in support of Plaintiffs' Motion for Preliminary Injunction, dated April 30, 2022, Dkt. 119-7, which I incorporate here by reference. I was deposed by Defendants' counsel on November 20, 2024. On August 29, 2025, I am informed and believe that Plaintiffs served a supplemental report describing new medical records and information provided to me. A true and correct copy of that report, which I incorporate by reference, is attached hereto as **Exhibit B**.

4. Most recently, I was provided with documentation related to two horrific in-custody deaths of individuals with mental illness housed in solitary confinement, euphemistically referred to by the Sheriff as Administrative Separation. These documents included 649 pages of medical records provided by the San Diego Sheriff's Office to the family of Corey Dean, three declarations regarding the July 13, 2025 death of Corey Dean by incarcerated witnesses, and psychiatric records from Corey Dean's time in the San Diego community dated 2014 to 2020. I also received five declarations from incarcerated witnesses regarding the July 28, 2025 death of Karim Talib at Central Jail. I have requested medical records for Mr. Talib. I would also like to review the autopsy reports and any incident reports or logs related to the deaths of these two men.

5. I was also provided declarations from 14 individuals currently or recently housed in Administrative Separation units at the Jail, as follows:

- Christopher Hawkins 25710758 – Administrative Separation at Central (Unit 6/E) since approximately March 2025 **(approximately 6 months)**
- David Thomas 25702881 – Administrative Separation at Central (Unit 4/E) from approximately late February to early May 2025 **(over 2 months)**; Outpatient Step Down Unit at George Bailey (Unit 4/B) from approximately early May to mid-September 2025
- Ismael Betancourt 20944974 – Administrative Separation at George Bailey (Units 5/A, 5/B, and 6/A), Central (Units 4/E, 5/E, and 7D), and Vista (Unit E/3) since approximately July 2021 **(over 4 years and 2 months)**

- Jaelin Kearse 25709948 – Administrative Separation at Las Colinas (Unit 5/A) since approximately early June 2025 **(over 3 months)**
- Julio Serrano 25701924 – Administrative Separation at Vista (Unit E/3) from approximately mid-January to early August 2025; Administrative Separation at George Bailey (Unit 6/C) since approximately early August 2025 **(over 8 months)**
- Keith Sekerke 25731708 – Administrative Separation at Vista (Unit E/2) since approximately August 16, 2025 **(over 1 month)**
- Keona Smith 25730064 – Administrative Separation at Las Colinas (Unit 5/A) since approximately mid-July 2025 **(over 2 months)**
- Larry Millete 21140844 – Administrative Separation at Vista (Unit E/3, "the hole") from early July to late December 2023 **(over 5 months)**; Administrative Separation at George Bailey (Units 4/A and 4/C) starting late October 2024 **(for approximately 7 months)**
- Miguel Altamirano 25706406 – Administrative Separation at Vista (Unit E/4) from approximately mid-February to mid-August 2025 **(approximately 6 months**)
- Owerrie Bacon, Jr. 25724908 – Administrative Separation at George Bailey (Units 5/A, 5/B, and 5/C) in 2023 **(approximately 1 year)**; state hospital in 2024; Administrative Separation at Central (Unit 7/E) from approximately June to mid-September 2025; Administrative Separation at George Bailey (Unit 5/A) since approximately mid-September 2025 **(over 3 months)**
- Patrick Kelley 24746771 – state hospital or medical unit for most of 2023 and 2024; restricted housing at Central (Unit 7/D) from approximately November 2024 to mid-August 2025; Administrative Separation at Central (Units 4/E and 5/E) since approximately mid-August 2025 **(over 1 month)**
- Raymond Molina 25726269 – Administrative Separation at Vista ("the hole" and Unit E/4) from approximately late June to mid-August 2025 **(over 1 month)**
- William Sterling 24719410 – Administrative Separation at George Bailey (Units 5/A and 5/B) from approximately May to September 2024; Administrative Separation at Vista (Units E/2 and E/3) from approximately September 2024 to March 2025; Administrative Separation at George Bailey (Unit 6/A) from approximately March to May 2025; Administrative Separation at Vista (Unit E/2) from approximately May to July 2025; Administrative Separation at George Bailey (Unit 6/C) from approximately July to September 2025 **(approximately 1 year and 4 months)**
- Yolanda Marodi 25712651 – Administrative Separation at Las Colinas (Unit 5/A) since approximately early August 2025 **(over 1 month)**.

6. I was also provided the following jail policies and procedures:

- SDSO Detention Services Bureau Policy J.3 (Separation: Definition and Use)
- SDSO Detention Services Bureau Policy I.64 (Safety Checks: Housing and Holding Areas of Incarcerated Persons)
- SDSO Detention Services Bureau Policy T.11 (Exercise and Recreation)
- SDSO Medical Services Division Operations Manual Policy G.2.1 (Segregated Inmates)

**Summary of My Opinions**

7. As I explained in my Rule 26 report, I am deeply troubled by San Diego County's widespread and extreme use of solitary confinement-type housing for incarcerated persons with serious mental illness, with conditions that are extraordinarily restrictive, harsh, and damaging to a person's mental health—particularly for someone with preexisting, serious mental illness. As discussed in my reports and prior declaration, the County's practice of housing individuals with serious mental illness in solitary confinement is counter therapeutic and inconsistent with current correctional standards and scientific research. San Diego County's jail system does not come close to complying with the guidance set forth by the United States Department of Justice, the United Nations, the National Commission on Correctional Health Care ("NCCHC") and respected medical groups, or with recommendations that have been made repeatedly by parties inside and outside of the County. My inspection of the jail system's solitary confinement-type units, my interactions with incarcerated persons with serious mental illness in those units, and my review of records, declarations, and documents all point to the conclusion that the San Diego County Jail's system of Administrative Separation has caused, and currently is causing, serious and unjustified harm on a broad scale, up to and including death.

8. In fact, the conditions in San Diego's Administrative Separation units constitute some of the harshest, most restrictive forms of solitary confinement I have ever witnessed in a jail system. This is confirmed by the horrific deaths that have

occurred in Administrative Separation since January 1, 2021, including Lonnie Rupard who wasted away in Administrative Separation Unit, and whose death was labeled a homicide by San Diego's medical examiner, as well as three other individuals with serious mental illness who died by suicide in the Administrative Separation Units in May 2021 (Lester Marroquin), August 2022 (Matthew Settles), and July 2023 (Jonathan McDowell), as discussed in my prior reports and below. The testimony of individuals currently incarcerated in Administrative Separation show that the conditions continue to violate the standard of care, making it inevitable that additional individuals will die in these units, as occurred in July of this year. It is my opinion that San Diego should immediately stop the practice of placing individuals with serious mental illness in Administrative Separation units, absent exigent circumstances, and then only for a period not to exceed 72 hours and with significant safeguards in place.

**San Diego County Jail's Administrative Separation Units are Solitary Confinement and are Regularly Used to House Individuals with Serious Mental Illness**

9. As explained in my August 21, 2024 report, conditions in the San Diego County Jail's Administrative Separation units are among the harshest and most restrictive forms of solitary confinement I have seen in over 35 years of practice. See Dkt. 937-5 at ECF pp. 73-84. The Jail has only a few relevant policies, SDSO Detention Services Bureau Policy J.3 (Separation: Definition and Use) and SDSO Medical Services Division Operations Manual Policy G.2.1 (Segregated Inmates), which are wholly inadequate to protect individuals with serious mental illness from the harms of solitary confinement. *See* Dkt. 119-7 at ECF pp. 15-17.

10. By policy, incarcerated people in San Diego County Jail, including in the Administrative Separation units, are afforded 10 hours of out-of-cell time distributed over a period of seven days. *See* SDSO Detention Services Bureau Policy T.11 (Exercise and Recreation). My understanding is that, in practice, people in Administrative Separation are locked down much more than that; they are often

not permitted to leave their cells for over 23 hours per day and sometimes even 24 hours per day. Often, they are let out after daylight hours, including in the middle of night, such that they are unable to contact outside individuals by phone. This is even more restrictive than units deemed solitary confinement in other carceral systems, where individuals generally spend 22-23 hours each day in their cell, as explained in a 2023 amicus brief which I joined.[1]

11. The Administrative Separation cells that I inspected at George Bailey and Central ranged from approximately 70 to 75 square feet in size. This is typical of solitary confinement units in other carceral settings I have observed. I am informed that the Administrative Separation cells at Vista are similar in size. As is common generally with cells designed for solitary confinement, the Administration Separation cells at the facilities I inspected were generally constructed of concrete and lacked access to or a view of natural surroundings or natural light.

12. As is typical in solitary confinement, incarcerated people in San Diego County Jail Administrative Separation units are deprived of mental stimulation or any means of distracting themselves and passing the time. To my knowledge, the County fails to provide structured out-of-cell programming, such as group therapy, to individuals in Administrative Separation. They are also denied the kind of in-cell stimulation that would be provided by books, workbooks, radios, or tablets. In some San Diego County Jail Administrative Separation units, incarcerated people spend their brief out of cell time alone in a caged area in the dayroom. This does not provide opportunities for meaningful human contact.

13. Like other people in the Jails, individuals in Administrative Separation are rarely allowed contact visits with outside individuals. When in-person visits do occur, they are generally only permitted through glass partitions and over phones.

[1] Brief for Amici Curiae Terry Kupers, Craig Haney, Pablo Stewart, and Stuart Grassian in Support of Plaintiff-Appellee and Affirmance, *Cintron v. Bibeault*, 1st Cir. No. 22-1716 (May 10, 2023).

This is consistent with the practices of solitary confinement units in other institutions. The declarations I reviewed also confirmed that individuals in Administrative Separation are allotted only short periods of time on the phone (i.e., when they are permitted out of their cell), and often are unable to have meaningful human contact through the phones because they are let out after daylight hours.

14. As explained in the *Cintron* amicus brief, *supra*, note 1, solitary confinement magnifies the damage from underexposure to positive stimuli by overexposing individuals to negative stimuli such as the shouting of officers and incarcerated people, banging of heavy doors, pounding on walls, and foul smells. This causes individuals to experience intensified psychiatric symptoms and suffer from frequent, or even chronic, sleeplessness. My observations from the inspections as well as the incarcerated person testimony I reviewed have made clear that individuals housed in the San Diego County Jail Administrative Separation units regularly experience these symptoms.

15. The declarations I reviewed also confirm that individuals in Administrative Separation units are often required to wear restraints such as leg shackles, wrist chains, and waist chains when they leave their living space. This is consistent with practices of solitary confinement units in other institutions and contributes to a state of hypervigilance. The practice is in fact even more extreme at San Diego County Jail, where people are put in restraints when they are moved not just outside the housing unit, but even between their cell and the caged area in the dayroom. I spoke with some individuals who chose not to leave their cell, ever; they told me that the restraints are simply too painful and/or dehumanizing.

16. As a result of mental health decompensation, many incarcerated people in Administrative Separation live in cells filled with urine, feces, and food waste. The declarations I reviewed demonstrated that staff members often do not provide assistance in cleaning the cells, and often do not provide cleaning supplies so that incarcerated people can clean their own cells.

17. Having reviewed declarations, policies, reports, and other relevant documents provided to me, and also having visited three of the four San Diego jails with Administrative Separation housing units, I can confirm that these units constitute solitary confinement-type conditions, including as has been defined by the United States Department of Justice ("U.S. DOJ"). *Report and Recommendations Concerning the Use of Restrictive Housing* at 3 (Jan. 2016), available at https://www.justice.gov/dag/file/815551/dl (restrictive housing-type segregation is characterized by (1) "Removal from the general inmate population, whether voluntary or involuntary"; (2) "Placement in a locked room or cell, whether alone or with another inmate"; and (3) "Inability to leave the room or cell for the vast majority of the day, typically 22 hours or more").[2]

18. Further compounding the harsh conditions in those units, the County fails to provide mental health treatment or supports that are urgently and clearly necessary to meet the needs of the incarcerated population with mental illness. As explained in my August 2024 report, confidential, out-of-cell clinical contacts are rare for incarcerated people in Administrative Separation. Rather, the vast majority of mental health contacts for those in Administrative Separation are quick, cell-front conversations with Sheriff's deputies present, consisting of a few cursory questions about how the person is sleeping and feeling. The recent declarations from incarcerated people provided to me confirm that the practices documented in my August 2024 report are still in effect. Such brief, non-confidential interactions do not constitute mental health care, much less adequate mental health care for this

[2] SDSO Medical Services Division Policy G.2.1 falsely claims that it does not practice solitary confinement, which it defines as "segregation where an inmate is isolated and encounters staff or other inmates fewer than three times a day." First, it is likely that many incarcerated people do not encounter staff or other incarcerated people three or four times per day based on the declarations I have reviewed. Regardless, the narrow definition espoused by policy G.2.1 is not consistent with the United States Department of Justice and other well-regarded entities defining solitary confinement, as discussed above.

vulnerable population.

19. As explained in my August 2024 report, the County fails to conduct timely and appropriate psychiatric follow-up appointments for those on psychiatric medications. This failure is particularly dangerous in the Administrative Separation units at the Jail. I have never seen such poor psychiatric care provided to people in restrictive housing units in any other correctional system.

20. The County also fails to conduct safety checks in its Administrative Separation units every 30 minutes at irregular intervals, and instead conducts them only once every 60 minutes. *See* SDSO Detention Services Bureau Policy I.64 (Safety Checks: Housing and Holding Areas of Incarcerated Persons).[3] As I have explained in my prior declaration and reports, conducting safety checks at least every 30 minutes in staggered, irregular intervals, is a basic, common-sense, and standards-based practice that can save lives in solitary confinement settings. Conducting safety checks in Administrative Separation only hourly constitutes an unacceptable failure to implement an established safeguard to address the significant danger that people, especially people with mental illness, face in those units.

21. This danger is exacerbated because, to my knowledge, the Jail fails to adequately track which individuals in the Administrative Separation units have serious mental illness and how long they have been in the units. The declarations provided to me from currently incarcerated individuals suggest that their time in Administrative Separation has been significant. Shockingly long stays in Administrative Separation is also reflected in the medical records I reviewed, such as that of Christopher Hawkins, who is discussed in my supplemental report, Ex. B at 12-13, and who I understand to be currently in Administrative Separation at Central Jail. The longer a person is subjected to these conditions, the more likely

[3] As noted in my Rule 26 report, the State Auditor and others have criticized the manner in which San Diego conducts safety checks as well. Dkt. 937-5 at ECF pp. 126-129.

they are to experience a deterioration in their mental health and the more they are at risk of substantial harm, up to and including death. Yet without any mechanism for tracking the individuals most at risk and their length of stay, the Jail is further hampered in its ability to address and potentially mitigate the effects of solitary confinement.

**San Diego's Use of Solitary Confinement for Incarcerated People with Serious Mental Illness is Dangerous and Deadly**

22. As I have previously stated in my declaration and reports in this case, it is now widely accepted that people with serious mental illness should not be placed in solitary confinement-type conditions. In such settings, they are exceedingly vulnerable to deterioration and decompensation of their mental health conditions, intensification of their symptoms, and at substantial risk of psychosis, self-harm, and suicide. Dkt. 937-5 at ECF pp. 70-71.

23. Serious mental illness is a subset of mental illness. The American Psychiatric Association has defined this condition as follows: "Serious mental illness is a mental, behavioral or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Examples of serious mental illness include major depressive disorder, schizophrenia and bipolar disorder." *See* https://www.psychiatry.org/patients-families/what-is-mental-illness.

24. Placing people with serious mental illness in solitary confinement can and likely will worsen their mental health symptoms, including but not limited to increased feelings of depression or anxiety, worsening psychosis, such as increasing hallucinations or paranoia, and/or catatonia. These worsening mental health conditions manifest as failing to complete activities of daily living such as bathing oneself and cleaning one's living space; decreasing caloric and fluid intake (*i.e.*, not eating or drinking); engaging in self-injurious behaviors, such as head-banging, cutting, pulling out one's hair or teeth, or drinking cleaning fluid; presenting with

other unusual behaviors that are dangerous to the individual's physical health, such as touching, "playing with," or even eating one's own feces; and engaging in suicidal behaviors.

25. These behaviors and other mental health symptoms can be seen in the medical records of people with mental illness who are placed in segregated housing that I have reviewed over the past three years and in the declarations I have received from individuals currently incarcerated at the Jail. [redacted] This is a well-known response to profound distress, trauma, anxiety, and mental health deterioration. [redacted]. The evidence strongly suggests that the Administrative Separation setting worsens the mental illness of Mr. Hawkins and others like him.

26. The declarations of other individuals currently incarcerated at the Jail demonstrate psychiatric deterioration while housed in Administrative Separation units. These individuals describe feeling "so suicidal that I told my attorney that I wanted a lethal injection at court," "enter[ing] into a fugue state," "experiencing auditory and visual hallucinations," "attempt[ing] suicide … by overdosing on Tylenol pills," "hav[ing] uncontrollable meltdowns," and "constantly th[inking] about dying." These individuals also describe symptoms of psychiatric deterioration by other incarcerated people housed in Administrative Separation such as people "screaming and talking to themselves," "banging on the desk[s] and doors" "refus[ing] to shower or eat," "cut[ting their] wrist[s]," "defecat[ing] in the shower areas," and "regularly flood[ing] their cell with feces."

27. These behaviors, all of which are recognized symptoms of serious mental illness, can lead to death, for example, through suicide or due to the consequences of a self-injurious behavior. In addition, acutely psychotic individuals who have stopped eating or drinking may starve to death.

28. For example, as described in my Rule 26 Report, Lonnie Rupard, a 46-year-old man with serious mental illness housed in the Administrative Separation unit at Central Jail, died on March 17, 2022 from pneumonia, malnutrition and dehydration in the context of neglected schizophrenia. Notably, the manner of his death is listed by the County's own medical examiner as a "homicide" due to the extensive neglect Mr. Rupard encountered in Administrative Separation. Mr. Rupard was placed in solitary confinement despite clear clinical contraindications and a need for a higher level of care; he was then neglected in that setting until he starved to death. *See* Dkt. 937-5 at ECF pp. 103-106.

29. There have been other horrific deaths in Administrative Separation. Lester Marroquin, a 35-year-old man with schizophrenia, was housed in the Administrative Separation unit at Central Jail, where he drowned himself in the toilet after three months or more of solitary confinement and neglect. *See id.* at ECF pp. 106-109. The deaths by suicide of Matthew Settles in the Administrative Separation unit at Central Jail on August 16, 2022 and of Jonathan McDowell in an Administrative Separation unit at George Bailey on July 19, 2023 are additional examples of how the isolation and inadequate mental health care present in San Diego County Jail's Administrative Separation units cause substantial risk of serious harm, up to and including death. *See id.* at ECF pp. 98-103.

30. These symptoms and behaviors described in paragraphs 23-25 above can also have long-term negative effects on one's health, even short of death. It is well-established that the longer psychosis goes untreated in a patient, the more difficult it is for that patient to return to their baseline level of mental health. This deterioration can have a significant and lasting impact on the individual's ability to

re-integrate into society and avoid recidivism.

**San Diego County's Use of Solitary Confinement for Incarcerated People with Serious Mental Illness is Contrary to All Established Guidelines**

31. In recognition of the serious risks posed by solitary confinement, the U.S. Department of Justice and the National Commission on Correctional Health Care recommend—and other well-functioning detention systems that I have observed require—that incarcerated people with serious mental illness **not** be placed in solitary confinement except in rare circumstances. *See* Dkt. 937-5 at ECF pp. 71-72.

32. According to the United States Department of Justice, "[g]enerally, inmates with serious mental illness (SMI) should not be placed in restrictive housing." U.S. Department of Justice, *Report and Recommendations Concerning the Use of Restrictive Housing* at 99 (Jan. 2016). My review of San Diego County Jail's policies, procedures, and practices indicates that the Jail fails to follow this federal guidance.

33. The U.S. DOJ also provides detailed guidance as to the rare circumstances under which a person with serious mental illness may be placed in segregation-type housing:

- An inmate with SMI should not be placed in restrictive housing, unless:
    - The inmate presents such an immediate and serious danger that there is no reasonable alternative; or
    - A qualified mental health practitioner determines:
        - That such placement is not contraindicated;
        - That the inmate is not a suicide risk;
        - That the inmate does not have active psychotic symptoms; and
        - In disciplinary circumstances, that lack of responsibility for the misconduct due to mental illness or mitigating factors related to the mental illness do not contraindicate disciplinary segregation.

- Inmates with SMI who are diverted from restrictive housing should be placed in a clinically appropriate alternative form of housing, such as a secure mental health unit or other residential psychology treatment program. *Id.* at 99-100.

34. The NCCHC has issued a Position Statement on Solitary Confinement and Isolation, stating: "mentally ill individuals … should be excluded from solitary confinement of any duration." As discussed in my Rule 26 report, the NCCHC Standards for Mental Health Services in Correctional Facilities' Standard MH-E-07 (Segregated Inmates) also requires that for a patient being placed in segregation, it is necessary that "mental health staff reviews the inmate's mental health record to determine whether existing mental health needs contraindicate the placement [in segregation] or require accommodation." *See* Dkt. 937-5 at ECF p. 85.

35. The American Psychiatric Association has issued a Position Statement on Segregation of Prisoners with Mental Illness, stating: "Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates."[4]

36. The American Public Health Association has issued a similar statement: "Prisoners with serious mental illnesses should be excluded from placement in solitary confinement. … Prisoners should be closely monitored and removed from solitary confinement if continued placement becomes clinically contraindicated, if their physical or mental health deteriorates because of continued placement in solitary confinement, or if necessary medical or mental health services cannot be provided."[5]

[4] American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (Dec. 2012), available at http://nrcat.org/storage/documents/apa-statement-on-segregation-of-prisoners-with-mental-illness.pdf.

[5] American Public Health Association, *Solitary Confinement as a Public Health Issue* (Nov. 2013), available at https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue#:~:text=APHA%20calls%20upon%20federal%2C%20state,mental%20illnesses%20and%20chronic%20illnesses.

37. The American Medical Association passed a resolution in 2018 that supported "limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities." In addition, the resolution calls for health professionals to regularly monitor individuals placed in solitary confinement and stakeholders to implement alternatives to solitary confinement for all incarcerated persons.[6]

38. The U.N. Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has stated that "solitary confinement often results in severe exacerbation of a previously existing mental condition" and that "its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment."[7]

39. The harmful effects of solitary confinement have been established in numerous observations and empirical studies that date back to the nineteenth century, conducted in many different countries by researchers with diverse disciplinary backgrounds.[8] Psychologists have long established that social contact is fundamental to establishing and maintaining emotional health and well-being. Prolonged social deprivation is destabilizing because it denies individuals a fundamental aspect of their humanity, prevents them from having a sense of "affiliation," and deprives them of the opportunity to ground their thoughts and

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[6] American Medical Association, *Report of the Reference Committee on Amendments to Constitution and Bylaws*, "Resolution 412 – Reducing the Use of Restrictive Housing in Prisoners with Mental Illness" at 641 (June 2018), available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/hod/a18-reference-committee-reports.pdf.

[7] Méndez, J. *Torture and other cruel, inhuman or degrading treatment or punishment.* Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment at 21 (Aug. 2011), available at https://ccrjustice.org/sites/default/files/assets/UN-Special-Rapporteur-Report-on-Solitary.pdf.

[8] Craig Haney, *The Science of Solitary: Expanding the Harmfulness Narrative*, 115 Nw. U.L. Rev. 211 (2020).

emotions in a social context, including knowing what they feel and whether those feelings are appropriate. The deprivation of this fundamental need for social interaction predictably produces a wide range of negative effects.

40. For example, leading scientific studies demonstrate that social isolation alters the brain's neurochemistry, structure, and function. Researchers have observed that even one week in solitary confinement can lead to significant changes in electrical activity in the brain, slowing brain activity and negatively impacting individuals' performance on intellectual and perceptual-motor tests. Solitary confinement can lead to a reduction in the size of the hippocampus, a brain structure crucial to learning, memory, and emotional and stress control. In addition, it can lead to increased activity in the amygdala, the structure responsible for managing fear and anxiety symptoms. Studies performed on non-human animals demonstrate that solitary confinement negatively affects the cellular mechanism of aging, leading to a shorter life span based on changes to brain chemistry.

41. Furthermore, solitary confinement leads to and exacerbates a wide host of adverse psychological reactions, including heightened levels of anxiety and panic, paranoia, hallucinations, hypersensitivity to stimuli, depression, increased suicidality and self-harm. PTSD, depression, emotional numbing, anxiety, and hypervigilance may occur as much as ten times more often among individuals in solitary confinement than in the general population, where mental health issues are already more prevalent than in the population as a whole. Social isolation also increases an individual's salivary cortisol levels and blood flow to brain regions associated with physical pain, leading to aggression and antisocial behavior often known as "action-oriented coping." Likewise, lack of human touch is an established risk factor for neurodevelopmental disorders, depression, suicidality, and other self-destructive behavior.

42. These impacts may last long after an individual is released from solitary confinement, regardless of whether the individual overtly exhibits

symptoms of serious mental illness while in solitary confinement. Solitary confinement can have a long-term and negative impact on an individual's thinking, emotions, conduct, and personality—leaving them permanently diminished, and at greater risk of death, even after being released from solitary confinement. For example, a study conducted in the North Carolina prison system between January 2000 and December 2016 demonstrated that individuals in solitary confinement were 24% more likely to die and 78% more likely to die from suicide than individuals in the general population in the first year after their release.[9] These individuals were also 127% more likely to die of an opioid overdose in the first two weeks after being released from custody, and were more likely to return to custody. These findings controlled for other factors such as prior incarcerations, drug-related convictions, violence-related convictions, mental health treatment, and length of sentence.

43. Solitary confinement can also lead to devastating effects on an individual's *physical* health. Solitary isolation adversely impacts the functioning of the immune system, undermines health outcomes, and increases mortality. For example, one recent study found that individuals held in solitary confinement units experienced a 31 percent higher risk of hypertension, and higher risk of cardiovascular disease, than individuals in the general prison population.[10] The study estimated that for a population of only 25,000 individuals, the increase in hypertension **alone** would result in $155 million in future anticipated healthcare costs and a loss of 5,673 quality-adjusted life years. The study did not focus on other possible conditions worsened by solitary confinement, so these numbers likely underestimate solitary confinement's overall impact on healthcare related costs.

[9] Lauren Brinkley-Rubinstein, et al., *Association of Restrictive Housing During Incarceration with Mortality After Release*, JAMA Network Open (Oct. 2019).

[10] Brie A. Williams, et al., *The Cardiovascular Health Burdens of Solitary Confinement*, J. Gen. Internal Med. 34(10): 1977-80 (Oct. 2019).

The growing awareness of the health and fiscal risks of solitary confinement has led organizations such as the American Medical Association to call for the elimination of solitary confinement for individuals with serious mental illness, as discussed in paragraph 37 above.

44. Consistent with this widely accepted guidance and research, other California counties have banned the use of solitary for seriously mentally ill individuals. For example, nearby San Bernardino County's Policy No. 12.2515.05 states that "[i]nmates who are confirmed to be pregnant or who have serious mental illness or a developmental or intellectual disability shall not be placed in non-disciplinary administrative housing." Similarly, Orange County does "not place people" with "[s]erious [m]ental [i]llness or who have an [i]ntellectual or [d]evelopmental [d]isability" in its special management restrictive housing unit. San Mateo County excludes individuals diagnosed with serious mental illnesses, individuals with developmental or cognitive disabilities, individuals with dementia or delirium, and individuals with a history of seizures or traumatic brain injuries from administrative housing, except for a brief period of no more than 72 hours in cases of imminent violence or serious danger.

45. Consistent with these counties' practices and guidance from respected organizations and researchers, the best practice is to prohibit the placement of people with serious mental illness in solitary confinement. San Diego does not follow this guidance, and in fact appears to place individuals with serious mental illness in solitary confinement *because* of their mental illness.

46. Given San Diego's widespread use of solitary confinement for people with serious mentally illness, and the lack of precautions, such as sufficiently frequent safety checks, confidential mental healthcare, out-of-cell structured and unstructured time, and tablets or books, it is inevitable that people with serious mentally illness will worsen and even die in these units. I have discussed the Administrative Separation deaths of Messrs. Rupard, Marroquin, McDowell and

Settles at length in my previous report. *See* Dkt. 937-5 at ECF pp. 98-109. The tragic July 2025 deaths discussed below were likewise the foreseeable consequence of San Diego County's solitary confinement practices.

**The Death of Corey Dean (July 13, 2025) in Vista Administrative Separation Illustrates the Dangers of San Diego County's Administrative Separation Units**

47. Corey Dean, a 43-year-old patient with a known history of psychotic disorders and mood disorders, died on July 13, 2025 in an Administrative Separation unit at the Vista Detention Facility. Mr. Dean's medical records indicate that, throughout his 28-day incarceration, he was increasingly psychotic and unable to conduct meaningful self-care activities. Although deputies and medical and mental health staff at the Jail were aware that he was in distress and knew that he required a higher level of care, he was seen just once by psychiatric staff, even as that staff noted that he needed to be seen more often given his mental health condition. As indicated below, Mr. Dean should have been seen by a psychiatrist within a week of being prescribed a psychiatric medication. Once it was clear that the prescribed medication was not working, Mr. Dean should have received additional care, and certainly should have been removed from the Administrative Separation unit. Mr. Dean's death represents an egregious case of neglect.

48. Mr. Dean was booked on June 15, 2025. This was not Mr. Dean's first incarceration at the Jail, though it is not clear if his prior Jail mental health records were reviewed by staff. During Receiving Screening, a nurse noted that he had a history of mood disorders and psychotic disorders and therefore referred Mr. Dean to psychiatric sick call. [Dean Medical Records pp. 430, 440]. Mr. Dean was not evaluated by a psychiatric practitioner (in this case, a psychiatric nurse practitioner) until June 22, 2025—one week later. [*Id.* p. 539]. During that cell-side (*i.e.*, non-confidential) evaluation, the nurse practitioner noted that Mr. Dean was "disheveled … with strong urine [smell] coming from cell, towels on floor outside of cell," as well as "visib[ly] dirty and malodorous." [*Id.* p. 540]. The nurse practitioner note

further states that Mr. Dean "reports taking Depakote and Cogentin"—psychotropic medications—"in the past," and that he had stated that he would take "Zyprexa or Haldol if you have it." [*Id.*] The nurse practitioner assessed Mr. Dean as having an unspecified psychotic disorder, prescribed 5 mg of Zyprexa to be taken twice per day, and scheduled a follow-up psych appointment "in 2 weeks unless sooner visit is warranted." [*Id.* pp. 551-52.] Zyprexa is an antipsychotic medication. Mr. Dean was then placed in Cell 12 of Vista Unit E/4, an Administrative Separation unit, on June 28, 2025, where he remained until his death on July 13, 2025.

49. Despite the nurse practitioner's June 22, 2025 instruction that a follow-up appointment should happen, **no further psychiatric appointments or notes appear in Mr. Dean's medical records**. The Jail's failure to conduct a clinically indicated and clinically ordered follow-up appointment is extremely concerning and falls below the standard of care. In general, after prescribing a new psychiatric medication or a new dosage of an existing psychiatric medication, a practitioner should follow up with the patient after one week. *See* Dkt. 937-5 at ECF pp. 38-41, 101. Failing to conduct a psychiatric follow-up appointment with Mr. Dean **at all** after prescribing new medication violates the standard of care.

50. The failure to conduct a psychiatric follow-up appointment is even more concerning in this case given the obvious indications that Mr. Dean was not improving on the prescribed dose of Zyprexa. Mr. Dean's medical records indicate that he was relatively medication compliant, with a compliance rate of 76%. Yet, there are multiple notes stating that Mr. Dean's condition was not improving, with alarming symptoms that indicated serious mental health and medical concerns:

- A June 26, 2025 Progress Note states: "reports of severe mental illness w/ bizarre [behaviors] (e.g., yelling, urinating on the door, and unkept cell), etc." [Dean Medical Records p. 443].
- Another June 26, 2025 QMHP Progress Note states: "Per collateral, I/P urinating on himself to stay warm. Psychosis, disorganization, unkempt, urinating inappropriately. … Highly malodorous outside of cell. Flies. Thick bundle of blankets outside of cell to seep up urine. Pool of urine inside of cell in between toilet and door. … I/P presented

w/ disorganization, nonlinear TP [thought process], irrelevant responses, delusional TC [thought content]." [*Id.* at p. 451-52].

- On July 3, 2025, a mental health clinician noted a wet blanket outside Mr. Dean's cell door and "additional liquid outside of his cell. Per housing deputy, the liquid was most likely a combination of urine and water." [*Id.* at p. 459]. The clinician further noted that Mr. Dean exhibited psychotic symptoms, including delusions, *e.g.*, Mr. Dean, who was 43 years old at the time of his death, reported that he served in the military from 1932-1940—nearly a century ago. [*Id.* at pp. 460, 465].
- Also on July 3, 2025, a different mental health clinician noted that Mr. Dean was "[d]isheveled/unkempt"; his cell was "[u]nkempt/foul smell," with a history of "toilet being flo[o]ded and having feces on cell"; and that he experienced delusions. [*Id.* at pp. 471-72].
- On July 10, 2025, a mental health clinician noted that Mr. Dean was disheveled and his cell had a foul smell, with a blanket "soaked in water and urine," despite a report that deputies "had just cleaned his cell the day before." The clinician also noted that Mr. Dean did "not appear to be appropriately aware of his surroundings." [*Id.* at pp. 490-91].
- Also on July 10, 2025, a different mental health clinician noted that Mr. Dean had "been yelling random numbers" and that he "responded illogically and nonsensically" to questions, including answering a question about the day's date with "USSR," and that he "was not able to engage in much of a linear conversation." The clinician also noted that Mr. Dean "had what appeared to be a towel on his head" and that his "toilet appeared to be overflowing." The Progress Note also indicates that, about 5 days prior, there had been an incident in which water had been seen dripping down the wall of Mr. Dean's cell, and Mr. Dean had confirmed when asked by a deputy that he had been "placing water into the cell intercom or into the vent," resulting in a "strong odor of burning metal" in his cell. [*Id.* at 482-83, 485].

51. These observations show that Mr. Dean remained psychotic over an extended period—a condition that was also observed by the incarcerated people in his unit who reported that he spent days constantly yelling, complaining that he did not feel well, regularly flooding his cell with water from his toilet, and covering himself in his own feces and urine.

52. This behavior should have indicated that Mr. Dean required augmented psychiatric treatment, *i.e.*, a change or increase in his medication regimen and/or transfer to a higher level of care, yet he was never again seen by a psychiatric practitioner who could have made that medication adjustment or ordered the transfer

to a more therapeutic environment or the Emergency Department of a hospital. The County's failure to follow up in the face of obvious symptoms of psychosis is a shocking departure from the standard of care.

53. According to court records I have been provided, on June 30, 2025, the Superior Court for the County of San Diego suspended criminal proceedings against Mr. Dean pursuant to Penal Code section 1368 and instead ordered a forensic evaluation of his competence to stand trial—one more indication that Mr. Dean should not have been in Administrative Separation.

54. I have also reviewed Mr. Dean's medical records from treatment he previously received in the community between 2014 and 2020. Those records show that Mr. Dean experienced long periods of stability on antipsychotic medication. In other words, Mr. Dean's psychosis likely could have been managed with medication and appropriate psychiatric follow-up in a setting other than Administrative Separation. He simply was not given the treatment that he needed while incarcerated in the Jail.

55. It is striking that Mr. Dean was referred for placement in a mental health unit three weeks before he died, when a Qualified Mental Health Professional referred him to the Jail's Outpatient Stepdown Unit ("OPSD"). [*Id.* at p. 451]. While my previous report is critical of the Jail's OPSD, *see* Dkt. 937-5 at ECF p. 138, as well as its overall mental health staffing, psychiatric follow-up, and safety checks, *id.* at ECF pp. 26-70, 136-49, 208-210, an OPSD placement would have been an improvement over Administrative Separation.

56. Based on the information I have been provided, Mr. Dean needed intensive and immediate medical and psychiatric care, along with other mental health interventions and placement in a more therapeutic environment, where he could receive out-of-cell time and increased access to family members (by phone or otherwise). None of this occurred. Mr. Dean was never actually transferred to OPSD or any other mental health unit and instead remained in Administrative

Separation for 17 days after that referral, until his death. Such denial of clinically indicated care and the continued isolation of the Administrative Separation placement were clearly dangerous for this patient. To my knowledge, the Jail has no system for tracking how long individuals are waiting for placement in OPSD or the higher level of care, the Jail's Psychiatric Safety Unit ("PSU").

57. Mr. Dean's medical records contain evidence that he was likely experiencing protein-calorie malnutrition and dehydration, *i.e.*, that he was starving. Lab tests received by the Jail on July 1, 2025 (from a blood draw on June 30, 2025) show "out of range" results for Urea Nitrogen (BUN), Creatinine, and BUN/Creatinine Ratio. [*Id.* at p. 562]. Those labs suggest that Mr. Dean was likely dehydrated and that his muscles were breaking down. The results should have—at minimum—raised the concern of Jail health staff that Mr. Dean was not eating or drinking enough. That concern should have been further heightened by the multiple notations in Mr. Dean's medical records suggesting that he was not eating, specifically:

- On June 19, 2025, a clinical counselor noted that Mr. Dean's toilet was "clogged with food wrappers." [*Id.* at p. 557].
- On June 22, 2025, a psychiatric NP wrote that Mr. Dean stated: "I am hungry, they don't feed me." [*Id.* at p. 540].
- Another mental health clinician noted on June 22, 2025 that Mr. Dean "stated he has not been given any meals" and that there "appeared to be scraps on the floor, possibly from food." [*Id.* at pp. 445-46].
- On July 3, 2025, an LVN noted that the toilet in Mr. Dean's cell was "clogged by food trays." [*Id.* at p. 443].

58. These notations are consistent with the testimony of the incarcerated witnesses, who reported that Mr. Dean spent days "constantly yelling," "regularly flood[ing] his cell with water from his toilet," and "cover[ing] himself in his own feces and urine," including "rub[bing] feces on his face and into his beard." According to these declarants, Mr. Dean was left in his cell in this state for "several days" before "custody staff brought him out to shower once," at which point

incarcerated workers removed "a flood of brown water mixed with food and trash" out of his cell. The declarations also confirm that staff did not remove Mr. Dean from Administrative Separation, but rather returned him to his cell where he "continued to cry and ask for help" until he gradually went quiet and was found dead.

59. As explained above, it is not uncommon for psychotic patients in extreme, harsh, and isolation settings, like the restrictive conditions of solitary confinement, to become so disorganized that they do not eat or simply cannot eat, even when hungry. Each of the above observations—including Mr. Dean's reports of hunger and the appearance of food scraps, packaging, and debris on the cell floor and in the toilet—suggest that is what was happening in Mr. Dean's case: his untreated mental illness in a solitary confinement setting may have predictably resulted in him not eating and in fact wasting away, as Mr. Rupard did in 2022.

60. Not eating can be a sign of other serious medical conditions. Whatever the cause, protein calorie malnutrition is a potentially life-threatening condition, as it may result in multiple organ failure and death. Medical staff should have investigated that possibility and intervened in Mr. Dean's case, given the multiple indicators that Mr. Dean was suffering and not eating. In fact, it would have been reasonable to send Mr. Dean to the hospital emergency department on July 1, 2025, when his alarming lab results came back, in pursuit of further testing and treatment. This did not occur.

61. Instead, there are multiple indications in his medical records that Mr. Dean was prevented from obtaining medical care because custody staff viewed him as an alleged "security risk." On both July 1 and July 2, 2025, nurses noted that they "[a]ttempted" to bring Mr. Dean to clinic for an electrocardiogram ("EKG"), but were unable to because "per dep[uty]" Mr. Dean was a "safety concern" or "[s]ecurity concern." [*Id.* at p. 443].

62. Notably, Mr. Dean's records suggest that custody staff viewed some of

the clear symptoms of his mental illness described above, *e.g.*, his lack of hygiene and pattern of flooding his cell with urine, as a "safety concern." [*Id.*]. One mental health clinician, in documenting Mr. Dean's medical history, noted the following:

> Per JIMS ISR dated 06.28.25, at VDF, a deputy noticed a foul odor coming from IP's cell. There were multiple blankets rolled up at the base of the cell door and the blankets were saturated in urine. IP had trash and clothing clogging his toilet. A mixture of urine and water formed a pool on the cell floor. IP's cell was cleaned. IP appeared to be unbothered by his unkempt cell and living conditions. IP has consistently shown that he cannot conform the minimum jail standards. **For IP's safety and the safety of other incarcerated persons and staff**, IP will be placed into Ad-Sep.

[*Id.* at p. 459 (emphasis added)].

63. I see ***no*** indication of so-called "safety" concerns in Mr. Dean's medical records other than references to his unkempt living behaviors and a vague reference to "disruptive" behavior "during the night which disturbed other [incarcerated persons'] sleep." [*See id.*]. This may have been the yelling referred to by the incarcerated witnesses. Neither yelling nor malodorous urine are threats to the safety of others; they are unpleasant but call for treatment, not further isolation. Yet it appears from Mr. Dean's medical records that he was placed in Administrative Separation, and not taken to the clinic to receive medical care, *because of* his untreated psychotic disorder.

64. In summary, Mr. Dean was visibly decompensating throughout his incarceration in the Jail, especially once he was placed in Administrative Separation. Mental health and custody staff repeatedly noted that Mr. Dean was presenting as psychotic and failing to engage in basic activities of self-care. Jail staff referred him to a mental health placement in the OPSD unit. Rather than effectuate that mental health placement, or provide him with psychiatric follow-up that was clinically indicated and ordered, or take him to the medical clinic for appointments, or send him to the hospital, the Jail left him to decompensate in Administrative Separation, where he died.

**The Death of Karim Talib (July 28, 2025) is Likely Related to His Placement in Administrative Separation**

65. Karim Talib was an 82-year-old man who died in the Administrative Separation unit of the San Diego Central Jail on July 28, 2025. According to records from the Sheriff's Office, he was awaiting a mental competency proceeding. This fact strongly suggests that Mr. Talib had a mental illness.

66. Mr. Talib was arrested and booked into Central Jail on May 27, 2025. It appears that he was placed in a Medical Observation Unit, suggesting he was seriously ill, until approximately a week before his death. The declarations I reviewed from other *Dunsmore* class members about Mr. Talib's behavior when incarcerated in the Administrative Separation unit state that he used a wheelchair and wore a diaper, which he required assistance from medical staff to change. Those declarations also indicate that both Mr. Talib himself and his cell regularly smelled of feces, and that Mr. Talib often failed to respond when asked questions by staff and other incarcerated people. One incarcerated person reportedly asked Mr. Talib a question from outside his cell, but Mr. Talib "just stared back at [him] without saying anything." Based on this information, Mr. Talib was likely catatonic. According to the declarations, Mr. Talib only left his cell once during the time he was in Administrative Separation. At the time of his death, uneaten trays of food were observed in his cell.

67. I would like to see Mr. Talib's medical records. Without them, I do not have the full picture of what happened to him. However, based on the information I do have, it seems highly likely that housing Mr. Talib in Administrative Separation was dangerous, as he could not, and did not, receive the care he needed there. Conditions like those in Administrative Separation are extremely dangerous for those with serious mental health conditions, particularly for an elderly man with other health conditions and disabilities like incontinence.

**San Diego County Must Stop Placing Incarcerated People with Serious Mental Illness in Administrative Separation**

68. To prevent future deaths of this nature and reduce the deleterious effects of solitary confinement, the Jail needs to make changes as described in my prior declaration and reports. Most importantly, the Jail should follow other California counties like San Bernardino, Orange, and San Mateo in adopting a prohibition on the use of solitary confinement for individuals with serious mental illness. As discussed above, extensive scientific literature, good correctional practice and accepted standards have shown that individuals with serious mental illness cannot receive the care they need in solitary confinement, and that such a setting affirmatively harms them.

69. My inspections of San Diego County Jail facilities confirm that it is virtually impossible to provide therapeutic out-of-cell time, dayroom, and confidential mental healthcare in the Administrative Separation units because of their configuration and staffing. Without these protections, as well as devices like tablets for communication and programming, and without 30-minute safety checks, these units are simply too dangerous for incarcerated people with serious mental illness.

70. If solitary confinement is used (as when there is an immediate threat to physical safety), it must be limited to short periods of time such as 72 hours, similar to the limit placed in San Mateo County, and must be subject to multiple protections not present in San Diego County Jail. These include but are not limited to careful psychiatric follow-up and monitoring, including with respect to psychiatric medication, confidential mental health consultations, significant therapeutic out of cell programming, significant unstructured out of cell time, staggered and irregular safety checks, a level of care mental health system with meaningful therapeutic programming, tracking individuals with serious mental illness, and providing access to in-cell stimulation and communication devices such as tablets.

71. The Jail currently has several mental health units including one called OPSD. It also has Medical Observation Units at each of the jails that have Administrative Separation units. At least in Medical Observation and in the PSU, San Diego County's policy requires safety checks every 30 minutes, *see* SDSO Detention Service Bureau Policy I.64 at 1. My prior reports have been critical of the mental healthcare provided in PSU and OPSD. Still, these units are more therapeutic, and safer, than the Administrative Separation units. I strongly urge San Diego County to follow the standard of care and prohibit the placement of people with serious mental illness in Administrative Separation, and to instead house those individuals in the OPSD, the PSU, or Medical Observation units, while working to improve mental health programming to meet the needs of the population.

72. These changes would not only lead to improved mental and physical health outcomes for incarcerated individuals but would also have a positive impact on SDSO and San Diego County as a whole. As discussed above, the fiscal savings resulting from improved health among individuals diverted from solitary confinement are substantial.

73. Moreover, as demonstrated by a recent case study performed in Oregon, eliminating solitary confinement conditions for individuals with serious mental illness would lead to improved conditions for the Jail's deputies and mental health staff.[11] As discussed in the Oregon study, correctional staff often experience physical and psychological injury and vicarious trauma due the harmful effects of solitary confinement. This leads to poor job satisfaction, lower life expectancy and increased risk of alcoholism, depression, and suicide. As a result of eliminating solitary confinement conditions for individuals with serious mental illness, the unit in the Oregon study saw an 85.7% decrease in use of force incidents, a 55.7%

[11] David H. Cloud, et al., *The Resource Team: A Case Study of a Solitary Confinement Reform in Oregon*, PLoS ONE 18(7) (July 2023).

decrease in disciplinary infractions, and a 73.9% decrease in assaults (including zero staff assaults). Staff members reported dramatically reduced work-related stress, conflict, and violence, increased job satisfaction, and an increased sense of occupational purpose. Jail operations also benefited as a whole, as the study found a 23% reduction in use of sick leave for participating staff members.

74. I urge San Diego County to adopt a ban on solitary confinement for people with serious mental illness and to improve and expand its OPSD and PSU units. The need for change is urgent before more individuals tragically die.

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75. The information and opinions contained in this declaration are based on the evidence and documentation available to me and on my professional knowledge and my experiences working in correctional settings. I reserve the right to modify or expand these opinions should additional information become available to me, including but not limited to the medical records of Karim Talib and the autopsy reports for Messrs. Dean and Talib.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge, and that this declaration is executed at Honolulu, Hawaii this 30th day of September, 2025.

Pablo Stewart, M.D.