GAY C. GRUNFELD – 121944
VAN SWEARINGEN – 259809
PRIYAH KAUL – 307956
ERIC MONEK ANDERSON – 320934
HANNAH M. CHARTOFF – 324529
BEN HOLSTON – 341439
ROSEN BIEN
GALVAN & GRUNFELD LLP
101 Mission Street, Sixth Floor
San Francisco, California 94105-1738
Telephone: (415) 433-6830
Facsimile: (415) 433-7104
ggrunfeld@rbgg.com
vswearingen@rbgg.com
pkaul@rbgg.com
eanderson@rbgg.com
hchartoff@rbgg.com
bholston@rbgg.com

AARON J. FISCHER – 247391
LAW OFFICE OF
AARON J. FISCHER
1400 Shattuck Square Suite 12 - #344
Berkeley, California 94709
Telephone: (510) 806-7366
Facsimile: (510) 694-6314
ajf@aaronfischerlaw.com

CHRISTOPHER M. YOUNG – 163319
ISABELLA NEAL – 328323
OLIVER KIEFER – 332830
DLA PIPER LLP (US)
4365 Executive Drive, Suite 1100
San Diego, California 92121-2133
Telephone: (858) 677-1400
Facsimile: (858) 677-1401
christopher.young@dlapiper.com
isabella.neal@dlapiper.com
oliver.kiefer@dlapiper.com

Attorneys for Plaintiffs and the
Certified Class and Subclasses

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

DARRYL DUNSMORE, ANDREE ANDRADE, ERNEST ARCHULETA, JAMES CLARK, ANTHONY EDWARDS, LISA LANDERS, REANNA LEVY, JOSUE LOPEZ, CHRISTOPHER NELSON, 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

REBUTTAL EXPERT REPORT OF JEFFREY E. KELLER, M.D.

Judge: Hon. Anthony J. Battaglia
Magistrate: Hon. David D. Leshner

Trial Date: None Set

TABLE OF CONTENTS

Page

1. I previously issued a Rule 26 Report, submitted on August 21, 2024. I make this Rule 26 Rebuttal Report to address certain opinions set forth in the Expert Report of Owen J. Murray, DO, dated August 21, 2024 ("Murray Report").

2. I am a physician with substantial experience in correctional medicine, both as a medical provider and as the Chief Medical Officer for Centurion, a correctional medical company. A full description of my experience and my curriculum vitae are included in my initial report.

3. According to Dr. Murray's report, the San Diego Sheriff's Office ("SDSO") retained Dr. Murray to prepare an expert witness report to evaluate the allegations in the *Dunsmore* class action lawsuit related to medical services at the San Diego County Jail ("Jail"). According to his report, Dr. Murray and a team of several other individuals reviewed medical records and data provided to them by defense counsel, visited seven Jail facilities, and interviewed Dr. Freedland, CEO and Chief Medical Officer of Correctional Health Partners ("CHP"), and Dr. Nas Rafi, Medical Director of CHP operations at the Jail. Following his review, Dr. Murray opined that all of the Plaintiffs' allegations in *Dunsmore* regarding the problems with the medical system at the Jail are "false." Murray Report at 41-44. He concluded that "[t]he current SDSO healthcare delivery system is neither indifferent nor insensitive to the medical needs of its [incarcerated person] patients." *Id.* at 44.

4. As set forth below, I disagree with Dr. Murray's ultimate opinion regarding the adequacy of the medical care provided to incarcerated people in the Jail. As I set forth in my initial report and as I explain below, the medical system at the Jail places incarcerated people at a substantial risk of serious harm. Moreover, I disagree with many of the opinions Dr. Murray offered in his report regarding the adequacy of specific parts of the medical system at the Jail.

/ / /

/ / /

I. Dr. Murray has limited experience working in jail settings and has not done so since the 1990s.

5. The ideal qualifications for someone performing a comprehensive survey of a county jail's medical program would be clinical and supervisory experience in a county jail setting. According to his own description of his experience, Dr. Murray has not worked at a jail since he was an administrator at the Cook County Jail in the 1990s.[1] Since 2009, Dr. Murray has been a senior administrator within the Texas prison system. Similarly, none of the other three individuals with resumes included within Dr. Murray's report list jail experience in their resumes. *See* Murray Report at 146-51. Kirk Abbott has been a nursing administrator in the Texas Prison system since 2000. Melanie Roberts has been a staff pharmacist in the Texas Prison system since 2001. Kelly Coates appears to be an administrator for the medical system for the Texas state prison system, but has never worked in a jail and has no medical training.

6. While prisons and jails are similar in some respects (both house incarcerated persons), they are also different in many significant ways. Most patients arriving at a jail enter the jail directly from the community. Many jail patients have not been receiving regular medical care in the community prior to arriving at a jail. As a result, jails must evaluate incarcerated people quickly and accurately and be ready to provide immediate treatment for a wide variety of urgent,

[1] On his CV, Dr. Murray indicates that, in his role as the Senior Vice President for the Offender Health Services at the University of Texas Medical Branch Correctional Managed Care, he is "[r]esponsible for ensuring the provision of all medical, mental health, and dental services for approximately 100,000 adult offenders in Texas Department of Criminal Justice state jails and prisons." Murray Report at 45. My understanding is that the "state jails" to which Dr. Murray refers only confine "adult felony offenders who are sentenced" to those jails. *See* Texas Department of Criminal Justice, *Prison and Jail Operations*, https://www.tdcj.texas.gov/divisions/cid/prison_jail_ops.html. As such, though those facilities are referred to as "jails," they are different from the San Diego County Jail and other jails in which I have worked in that they do not confine unsentenced criminal detainees who are coming to the facility straight from the community.

acute, and chronic medical problems, such as withdrawal from alcohol, opiates, and other substances, chronic diseases such as diabetes, infections, and many other medical conditions. On the other hand, most incarcerated people arriving at a prison are not arriving from the community. Most have been incarcerated in a jail for some period of time before arriving at the prison. This distinction is important in a few respects. First, because individuals arriving at prison have generally already been in a jail, they usually have already had any medical conditions diagnosed and received treatment for those conditions. As a result, people arriving at prison are much less likely to be suffering from out-of-control chronic or acute medical conditions. Second, because drugs and alcohol are less available in jails than in the community, individuals arriving at prison are much less likely to be experiencing withdrawal.

7. Another important difference between jails and prisons is that patients typically stay for a short period of time in a jail—on average around a month—whereas patients in prison typically are incarcerated in a prison for at least a year and usually much longer. Consequently, it is much more important for a jail to maintain communication and continuity of care with outside medical practitioners who were taking care of a patient before they came to jail and will be caring for them again once they leave jail.

II. Dr. Murray offered opinions about the adequacy of the Jail medical system without speaking to incarcerated people.

8. Dr. Murray's report does not indicate that he spoke with any incarcerated people in the Jail. Plaintiffs' counsel has informed me that Plaintiffs agreed that Defendants' experts, including Dr. Murray, could speak with incarcerated people in the Jail so long as Plaintiffs' counsel was present for the conversations. The fact that Dr. Murray did not speak with any incarcerated people, despite the opportunity to do so, undermines his opinions. Such interviews are an essential component of any review of a healthcare system because they provide an understanding of the system from the perspective of patients. For example, when

the National Commission on Correctional Health Care ("NCCHC") evaluates a facility, it interviews a substantial number of incarcerated people. NCCHC Report, January 2017, DUNSMORE0260623.

III. Dr. Murray offered opinions about the adequacy of the Jail medical system without conducting a substantive review of any in-custody deaths.

9. As I discussed at length in my initial report, one of the most critical functions of any health care system, but especially a correctional health care system, is to carefully review any in-custody deaths "to identify medical errors that led to adverse outcomes ... so that those errors can be avoided in the future." Keller Report ¶ 92. This type of review is especially important for the Jail. In recent years, the County been the subject of multiple, high profile wrongful death lawsuits and four reports critical of the healthcare system and/or high death rate in the Jail: one by Homer Venters, one by NCCHC, one by the State Auditor, and one by Analytica Consulting. *See* NCCHC Report; Venters Report, March 2020, SD_215361; California State Auditor Report ("State Auditor's Report"), February 2022, SD_174794; Analytica Consulting Report ("Analytica Report"), DUNSMORE0116319.

10. It is my opinion that any systematic review of a correctional health care system must closely review any in-custody deaths, as those adverse outcomes provide important information regarding the adequacy of care. The existence of preventable deaths, especially multiple preventable deaths, is an important indicator that the health care system is not providing adequate care. In my opinion, any review of a correctional medical system that does not examine in-custody deaths is foundationally flawed.

11. In my report, I examined a number of deaths that occurred at the Jail and found that problems with the medical system contributed or caused many of the deaths. Keller Report ¶¶ 86-242. I discussed seven deaths from 2022 and 2023 at length. *Id.* ¶¶ 119-237. I then discussed how the problems I found with the medical

care provided to the decedents reflected numerous systemic problems with the healthcare system at the Jail, including that medical staff failed to examine very sick people, conducted evaluations at cell front, ordered medications and diagnosed patients without seeing them, failed to adequately communicate with each other, and failed to continue care plans when people return from the hospital. *Id.* ¶¶ 238-39. My findings related to these in-custody deaths formed one of the pillars of my overall conclusion that the medical system at the Jail exposes incarcerated people to a substantial risk of serious harm, including death.

12. Dr. Murray did not offer any opinions regarding any in-custody deaths in his report. Defendants provided Dr. Murray with medical records for five individuals who died in 2024 while in custody at the Jail from non-homicide/non-suicide causes. Murray Report at 39. Dr. Murray claims that "[t]hese medical records were ... reviewed," though he does not indicate by whom. *Id.* at 39. Dr. Murray attached as Appendix Q to his report short summaries for each of the deaths. Notably, however, Dr. Murray did not provide any analysis regarding whether the medical care provided to these five individuals before they died met the standard of care. He also did not opine on whether the deaths were preventable, whether any deficiencies in the Jail healthcare system were factors in the deaths, or whether the Jail should have made any changes to its medical system in response to the deaths.

13. Dr. Murray did not mention, let alone review or analyze, any deaths that occurred prior to 2024.[2] His Appendix B, which lists all of the materials he was provided for review, also does not list any records for any of the individuals who died in-custody prior to 2024.

[2] The only opinion that Dr. Murray offers related to mortality at the Jail is to question whether the data regarding the Jail's mortality rate are accurate. My response to Dr. Murray's opinions regarding the mortality rate is below. *See* Section IV, *infra*.

14. Because Dr. Murray did not offer any opinions regarding in-custody deaths at the Jail, it is my opinion that his opinions regarding the adequacy of care in the system are fundamentally flawed and unreliable. Put simply, any review of any medical system that does not consider whether the system performed adequately in situations where patients died is worthless or nearly so. It is not possible to understand the strengths and weaknesses of a medical system without understanding what happened when patients being cared for in the system have died. Dr. Murray's failure to review any of the in-custody deaths at the Jail is particularly egregious given that in-custody deaths are at the very core of the allegations and evidence in this case. The words "death" and "deaths" appear over 100 times in the Third Amended Complaint. The State Auditor's Report, which was cited extensively by Plaintiffs in the Third Amended Complaint, concluded, based on a review of 30 in-custody deaths, that "deficiencies with how the Sheriff's Department provides care for ... incarcerated individuals ... likely contributed to in-custody deaths." SD_174794. Dr. Murray himself acknowledged that in-custody deaths are important, stating in his report that "[i]n-custody mortality is an important metric that should be reviewed in all jail healthcare systems." Murray Report at 40. Though he wrote this statement in the context of a discussion of the mortality rate at the Jail rather than as part of an analysis of any specific deaths, it shows that he knows that in-custody deaths are central to this case and relevant to the evaluation of the adequacy of healthcare systems.

15. The Joint Commission of Accreditation of Health Organizations ("Joint Commission"), an organization that evaluates hospitals, provides a model for how to perform investigations into whether poor or inadequate medical care contributed to a death and whether the death was preventable. The Joint Commission has a guideline for evaluating deaths or other sentinel events called the Framework for Root Cause Analysis and Corrective Actions, which is available at https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-

topics/sentinel-event/rca_framework_101017.pdf. The Joint Commission does not determine whether inadequate medical care contributed to a death by simply looking at hospital systems—for example, determining whether there is an emergency department, whether the inpatient floors are staffed with nurses, or what the average lab turnaround time is. When investigating deaths, they look in detail at those specific cases to determine whether poor emergency department care, short staffing, lab problems, or any other system failures contributed to the deaths. To this end, the Root Cause Analysis includes 24 questions, many of which include sub-questions, to determine whether the system contributed to the specific sentinel event, such as a death.

16. It is my opinion that Dr. Murray and his team cannot opine that the Jail has no systemic problems without evaluating the medical care provided to patients who died while in the Jail. To have not evaluated the deaths at all is a fatal flaw in Dr. Murray's methodology that negates his entire thesis.

A. For the three 2024 deaths I reviewed, one was likely preventable, another may have been preventable, and I lack sufficient information to offer an opinion regarding the third.

17. In or around September 21, 2024, Plaintiffs' counsel provided me with the medical records for the five deaths summarized in Appendix Q of Dr. Murray's report. These records were not available to me at the time I wrote my initial report. A full list of the materials I considered for this report (all of which I reviewed after the disclosure of my initial report on August 21, 2024) is attached hereto as Appendix C.

18. My understanding is that Plaintiffs' expert on substance use disorders will be offering opinions regarding two of those deaths (the deaths of Eric Wolf and Richard Woodford); I therefore offer no opinion related to Mr. Wolf and Mr. Woodford's deaths. For the remaining three deaths, I offer the following opinions, explained in more detail below. First, it is my opinion that Chase Mitchell's death from sepsis was potentially preventable. Moreover, it is my

opinion that problems with the medical system that I identified in my initial report caused, at least in part, his death. Second, since I have not been provided with the cause of death for Liutoa Vili, I am unable to opine regarding whether his death was preventable. That said, the care he received in the days preceding his death for a serious leg infection fell below the standard of care and it is therefore possible that Mr. Vili's death was preventable and caused, at least in part, by the substandard care. Third, I am unable to offer an opinion regarding the death of Majid Almajid, as his medical records do not include a cause of death. I can opine, however, that the care he received in the Jail for a back injury did not meet the standard of care.

1. Chase Mitchell – 24724484

19. Mr. Mitchell's medical records show that he died of sepsis on July 15, 2024, after surgery and treatment at the hospital were unable to address an infected abscess on his back. In my opinion, Mr. Mitchell's death was likely preventable.

20. Mr. Mitchell's Medical Clearance was done on June 13, 2024. His vital signs were normal. Mitchell Med. Rcd.[3] at 2. He was reported as being "uncooperative, yelling, not answering questions." *Id.* at 3. Most of the Receiving Screening was left blank. *Id.* at 5. Mr. Mitchell weighed 150 lbs. *Id.* at 26. Mr. Mitchell was reported as refusing a Health Assessment the same day. *Id.* at 58, 66. On June 13, 2024, Mr. Mitchell's reportedly refused a Second Stage Nurse Evaluation. *Id.* at 23.[4]

---

[3] For nearly all of the medical files that I reviewed that Defendants produced for Dr. Murray's report, there was one medical file for each individual. Throughout this report, I cite to the corresponding records using the person's last name. The page numbers indicate the page number of the PDF.

[4] Mr. Mitchell's refusals were inappropriately handled. I discussed the problems with refusals in my report and how the SDSO inadequate and inappropriate refusal policies can and do harm patients. Mr. Mitchell is another example of this. When Mr. Mitchell came to the jail on June 13, 2024, he was agitated and uncooperative. In this state, he refused a Health Assessment when it was offered. However, that does not mean that he would refuse a Health Assessment forever. In fact, Mr. Mitchell is documented as being cooperative with examinations and medical care as soon as a few days later. But the medical staff never tried again to do a Health Assessment. I note that Mr. Mitchell never had a physical examination by a

21. On July 4, 2024, he was diagnosed by mental health care staff as having schizophrenia, though he refused to take medicine. *Id.* at 34, 39, 41, 53.

22. On July 3, 2024, Jasmine Angel MHC did a wellness check. *Id.* at 68. She stated "IP was amenable to talk at his cell door." *Id.* He appeared well groomed and was eating.

23. On July 7, 2024, Mr. Mitchell "den[ied] health concerns" during a wellness check. *Id.* at 56.

24. On July 13, 2024 at 11:13 p.m., Kyra Whited, a remote STATCare practitioner, wrote "nurse called with reports of looking clammy by custody staff and responding to que[stions] but not very talkative. nurse reports BP 96/66 sitting, 91/62 standing. no abnormal findings on neurological exam reported. does report 25 lb wt loss in one month."[5] *Id.* at 56. Mr. Mitchell's weight at this visit was 126 lbs., confirming his report of weight loss. This extreme weight loss alone should have set off alarm bells. After all, Mr. Rupard and Ms. Bartolacci, discussed in my initial report, also died after losing a large amount of weight. *See* Keller Report ¶¶ 193-220.

25. On that same day, Martha Burgess, STATCare NP wrote to "keep pt in medical, PO fluids, Boost TID" as well as neuro checks. *Id.* at 56. At no point on that date was Mr. Mitchell examined in person by a medical practitioner.

26. On July 14, 2024 at 6:13 a.m., RN Baluca wrote that Mr. Mitchell was transferred to M2 for observation. *Id.* at 56.

27. On July 14, 2024 (documented at 9:30 a.m., although the encounter was earlier than 9:00 a.m.), RN Anil Kumar saw Mr. Mitchell for a complaint of a headache. She documented this on a Headache Nursing Protocol form. *Id.* at 27.

---

medical practitioner the entire time he was incarcerated.

[5] The nurse who called STATcare did not write any note that appears in Mr. Mitchell's file.

She did not record any vital signs. RN Kumar ordered acetaminophen for Mr. Mitchell. She appropriately referred Mr. Mitchell to be seen immediately by a practitioner. *Id.* at 28.

28. At 9:00 a.m., NP Christine Sullivan saw Mr. Mitchell, and noted that he was dyspneic, weak, and tachycardic. She suspected that Mr. Mitchell was dehydrated and appropriately sent Mr. Mitchell to the hospital. *Id.* at 57.

29. At the hospital, Mr. Mitchell was noted to have "cellulitis on his back and an abscess that is partially open and actively draining." *Id.* at 110. He also was found to have septic shock. Mr. Mitchell had surgery to drain his abscesses and then was sent to the ICU, but died on July 15, 2024 from sepsis. *Id.* at 117.

30. **In my opinion, Mr. Mitchell's death was likely preventable**. The nurse's findings on July 13, 2024—that Mr. Mitchell had lost 25 pounds in a month and was suffering from serious symptoms, including hypotension, after reporting only six days earlier that he had no medical concerns—should have resulted in either an urgent, in-person physical examination by a medical practitioner (which likely would have identified the open and draining abscess on his back and then resulted in emergency transportation to the hospital) or immediate transportation of Mr. Mitchell to the hospital. Neither of those occurred. One reason a physical examination did not occur at the Jail is because of the County's reliance on remote STATCare practitioners, who cannot perform physical examinations because they are not present at the Jail. Here, the RN who identified some of Mr. Mitchell's symptoms contacted a STATCare practitioner, who then entered orders for treatment without examining Mr. Mitchell. That decision to treat Mr. Mitchell without an evaluation did not meet the standard of care and likely contributed to his death.

31. Because the Jail, on July 13, 2024, neither examined Mr. Mitchell nor sent him to the hospital, the diagnosis of Mr. Mitchell's abscess and related sepsis was delayed by a significant number of hours. Had the abscess and infection been

diagnosed earlier, it is possible that the infection would have responded to surgery and treatment and that Mr. Mitchell would have survived.

2. Liutoa Vili – 23725430

32. The medical records for Mr. Vili indicate that, on February 4, 2024, while being wheeled to medical, Mr. Vili slumped over and fell out of his wheelchair. He was unresponsive, apneic, and pulseless. Vili Med. Rcd. at 272. CPR was started, as well as ACLS when the paramedics arrived. *Id.* Mr. Vili was transferred to the hospital where he was declared dead. *Id.* Neither the paramedic transport records nor the hospital records for this event are included in the records provided to me. I also do not have access to the autopsy report.

33. Without knowing the autopsy results, including the cause of death, I cannot say whether Mr. Vili's death was preventable. I can, however, opine that much of the care he received for a chronic leg infection, including care in the days leading up to his death, fell below the standard of care. It is therefore possible that Mr. Vili's death was preventable and caused by substandard care at the Jail.

34. Mr. Vili had chronic venous insufficiency of the legs with skin breakdown and a recurrent infected leg ulcer. This was a complicated ulcer. It became infected, was treated with antibiotics and local wound care, improved, then recurred through two cycles leading up to January of 2024. Vili Med. Rcd. at 232-269. Mr. Vili was treated with frequent local wound care, wound cultures and antibiotics. *Id.* For reasons unclear, this complicated, serious infected leg ulcer did not result in a detailed work up and specialty consultation. Specifically, no one seems to have considered that Mr. Vili might have a more serious underlying septic process, such as osteomyelitis, deep abscess, or fasciitis. Further work up that could have been done included 1. Blood tests: C-reactive protein (CRP) and Erythrocyte sedimentation rates (ESR) and blood cultures looking for systemic sepsis. 2. Imaging: ultrasound looking for deep fluid collections, plain x-rays and CT/MRI to look for osteomyelitis (bone infection). Finally, referral to a hospital wound care

clinic for more advanced wound care, such as surgical debridement, was never considered.

35. The last cycle of worsening of the infection began about six weeks before Mr. Vili died. On December 19, 2023, RN Vivona wrote "wounds to left leg healed and scabbed." *Id.* at 264. Mr. Vili's next wound check occurred on December 28, 2023. RN Stephanie Yee found that the wounds had again worsened: "Old Band-aids removed. Areas cleansed with Anasept spray, pat dry, and photos obtained revealing beefy, red, raised wounds, more significant on right calf than left." *Id.* at 266. RN Yee did local wound care as had been done the preceding four months.

36. On December 29, 2023, RN John Wyatt wrote "Patient has sores to back of lower extremities bilaterally." *Id.* On December 30, 2023, NP Matthew Wallace reviewed photos of the wounds and ordered wound care. *Id.* Wound care was done every other day through January 2024. *Id.* at 22.

37. On January 30, 2024, RN Yee wrote that Mr. Vili was brought to clinic for "'trouble breathing,' back pain and chest pain." She also noted that "while in clinic, [a] foul smelling open wound [was] discovered on left lateral lower leg." *Id.* at 269. Mr. Vili's vital signs showed him to be hypotensive at 94/70. *Id.* at 38.

38. Dr. James Veltmeyer saw Mr. Vili and wrote that Mr. Vili was "thin, possibly under nourished." Mr. Vili had a tender 2 cm painful ulcer. Dr. Veltmeyer assumed "LLE ulcer-likely infected with staph pyogenes vs mrsa" and he started Bactrim (the third course of Bactrim Mr. Vili had taken, *id.* at 242, 262). Most importantly, Dr. Veltmeyer noted that Mr. Vili was hypotensive but assumed that this was due to hypertension meds and stated "vitals stable." *Id.* at 269. However, Mr. Vili's low blood pressure was not stable per his blood pressure log, which showed readings of 129/88 and 133/83 on January 25, 2024, but of 94/70 on January 30, 2024. *Id.* at 38.

39. Dr. Veltmeyer's decision not to send Mr. Vili to the hospital was a

medical mistake. Mr. Vili had multiple co-morbid conditions, including renal insufficiency and venous stasis, and had experienced a recurring leg infection for months. He presented sick and malnourished and had abnormal vital signs. He should have been sent to the ER at this point. At a minimum, his status should have been reassessed and his vital signs remeasured. Dr. Veltmeyer did write for "daily wound care with wet to dry daily dressings." *Id.* at 269. However, there is no note indicating that Mr. Vili was assessed again by medical personnel before he died five days later (other than notes that the dressing changes were "administered" by LVNs through the morning of February 1, 2024). *Id.* at 29. Mr. Vili had five subsequent "refusals" of dressing changes, but his dressing was changed the morning of February 4, 2024, about 3 hours before he died. *Id.*

40. In my opinion the care for Mr. Vili's leg infection fell below the standard of care in the following ways:

- Mr. Vili had a recurrent infection of his leg. It did improve with antibiotic treatment, but when it recurred and then recurred a second time, the medical practitioners should have intensified their diagnostic and therapeutic efforts. They should have considered labs and imaging studies looking for osteomyelitis, fasciitis, or deep abscesses. Alternatively, they could have referred Mr. Vili to a hospital wound clinic for a consultation, including whether surgical debridement should be done.
- On January 30, 2024, Mr. Vili was found to be ill appearing with a "foul-smelling" wound and he was hypotensive. He should have either been sent to the hospital or have been reassessed by a medical practitioner with repeat vital signs within a short period of time. The Jail did neither of those things. He then died five days later.

3. Majid Almajid – 23751645

41. The medical records for Mr. Almajid indicate that on May 5, 2024,

staff found him unresponsive and pulseless. Almajid Med. Rcd. at 26, 106. NP Wycoco wrote: "Skin color appeared to be pale to mottled/purplish/cyanotic on his chest, cold" and "arms/lower extremities were stiff, fingernails cyanotic. During the CPR, the arms/fingers stayed on their position." *Id.* at 26. By this description, Mr. Almajid already had rigor mortis and livor mortis indicating he had been dead for some time before he was discovered.

42. Without knowing the autopsy results or the cause of Mr. Almajid's death, I cannot say whether his death was preventable.

43. From my review of his records, however, I can say that the treatment he received for lower back pain fell below the standard of care.

44. Mr. Almajid had his Medical Clearance and Receiving Screening done on December 20, 2023. *Id.* at 12, 14. He reported piriformis syndrome (which causes buttock and posterior hip pain) and sciatica as his medical problems. *Id.* at 17. He reported no substance abuse issues.

45. Mr. Almajid had a 2nd stage nursing evaluation done the next day, December 21, 2023. He again reported sciatica treated with a back brace. Mr. Almajid asked for ibuprofen. *Id.* at 24, 108. This was the last time Mr. Almajid had his vital signs checked. *Id.* at 162.

46. Mr. Almajid was scheduled for a doctor chronic care visit on December 23, 2023, but on the scheduled day, NP Nicholas Kahl did not see him; instead, NP Kahl requested old records and approved "Motrin & Tylenol prn." *Id.* at 24, 25.

- NP Kahl should have seen Mr. Almajid in person. He did not know what Mr. Almajid meant by the term "sciatica." Sciatica is understood in the medical community to mean pain in the hip and leg caused by compression of a nerve root in the spine. But the term "sciatica" is also used by lay people to mean "severe back pain." Either way, this could be a serious medical condition. It is true that having Mr. Almajid's old records would help. But doing a thorough physical examination would

help more and could be done immediately. NP Kahl did not know what was going on with Mr. Almajid without an examination.

- There is no evidence that old records were ever ordered, received, or reviewed. It appears that NP Kahl's order to obtain old records was ignored.

47. On January 3, 2024, Mr. Almajid reportedly refused to have a Health Assessment done. *Id.* at 91. However, only one deputy witnessed the refusal and the refusal to sign the refusal form. *Id.* at 95, 100. The same day, Mr. Almajid wrote a Health Care Request stating "Sciatica pain and discomfort. Please help me. I need to see doctor ASAP." *Id.* at 223. It makes no sense for Mr. Almajid to request to see a doctor "ASAP" and then refuse a medical evaluation. I question the legitimacy of this "refusal." In addition, the Jail appears to have ignored the request, as I see no response to this request in his chart, not even a face-to-face visit with an RN.

48. On January 10, 2024, Mr. Almajid wrote, "My sciatica is getting worse . . . need more pain meds." *Id.* at 255.

49. On January 15, 2024, NP Frederick Wycoco responded to Mr. Almajid's January 10, 2024 sick call slip simply by renewing his ibuprofen. *Id.* at 25. He did not conduct a visit with or examine Mr. Almajid. NP Wycoco should have seen Mr. Almajid face-to-face and done a thorough physical examination. Again, Mr. Almajid had been using the term "sciatica" ever since he was booked. But did he mean that he had documented compression of a nerve root in his spine, or did he just mean severe chronic back pain? NP Wycoco did not know. Nobody had obtained old records. Nobody had done any medical examination of Mr. Almajid. Worsening symptoms due to a compression of a nerve root in the spine can require urgent surgery. And back pain can be a symptom of many serious medical problems, such as cancer, aortic dissection, compression fractures, infections, and more. NP Wycoco could not say that Mr. Almajid did not have any of these serious

problems, because he did not examine him. This was a serious medical mistake.

50. On February 6, 2024, Mr. Almajid wrote a Health Care Request that stated, "I want to be removed from the lower bunk chrono." *Id.* at 226. The Jail scheduled him for a doctor chronic care visit and noted "Pt would like to be removed from lower bunk chrono. Pt with continuous complaints of back pain. Pls review chart." *Id.* at 25.

51. On February 16, 2024, NP Wycoco again failed to meet the standard of care by continuing the lower bunk designation (against Mr. Almajid's request) without conducting a visit with or examining Mr. Almajid. *Id.* at 25.

52. On May 5, 2024, Mr. Almajid died in the Jail, as described above.

53. Collectively, the care provided to Mr. Almajid for his back pain fell below the standard of care. He arrived at the jail complaining of "sciatica," which is a vague medical term that can mean different things to different people. No one ever established what work up had been done prior to incarceration, what diagnosis Mr. Almajid had been given, or what therapies had been prescribed in the past. No one ever conducted a physical examination of Mr. Almajid over the course of 4.5 months despite repeated complaints of worsening and continuous back pain. All of the following are examples of medical mismanagement in his case:

- NP Kahl did no examination of Mr. Almajid on December 23, 2023 to determine what, exactly, was the source of his chronic back pain.
- NP Kahl ordered old records on December 23, 2023, but this order was ignored.
- On January 3, 2024, Mr. Almajid wrote a Health Care Request that said, "Sciatica pain and discomfort. Please help me. I need to see doctor ASAP." This was ignored.
- On January 10, 2024, Mr. Almajid wrote a Health Care Request that said "My sciatica is getting worse." No nurse saw him face-to-face. NP Wycoco did no examination.

- On February 16, 2024, NP Wycoco received notification that Mr. Almajid had "continuous complaints of back pain." Again, NP Wycoco did not see Mr. Almajid to find out what was going on nor did he do a physical examination.
- Mr. Almajid refused to have a Health Assessment on January 3, 2024, as reported by security staff. This is not credible since this is the same day that Mr. Almajid wrote "I need to see doctor ASAP."

B. Newly available documents regarding two other deaths at the Jail reflect serious problems with the care provided at the Jail and the Jail's reporting of in-custody deaths.

54. Below, I provide opinions regarding two additional in-custody deaths. These two deaths, one of which I discussed in my initial report, both reveal extraordinarily serious problems with the medical system in the Jail. I am presenting opinions regarding these deaths now because documents relevant to these deaths have become available since I issued my initial report.

1. Keith Bach – 23739381

55. Mr. Bach died on September 28, 2023. I previously discussed the death of Keith Bach in my initial report in the context of failures of the Jail's morbidity and mortality reviews. Keller Report ¶¶ 108-114. I opined that the death review conducted by NaphCare was deficient for multiple reasons. *Id.* At the time that I issued my initial report (August 21, 2024), the County had not yet completed its investigation into his death and therefore the autopsy report was not available to me. On September 18, 2024, the Coroner for San Diego County released the autopsy report. Thereafter, Plaintiffs provided it to me.

56. The information contained in the coroner's report is shocking. As discussed in more detail below, the coroner's report includes information which establishes that Mr. Bach's death was 100 percent preventable. Even more troublingly, the coroner found that the care that the County provided to Mr. Bach was so deficient that the coroner classified the death as a homicide. Bach Coroner's

Report at PDF 5, 8. I offer no opinion on whether the death was, in fact, a homicide. But, having now reviewed the medical records for Mr. Bach, I fully agree that his death was preventable.

(a) Background Regarding Type 1 Diabetes

57. Mr. Bach died from complications related to his Type 1 diabetes. Type 1 diabetics make no insulin and so, unlike Type 2 diabetics, they need insulin to survive. The Standard of Care for the treatment of Type 1 diabetics is found in Diabetes Management in Detention Facilities: A Statement of the American Diabetic Association.[6] Some of the relevant ADA standards pertinent to Mr. Bach's case are:

- Within 24 hours "[i]ndividuals diagnosed with diabetes should promptly undergo a comprehensive medical history review and physical examination by a health care professional" *Id.* at 545 (Intake Screening).
- Individuals with insulin pumps "should retain uninterrupted access to these tools upon their introduction to the detention system." *Id.* Insulin pumps work by infusing a steady supply of insulin all the time. This is called the "basal" insulin, which Type 1 diabetics need for their basic metabolism, even if they do not eat. Patients with an insulin pump can then trigger the pump to give them additional boluses of insulin every time they eat. This is called "prandial" insulin, meaning insulin needed to metabolize their food.
- If patients are not using an insulin pump, "[p]eople with type 1 diabetes should be treated with a daily injection of long-acting basal insulin plus

[6] Daniel L. Larber et al., *Diabetes Management in Detention Facilities: A Statement of the American Diabetes Association*, 47 Diabetes Care 544 (2024) ("Diabetes in Detention"); American Diabetes Association, *Diabetes Management in Detention Facilities: Position Statement* (2021). The 2024 standards do not differ materially from the 2021 standards as cited in this report.

rapid-acting prandial insulin at mealtimes." *Id.* at 548 (Medications). Type 1 diabetics need long-acting basal insulin even if they do not eat. (Examples of long-acting insulins are Lantus and Semglee. They are usually dosed once a day). The short-acting prandial insulin is only given at mealtimes. The amount of prandial insulin taken by a Type 1 diabetic for each meal varies depending on the amount of carbohydrates in that particular meal. Type 1 diabetics are practiced in calculating the number of carbohydrates in a particular meal and calculating the units of insulin they need to metabolize those carbohydrates. The correct dosage will vary with each meal and will also vary if the patient decides not to eat the entire meal.

- "Insulin omission [in a type 1 diabetic] can lead to severe metabolic decompensation, including DKA [Diabetic Ketoacidosis]." *Id.* at 545 (Intake Screening).

(b) Summary of Medical Care

58. Mr. Bach was booked into the Jail on September 26, 2023 after two trips to the ER to be assessed for hyperglycemia and syncope. His receiving screen was done at 3:12 a.m. SD_711406.

59. A remote STATCare NP, Katherine O'Neal, did Mr. Bach's STATCare Intake Assessment and Orders at 3:49 a.m. She was informed that Mr. Bach had a continuous Glucose Monitor (CGM), an insulin pump and that his blood sugar was 123. SD_711423. NP O'Neal ordered "continue insulin pump for now." SD_711424. NP O'Neal also wrote an addendum at 4:10 a.m. that stated "Pt. reports his current meds via insulin pump be consumed tomorrow morning around 8:00 AM." SD_711480. The Medical Examiner interprets this to mean that the pump would be empty on September 27, 2023 at 8:00 a.m., but it makes more sense to me if the pump was empty much earlier than this. I believe Mr. Bach meant that his insulin pump would be empty that upcoming morning, September 26, 2023.

60. On September 26, 2023, at 12:42 p.m., NP Nicholas Kahl visited with Mr. Bach "in Holding Cell." Mr. Bach requested 12 units of insulin prior to lunch. If Mr. Bach's insulin pump was full, he could have dosed himself with the 12 units of insulin. Since he asked NP Kahl for insulin, either the pump was already empty or nearly so. NP Kahl also wrote "records reviewed confirms pt on insulin pump." SD_711487. However, if NP Kahl had asked Mr. Bach about his insulin pump instead of looking at the medical records, Mr. Bach could have told him the same thing he told others, that his pump was almost empty. NP Kahl ordered "Novolin R (a short acting insulin)10 units with each meal." SD_711488. How NP Kahl chose this dose is puzzling to me. It is totally inappropriate for a Type 1 Diabetic, since the prandial dose should vary with each meal depending on the amount of carbohydrates in that meal and how many of the carbohydrates are eaten.

61. Instead, NP Kahl should have done one of two things. He should have refilled Mr. Bach's insulin pump with insulin (which Mr. Bach could then have used to manage his own diabetes without having to ask the nurses for insulin) or he should have converted Mr. Bach to "a daily injection of long-acting basal insulin plus rapid-acting prandial insulin at mealtimes." Diabetes in Detention at 548. He did neither. NP Kahl did schedule Mr. Bach for an MDCC (Medical Doctor Chronic Care) visit the next day. SD_711488. This visit never occurred.

62. On September 26, 2023 at 6:53 p.m., Ana Gonzalez RN wrote "Blood sugar checked at 1305. Blood sugar was 128 mg/dl. Withheld insulin. NP notified." *Id.* This decision, to withhold insulin based on a blood sugar of 123, makes no sense for a Type 1 Diabetic like Mr. Bach. Type 1 diabetics need short acting insulin boluses when they eat based on the amount of carbohydrates in that meal. Type 1 diabetic patients need short acting insulin to cover their meals even if their blood sugar is in the normal range. As I discussed in my initial report, the Jail does not have any Disease Management Guideline for Type 1 Diabetes that a nurse or a NP could refer to in order to understand how to treat a Type 1 Diabetic.

63. On September 27, 2023, at 12:42 a.m., RN Gemechu Bulti wrote "Current BS is 322 mg/dl. Patient refused the scheduled dose of 10 units of regular insulin and is requesting 20 units instead. Statcare alert sent." *Id.* The most likely reason that Mr. Bach's blood sugar spiked so dramatically at this time was that his insulin pump was empty and no longer delivering any basal insulin.

64. NP O'Neal answered this alert at 1:37 a.m. NP O'Neal wrote "[n]oted patient continues to have insulin pump and checks blood sugars 8 times a day." SD_711427. However, this cannot be true. Mr. Bach's insulin pump must have been empty or close to empty at this time, otherwise, he could have bolused himself with insulin in his pump and would not have needed to ask the nurse for insulin. NP O'Neal refused Mr. Bach's request for 20 units and authorized only 10 instead. *Id.*

65. RN Bulti gave Mr. Bach those 10 units at 1:51 a.m. *Id.*; SD_711393. That was the last dose of insulin Mr. Bach received prior to his death.

66. On September 28, 2023 at 4:54 a.m., LVN Evangeline Pedrozo wrote that Mr. Bach refused all his medications. There are actually three refusal forms in Mr. Bach's medical record. On September 27, 2023 at 11:34 p.m., Mr. Bach reportedly refused to take the medication atorvastatin and also refused to sign the refusal form as witnessed by two deputies. SD_711481. On September 28, 2023 at 1:34 a.m., Mr. Bach reportedly refused to allow his blood sugar to be checked and also refused to sign the refusal form as witnessed by two deputies. SD_711484. On September 28, 2023 at 4:48 a.m., Mr. Bach reportedly refused to take multiple medications and also refused to sign the refusal form as witnessed by two deputies. SD_711485.

67. These refusal forms are extremely suspicious. This last refusal form at 4:48 a.m. was timestamped forty minutes after Mr. Bach had been declared dead at 4:09 a.m. Bach Coroner's Report at PDF 3. It therefore is very likely (if not certain) that the deputies completed this refusal form without actually witnessing Mr. Bach refuse care. The other two refusals from earlier in the night are also

suspicious. During the very period that the first two refusals allegedly occurred, "[a]ccording to sheriff's investigation, he (Mr. Bach) was reported to have asked multiple deputies on numerous occasions for insulin. During mealtimes, Mr. Bach gave his food to fellow inmates, as he did not want to eat if he did not have access to insulin. Additionally, other inmates were attempting to assist Mr. Bach in requesting insulin by pointing out to deputies that the alarm on Mr. Bach's insulin pump was sounding and that the pump was empty." Bach Coroner's Report at PDF 7. I therefore find that these refusal forms are not credible because it is unlikely that Mr. Bach was attempting to get medical attention but also refusing his medications.

68. On September 28, 2023 at 3:40 a.m., Mr. Bach was found unresponsive, not breathing and with no pulse. *Id.* at PDF 3. CPR and ACLS resuscitation were attempted but Mr. Bach was pronounced dead at the scene at 4:09 a.m. *Id.*

69. An autopsy was performed on September 28, 2023 by Melanie Estrella, DO, Deputy Medical Examiner. *Id.* at PDF 2-4. Nearly a year later, Dr. Estrella concluded in the autopsy report that the cause of Mr. Bach's death was "Diabetic Ketoacidosis" and the Manner of Death was "Homicide." *Id.*at PDF 5, 8.

(c) Opinions

70. In my opinion, Mr. Bach's death was preventable. Medical staff violated the ADA standards of care for the treatment of Type 1 Diabetes on several occasions.

71. Mr. Bach never received "comprehensive medical history review and physical examination by a health care professional." NP Kahl did see him in his holding cell the day he was booked, but did not obtain or document a comprehensive medical history and did not perform a comprehensive physical examination. Most of the medical decision-making done in the case of Mr. Bach was done by a remote STATCare NP, who also did not perform a comprehensive

medical history review and, of course, did not perform an examination of Mr. Bach.

72. Mr. Bach was not allowed "uninterrupted access" to his insulin pump. He informed the medical staff that his insulin pump was low and would soon run out of insulin. According to the Medical Examiner, he repeatedly attempted to notify staff of his need for insulin, with no success. The correct response would have been to refill the pump with insulin. This would have been easy to do. Since it was not done, the insulin pump ran out of insulin sometime before his blood sugar was measured at 322 mg/dl. The pump running out of insulin was the most likely explanation of why Mr. Bach's blood sugar spiked so dramatically.

73. If the Jail medical practitioners intended to transition Mr. Bach off of his insulin pump and prescribe instead "a daily injection of long-acting basal insulin plus rapid-acting prandial insulin at mealtimes," the correct course of action would have been to do this: Ask Mr. Bach how much total insulin he gave himself using the insulin pump each day, on average. Half of this total daily dose should be given as long-acting insulin. The other half is given as short-acting prandial insulin divided between three meals. However, neither the STATCare NP nor NP Kahl at the Jail made any attempt to do this.

74. Besides allowing Mr. Bach's basal insulin need to go unmet, the Jail practitioners also underdosed his prandial insulin needs. We know this because Mr. Bach asked for more short-acting prandial insulin on two occasions. The most important of these was when he asked for 20 units of insulin in the early morning hours of September 27, 2023. There was no reason to refuse this request. Mr. Bach had historically done an excellent job of managing his own diabetes (Bach Coroner's Report at 6), which the Jail practitioners would have known had they obtained a "comprehensive medical history." The other occasion when short-acting prandial insulin was inappropriately withheld was on September 26, 2023, when RN Gonzalez did not give Mr. Bach his scheduled dose of 10 units because his blood sugar was 128 mg/dl. But Type 1 diabetics need their prandial insulin to metabolize

their meals even if their blood sugar is normal.

75. These missteps by the Jail—allowing Mr. Bach's insulin pump to go dry, not giving him any long-acting basal insulin, and underdosing his prandial insulin needs—resulted in "insulin omission" which led to "severe metabolic decompensation, including" diabetic ketoacidosis. Diabetes in Detention at 545. In Mr. Bach's case, the diabetic ketoacidosis resulted in his death. Bach Coroner's Report at 4.

76. In my opinion, an important factor that contributed to Mr. Bach's death was the fact that the Jail did not have any Disease Management Guideline for the treatment of Type 1 Diabetes. Had they had such a guideline, the Jail practitioners and the Jail nurses might have known how to appropriately manage Type 1 Diabetes and not made the many mistakes that resulted in Mr. Bach's death.

77. Had Mr. Bach received medical treatment conforming to the ADA Standards, he, more likely than not, would not have died.

78. In my opinion, the Jail medical practitioners showed gross incompetence in the care of Mr. Bach and violated the medical standard of care. Crucially, as confirmed by the coroner, their failures caused Mr. Bach's death:

> Review of outpatient medical records clearly indicates that Mr. Bach had demonstrable knowledge in managing his diabetes; however, as an inmate, he became reliant on the medical services provided by the jail for continued management of his condition. Following insufficient insulin administration while in custody, Mr. Bach developed diabetic ketoacidosis and died. This occurred despite medical records containing documentation of his medical condition, insulin requirements, when his pump would be depleted of insulin, and multiple unanswered requests for insulin by Mr. Bach and fellow inmates. The death is due to complications of a natural disease. However considering the inaction (i.e., neglect) characterizing the events leading to inadequate care while incarcerated of Mr. Bach's health conditions and ultimately his death, the manner of death is classified as **homicide**.

Bach Coroner's Report at PDF 8.

79. Though I express no opinion on whether his death was, in fact, a homicide, I agree with the coroner's description regarding how the deficiencies in

care caused Mr. Bach's death. Mr. Bach had a common medical condition. Had he received minimally adequate care—namely, being provided with insulin—he likely would not have died. No person in a correctional setting who is willing to comply with care and to accept insulin should ever die from diabetic ketoacidosis. That Mr. Bach died, despite his efforts to notify medical staff of his need for insulin, is shocking. In my opinion, any system in which such a death occurred suffers from serious, systemic problems that put incarcerated people at a substantial risk of serious harm.

80. In addition, the new information contained in the coroner's report makes the problems with the morbidity and mortality reporting for Mr. Bach's death, which I discussed in my initial report, even more concerning. *See* Keller Report ¶¶ 108-114. Following Mr. Bach's death, the NaphCare M&M Committee wrote: "Though not related to this patient's death, it has come to the committee's attention that specific policies on management of insulin pumps need to be established by San Diego County and communicated to STATCare, so they can be prepared to address patients with these medical devices." NAPHCARE041858. First, it is very troubling that the NaphCare M&M Committee, which should be looking critically at all in-custody deaths in order to identify where staff made mistakes (if any), concluded that Mr. Bach's death was not related to the management of his insulin pump. The coroner found the exact opposite. This failing of the M&M Committee suggests that it did not conduct a thorough investigation. Second, given the direct connection between the lack of chronic care guidelines for Type 1 diabetes and Mr. Bach's death, the Jail should have created such guidelines on an urgent basis. Yet, as of the date of Dr. Murray's report (August 21, 2024), nearly a year after Mr. Bach's death, the Jail still did not have in place any chronic care or disease guidelines. The County's failure in this respect suggest that it does not take seriously its obligation to care for incarcerated people.

/ / /

2. Jose Cervantes Conejo

81. I have also been provided with the outside medical records for Mr. Cervantes Conejo, who died at Palomar Medical Center on April 12, 2024 from facial and head trauma he experienced at the Jail approximately three hours after he was booked on March 29, 2024.[7] These records were not available to me prior to the issuance of my initial report. From the medical records provided to me, which do not include Mr. Cervantes Conejo's Jail medical records, it is not possible for me to opine regarding whether Mr. Cervantes Conejo's death was preventable.

82. What is notable about Mr. Cervantes Conejo's death, however, is that it is not included on the SDSO website listing in-custody deaths. *See* https://www.sdsheriff.gov/resources/transparency-reports (accessed on October 27, 2024). The website lists seven in-custody deaths in SDSO facilities in 2024, but does not list Mr. Cervantes Conejo's death.

83. The fact that Mr. Cervantes Conejo's death is not listed as an in-custody death is troubling and throws into question the Jail's reporting on in-custody deaths, an issue central to the *Dunsmore* lawsuit. Mr. Cervantes Conejo died from injuries he suffered at the Jail while he was in the custody of the SDSO. The federal Death in Custody Reporting Act, 34 U.S.C. § 60105, requires states to report to the U.S. Attorney General, "information regarding the death of any person who is detained, under arrest, or is in the process of being arrested, ... or is incarcerated at a municipal or county jail ...." The Bureau of Justice Assistance of the U.S. Department of Justice has published a document entitled "Death in Custody

---

[7] *See, e.g.*, Cervantes Conejo Government Claim at PDF 62 ("Patient is a 44-year-old male brought from Vista jail where he was intoxicated and subsequently noticed on the ground with several episodes of nausea and vomiting."); *id.* at PDF 80 ("[Patient] presents to the ED as a trauma code activation from jail for evaluation of head injury with vomiting and altered mental status. Per EMS, patient was intoxicated in his jail cell after being arrested. He was reportedly verbal and responsive upon arrest. Three hours into his arrest, police found the patient on the floor with altered mental status and was vomiting, prompting them to activate EMS.").

Reporting Act: Reporting Guidance and Frequently Asked Questions," which was revised in October 2024 and is available at https://bja.ojp.gov/funding/performance-measures/DCRA-Reporting-Guidance-FAQs.pdf. The Guidance includes the following frequently asked question: "If an inmate is transferred to a medical facility and dies there, not in a correctional facility, is that reportable? Yes. If the incarcerated person, absent the medical condition, would have been in prison at the time of death, it counts as a reportable death. Although the person was not physically in a correctional facility at the time of death, the death is still one of an incarcerated individual." *Id.* at 7. Accordingly, Mr. Cervantes Conejo's death should be considered an in-custody death.

84. The County's failure to count Mr. Cervantes Conejo's death as an in-custody death is problematic in a number of respects. First, it raises the question of whether the County has failed to count other in-custody deaths when people were injured or became ill at the Jail but did not die in the Jail. Second, Dr. Murray opines that the death rate at the Jail is trending in the right direction in 2024. But that rate would be higher if Mr. Cervantes Conejo's death was included in the count of in-custody deaths.

85. I also have some concerns about the care that Mr. Cervantes Conejo received at the Jail in the few hours he was there. Labs at the ER showed Mr. Cervantes Conejo's blood alcohol to be very high, at 324 mg/dL. Cervantes Conejo Government Claim at PDF 109. Imaging showed a skull fracture, an orbital fracture, and both subarachnoid hemorrhage and subdural hemorrhages around the brain. This was described as a "high complexity comprehensive trauma." *Id.* at 63.

86. Mr. Cervantes Conejo was admitted to the ICU. Several specialists consulted on his care, including a trauma surgeon, a neurosurgeon, intensive care specialist, and later, a palliative care specialist. *Id.* at 65, 66.

87. Despite intensive medical care, Mr. Cervantes Conejo died on April 12, 2024. The Summary of his hospital care included this statement: "[p]er trauma and

neurosurgery assessment and documentation the extent of injury is not compatible with a simple fall and seemed more traumatic however the events leading to it are unclear" *Id.* at 65, 66.

88. Mr. Cervantes Conejo's medical records from the hospital also raise serious questions about why the Jail accepted him in the first place. Mr. Cervantes Conejo had a very high blood alcohol level (324 mg/dL) when he arrived at the hospital. *Id.* at 109. Blood alcohol levels that high typically indicate that a person may have alcohol poisoning, which is a potentially life-threatening condition. Notably, Mr. Cervantes Conejo's blood alcohol level was likely even higher at the time he was booked into the Jail, as his body processed some of the alcohol in his system in the time between when he was booked and when hospital staff drew his blood to run the test three hours later. Nursing staff at the Jail also informed the hospital staff that Mr. Cervantes Conejo was "disoriented" when he was booked into the Jail. *Id.* at 98. Given this information, it seems to me that the Jail should have refused to accept Mr. Cervantes Conejo and transferred him immediately to the hospital. Had the Jail done so, he may not have suffered the injuries that appear to have caused his death.

IV. Dr. Murray's opinions regarding the death rate at the Jail are misleading and unsupported by evidence.

89. On February 3, 2022, the California State Auditor issued a report of its investigation into the alarming number of deaths that occurred in the Jail from 2006 to 2020. State Auditor's Report. The State Auditor's Report confirmed that the Jail had a higher rate of suicides and natural deaths (which can include deaths where deficient medical care is a factor) than jails in any other comparable county in California. SD_174812-13. The average death rate at the Jail in those years was 2.39 deaths per 1,000 incarcerated persons. SD_174856.

90. Dr. Murray correctly points out that "[i]n 2022, the San Diego County Citizen's Law Enforcement Review Board ('CLERB') contracted with Analytica

Consulting ... to analyze in-custody death data over the prior ten years." Murray Report at 38. Dr. Murray does not discuss the findings of the Analytica report, which corroborated the State Auditor's Report. The findings of the report included that "total deaths in San Diego Jails surpass the deaths expected based on the county's mortality rates," DUNSMORE0116321; that "[t]he number of excess deaths resulting from the actual and expected death difference is the highest in San Diego County" than any other comparable county in California, *id.*; and that "San Diego County is the only county with a statistically significant number of excess deaths," DUNSMORE0116322.

91. Dr. Murray suggests that the findings of the Analytica report may not be accurate because of "some significant potential confounders." Murray Report at 39. Nothing in Dr. Murray's description of his educational and professional background or his CV suggests that he has the expertise to analyze a complex data analysis like the one performed by Analytica. Even assuming he had that expertise, Dr. Murray's short criticisms of the Analytica study make little sense and/or have no basis.

92. First, Dr. Murray states that "[i]t is not clear whether mortality was captured and assessed in a consistent way across all compared county jail systems." *Id.* at 39. The report, however, makes clear that the authors relied on data collected by the California Board of State and Community Corrections ("BSCC") and the California Department of Justice. DUNSMORE0116325, 116331. Dr. Murray has not identified any specific issues with the data collection. His criticism is therefore nothing more than conjecture.

93. Second, Dr. Murray writes that "[i]t is not clear whether county jail population denominators were captured in a consistent way across all systems." Murray Report at 39. Dr. Murray does not identify to what "denominators" he is referring. And again, Dr. Murray's criticism is nothing more than conjecture, as he has not presented any evidence to support that the data was reported or collected

inconsistently across counties.

94. Third, Dr. Murray writes that "[i]t is not clear if expected rates for each county jail (based on the county-wide mortality rates) were generated by applying the age, race, gender structure of each county jail population." *Id.* at 39. But it appears that the Analytica authors did exactly that. DUNSMORE0116331, 116339.

95. Fourth, Dr. Murray writes that "[a]s the investigators note, data on physical health, mental health, substance use disorder, homelessness were not available. It is possible that an increased differential (on any of these factors) between the San Diego County jail and the San Diego general population could have partially driven the increased excess deaths observed in San Diego County jail population." Murray Report at 39. Dr. Murray is correct that the Analytica authors acknowledge these limitations. DUNSMORE0116339. But Dr. Murray has not provided any evidence to suggest that those limitations actually impacted the results of the study. Moreover, those limitations existed for all of the counties that Analytica evaluated.

96. Lastly, Dr. Murray writes that "[i]n general, it is not clear whether the observed excess deaths in the San Diego County jail system reflect a selection process that resulted in a greater contrast in baseline poor health between the county jail and the general population (compared to the other counties examined) or were related to correctional health care." Murray Report at 39. This criticism is accurate, but misses the point and is not supported by any evidence. The authors of the study concede that they were not attempting to explain why there were disparities among counties. DUNSMORE0116339 ("While our research has delineated the differences in deaths among county jails, we have yet to explain *why* they are different."). It is therefore possible, as I interpret Dr. Murray as suggesting, that the jail population in San Diego County has a worse level of baseline health, compared to the population in the community, than the jail populations in other counties. But again, Dr. Murray has not presented any evidence to support his conjecture.

97. In my opinion, none of Dr. Murray's criticisms of the Analytica study undermine its conclusion that San Diego County was the only large county in California where the deaths in the jail exceeded expected deaths by a statistically significant amount.

98. Later in his report, Dr. Murray writes that "[i]n-custody deaths reached a high in 2022 with 19 deaths as SDSO was emerging from the COVID-19 pandemic and have been declining since that time." Murray Report at 40. This statement is misleading. Though deaths in the Jail have declined in 2022 and 2023, they remain at extremely high levels. As discussed above, the California State Auditor found that the Jail's death rate for 2006-2020 of 2.39 per 1,000 incarcerated people was very high. SD_174856. The death rates in the subsequent years have greatly exceeded that average: 4.5 deaths per 1,000 in 2021; 4.75 deaths per 1,000 in 2022; and 3.27 deaths per 1,000 in 2023. Keller Report ¶ 88. Dr. Murray discusses only the trend, not the quantity, which remains high.

99. Dr. Murray also neglects to mention that the State Auditor's Report did not just examine the death rate. The Auditor also reviewed 30 in-custody deaths, with an emphasis on cases that occurred between 2016 and 2020. SD_174815. It concluded that "deficiencies with how the Sheriff's Department provides care for and protects incarcerated individuals" had "likely contributed to in-custody deaths" and that the SDSO had "not consistently taken meaningful action when such deaths have occurred." SD_174794. Accordingly, I disagree with Dr. Murray's opinion that the death rate in the Jail (a) has not been calculated correctly and (b) does not reflect problems with the healthcare system.

V. The audit of chronic care that Dr. Murray's team performed is methodologically and substantively flawed.

100. Dr. Murray's team reviewed 81 medical records for incarcerated people "with chronic care conditions ... to assess the quality of care being provided and to determine if the standard of care was met." Murray Report at 14-15. From this

review, Dr. Murray concluded that "[o]verall, there was evidence of high-quality care being provided to the IPs in the SDSO." *Id.* at 15. He further concluded that "[p]rovider chronic care was timely and consistent with a community standard of care." *Id.* at 44.

101. I did not receive the complete set of the 81 records reviewed by Dr. Murray until September 21, 2024. They were quite voluminous and I began reviewing them immediately. The medical files I reviewed averaged many hundreds of pages long and some files were over a thousand pages. On average, each file required at least half a day of work to review and write up my analysis. I had hoped to receive these records directly in TechCare, which I believe would have been more efficient, but was informed I could not have access. Under the circumstances, given the November 1, 2024, deadline for rebuttal reports, I was able to review 19 of the records. As described below, this was sufficient to conclude that Dr. Murray's opinions are flawed.

102. In my opinion, Dr. Murray's medical record review of the care provided to patients with chronic illnesses, who are the sickest and most difficult to treat in the Jail, is at the center of his report. As I explain below, Dr. Murray's purported audit suffers from serious methodological problems. Moreover, I disagree substantively with the findings of the review that the care provided to 75 of 81 class members (93%) met the standard of care. Murray Report at 15 & Appendix J. I therefore also disagree with Dr. Murray's overarching conclusions about the quality of the chronic care at the Jail. *Id.* at 15, 44.

103. Dr. Murray presents the findings from the review of each of the 81 records in Appendix J. Dr. Murray does not appear to have reviewed the medical files himself; each file includes the name for a "Reviewer" followed by the one of five names: Stephen Boone, MD. (Patients 1-25); Erin Freeman, PA-C (Patients 26-44); Jennifer Humphreys, FNP (Patients 45-46); Jane Leonardson, MD (Patients 47-60); and John Pulvino, PA (Patients 61-81). *See Id.* at 164-224. For each file, the

reviewer indicated whether the care provided by the County "Meets Standard of Care," "Does Not Meet Standard of Care," or "Meets Standard of Care – with some reservations."

104. Even before I reviewed some of the 81 medical files, I had concerns regarding the quality of the reviews conducted by the reviewers.

105. First, Dr. Murray did not share the qualifications for the five reviewers who conducted the audit. It is therefore not apparent that they are generally qualified to determine whether the care provided to a patient met the standard of care or specifically qualified to offer such opinions regarding care provided in a correctional environment.

106. Second, Dr. Murray did not indicate how the 81 files were selected or by whom or with what criteria.

107. Third, it is not clear in all cases what "standard of care" the reviewers used when evaluating the care. Though some reviewers did include that information for some patients, *see, e.g.*, Patients 30, 31, most of the reviewers did not include reference to any specific standards of care. The absence of reference to specific standards of care is problematic in at least two respects. First, the conclusions of the reviewers are not tethered to a documented standard of care and therefore are liable to vary from person to person. Also, practitioners who are poorly educated or who have not kept up with changes in medical knowledge may provide care outside of recognized appropriate boundaries. For example, for my report, the Standard of Care for Type 2 Diabetes that I used was *Diabetes Management in Detention Facilities: A Statement of the American Diabetes Association* (referred to elsewhere as "Diabetes in Detention"). None of the reviewers stated what standard for diabetic management they were using. Second, if the reviewers were not using agreed-upon, documented standards of care for their reviews, it becomes more likely that different reviewers would reach different conclusions regarding the care provided to the same patient.

108. Fourth, since the SDSO does not have Disease Management Guidelines or Chronic Care templates, *see* Murray Report at 15; Keller Report ¶¶ 501-505, the reviewers could not determine whether the County followed its own policies for providing chronic care, as there were no policies to follow. In my report, I explained why such policies are critical in a correctional environment.

109. Sixth, it is not clear to me that Dr. Murray's reviewers understand the policies and processes for providing medical care at the Jail. Accordingly, it is not clear that they evaluated whether the care the Jail provided was consistent with the Jail's policies and processes.

110. Beyond these methodological problems, I found significant issues with Dr. Murray's reviewers' substantive conclusions regarding whether the care the Jail provided to class members met the standard of care. I reviewed 19 of the 81 files which, in my opinion, was a sufficient sample to draw conclusions regarding the remaining reviews. I used the following process to select the files for review. First, at the time that Dr. Murray submitted his report on August 21, 2024, I already had partial medical files for [redacted] and [redacted] that covered their treatment through [redacted] 2023, so I reviewed those two files first. After Defendants produced the 81 files to Plaintiffs, I first reviewed updated records for Mr. [redacted] and Mr. [redacted] that extended through [redacted] 2024. I then randomly selected one of the two files reviewed by Jennifer Humphreys, FNP (Patients 45-46). I then selected 4 files for each of the other 4 reviewers, using a random number generator to determine which of the specific files I would review.

111. My review of the medical files confirmed my pre-review concerns and revealed other serious problems. In Appendix A, I have provided detailed analysis of the 19 medical records I reviewed.

112. First, for nearly all of the files I reviewed, I disagreed with the ultimate conclusion drawn by Dr. Murray's reviewers. The reviewers concluded that the care

the Jail provided met the standard of care for 18 of the class members.[8] I only agreed with Dr. Murray's reviewers with respect to the care provided to 2 of those class members. For the other 16 class members, I concluded that the care provided by the Jail did not meet the standard of care.

113. These failures by the County to meet the standard of care are very concerning. In some instances, they resulted in harm to incarcerated people. The most egregious of these cases include:

- [redacted] – When he was booked into the Jail, he was in the middle of a prostate cancer work up. The Jail failed to provide continuity of care for this critical evaluation for a potentially deadly disease.
- [redacted] – The Jail denied him, for months, an essential gastrointestinal medication prescribed by a specialist, despite Mr. [redacted] protests and deterioration of his condition.
- [redacted] – At intake, the Jail failed to continue 2 out of 3 diabetes medications, which caused Mr. [redacted] diabetic control to deteriorate immediately. Moreover, the Jail never provided appropriate treatment to Mr. [redacted] for diabetes. And the Jail made a serious medical error in judgment when it failed to send him to the hospital, after an incident when he passed out and was incontinent.
- [redacted] – The Jail failed to treat appropriately and bring under control his diabetes and hypertension.

My detailed reviews of the medical files for these individuals are in Appendix A.

114. Even the cases where the failures did not result in tangible, immediate harm to class member reflect serious problems with the system. Standards of care exist to ensure that medical professionals provide appropriate treatment to patients

[8] For one of these class members, [redacted] the reviewer concluded that the care provided by the Jail met the standa c with some reservations." *See* Murray Report at 209.

and do not expose their patients to unnecessary risk. A system that consistently provides care to patients that falls below the standard of care, like the Jail's system, necessarily exposes those patients to a substantial risk of serious harm. Not every failure to meet the standard will result in harm. But each failure presents a real risk. Accordingly, it is my opinion that the medical records that Dr. Murray's reviewers reviewed reflect a system that places patients at a substantial risk of serious harm.

115. Second, the reviews conducted by Dr. Murray's reviewers were generally of poor quality, were superficial, and often contained factual errors. *See, e.g.*, Appendix A, [redacted] (reviewer indicated that a practitioner performed an intake physical when actually an RN performed the physical, which was then countersigned by a doctor); Appendix A, [redacted] (reviewer indicated that an ultrasound was performed to address a hernia, when it was actually to evaluate gall stones, and that the ultrasound was normal even though the ultrasound report is not in the medical file and the results are not discussed anywhere in the record); Appendix A, [redacted] (reviewer indicated that doctor changed prescription from metformin to glipizide at the class member's request, but the class member was actually requesting to be placed on a different drug (Mounjaro)); Appendix A, [redacted] (reviewer indicated that class member refused an appointment when record showed the class member did not refuse, but was at work).

116. Third, because I randomly selected which files to review, it is likely that the same problems I identified—reviewers finding that the standard of care was met when it was not, conducting superficial reviews, and making factual errors—exist in many of the files I did not review. It is therefore my opinion that the chronic care audit that Dr. Murray included in his report—in which his reviewers concluded that the care the Jail provided met the standard of care in 93% of the cases—is unreliable. It is therefore also my opinion that any conclusions that Dr. Murray drew from the chronic care audit are also unreliable.

117. Fourth, in reviewing the medical files, I identified problems with care

that were consistent with my findings offered in my initial report. Accordingly, these medical files provide additional evidence of the serious problems with medical care at the Jail. Specifically, the medical files revealed problems with:

- Failures to continue medications class members were taking in the community – *See* Appendix A, [redacted] (diabetes medications); [redacted] (same); Wilson (asthma medication); [redacted] (GERD medication). *See also* Keller Report ¶¶ 285-303. In nearly all of these cases, the Jail removed the class member from a medication he was taking in the community because it was not on the NaphCare formulary and then prescribed a less effective medication.
- Failures to continue treatments that class members were receiving in the community – *See* Appendix A, [redacted] (treatment for retinal disease, MRI for prostate cancer, colonoscopy); [redacted] (referred to gastrointestinal specialist for treatment of GERD but was never seen over many months). *See also* Keller Report ¶¶ 304-312.
- Failures of the sick call process to address class members' medical concerns – *See* Appendix A, [redacted] (no response to request for C-PAP or, in alternative, sleep study for sleep apnea); [redacted] (substantial delays in responding to health requests). *See also* Keller Report ¶¶ 319-367.
- Alleged refusals of care, including refusals being witnessed only by custody staff and inadequate counseling of class members regarding the risks of refusals – *See* Appendix A, [redacted] *See also* Keller Report ¶¶ 387-415.
- Failures to conduct any or an adequate physical examinations of patients when necessary to provide them with appropriate treatment, including instances where no examination occurred because STATCare practitioners were providing care remotely – *See* Appendix A,

[redacted] *See also* Keller Report ¶¶ 416-417, 433, 442-47, 541-42, 546-47.

- Nurses providing care outside of their scope of practice – *See* Appendix A, [redacted] *See also* Keller Report ¶¶ 448-451.
- Failures to conduct diagnostic testing or to review the results of diagnostic testing – *See* Appendix A, [redacted] *See also* Keller Report ¶¶ 486-497.
- Non-existent or incomplete discharge planning – *See* Appendix A, [redacted] *See also* Keller Report ¶¶ 732-761.
- Inadequate custody staffing interfering with medical care – *See* Appendix A, [redacted] *See also* Keller Report ¶¶ 659-664.
- Failures to perform Health Assessments within 14 days of booking and after a year in the Jail – *See* Appendix A, [redacted]. *See also* Keller Report ¶¶ 261-284.
- Lack of confidentiality in medical visits – *See* Appendix A, [redacted] *See also* Keller Report ¶¶ 665-686.
- Failures to gather vitals signs at visits, including visits for hypertension – *See* Appendix A, [redacted]; [redacted] *See also* Keller Report ¶¶ 416-417, 443-44.
- Failures to conduct a face-to-face interview with a class member within 48 hours of submission of a health care request. *See* Appendix A, [redacted] *See also* Keller Report ¶¶ 342-354.
- Failures to provide appropriate follow-up care/chronic care – *See* Appendix A, [redacted] (no follow up care to determine whether leg swelling resolved with change of medication); [redacted] (no chronic care for hypertension, diabetes over 1.5 years; no follow up A1C every 3 months); [redacted] (no chronic care or repeat labs for seizures); [redacted] (no follow-up A1C; no referral for dilated retinal exam); [redacted]

(referred to be seen by a gastrointestinal specialist in [redacted] 2023, but still had not been seen by the end of the medical record in [redacted] 2024). *See also* Keller Report ¶¶ 709-731.

118. In his report, Dr. Murray opined that in the cases where his reviewers found the Jail had not met the standard of care, "there were minor deviations from the standard of care." Murray Report at 15. I disagree with this opinion from Dr. Murray. The failures I noted above are serious problems, not "minor deviations from the standard of care."

119. The medical files also reflected serious substantive problems with the care that the Jail provides to class members for many common chronic conditions, including:

- Hypertension – *See* Appendix A, [redacted]; *See also* Keller Report ¶¶ 181, 235.
- Diabetes – *See* Appendix A, [redacted]. *See also* Keller Report ¶¶ 526-551.
- Hernias – *See* Appendix A, [redacted] *See also* Keller Report ¶¶ 552-579.
- Asthma – *See* Appendix A, [redacted]; [redacted] *See also* Keller Report ¶¶ 613-630.
- Hepatitis-C screening – *See* Appendix A, [redacted] *See also* Keller Report ¶¶ 507-525.

120. My detailed findings with respect to my review of the 19 medical files I reviewed are contained in Appendix A to this report.

121. In sum, it is my opinion that the medical files I reviewed serve as strong evidence (in addition to evidence cited elsewhere in this report and in my initial report) that, on a systemic basis, the Jail exposes class members with chronic conditions to a substantial risk of serious harm.

VI. Dr. Murray's audit of intake and Health Assessments is methodologically and substantively flawed.

122. In his report, Dr. Murray opined:

> The intake screening process of newly incarcerated individuals upon arrival to a correctional facility holds significant importance in both clinical and operational contexts. This initial assessment serves as a critical opportunity to gather essential information about the incarcerated individual's medical history, mental health status, and any immediate healthcare needs. It allows healthcare providers to identify and address acute medical conditions or emergencies promptly, ensuring the safety and well-being of the incarcerated population as well as that of the staff. Moreover, intake screenings provide valuable insights into chronic health conditions, substance use disorders, and infectious diseases that may require ongoing management or treatment within the correctional facility. Beyond medical considerations, these assessments also play a pivotal role in identifying mental health issues such as depression, anxiety, and or suicidal ideation, which require specialized care and intervention. By conducting thorough intake screenings, correctional healthcare providers can establish a baseline for each incarcerated individual's health status, initiate appropriate plans of care, and facilitate continuity of care throughout their incarceration. This proactive approach not only supports the health and safety of incarcerated individuals but also contributes to the overall management and efficiency of the healthcare delivery system within the correctional setting.

Murray Report at 9. I agree with Dr. Murray about the critical importance of an adequate medical intake process at a jail.

123. To evaluate the intake process at the Jail, Dr. Murray's team audited 75 patient charts to determine the time from booking to intake screening, whether patients were "appropriately referred and subsequent evaluations [were] completed," whether "Chronic care/critical meds [were] identified on screening and continued," and whether the Health Assessment was performed within 14 days. *Id.* at 11-12 & Appendices G, I. Results are given in a yes/no table with no explanations.

124. Dr. Murray's audit is methodologically deficient in a number of respects.

125. First, Dr. Murray did not provide any definition for how he determined whether a patient was, at intake, "appropriately referred and subsequent evaluations completed."

126. Second, he similarly did not provide a definition for how he determined "whether Chronic care/critical meds identified on screening and continued." For example, would he consider a medication appropriately continued if, as the County frequently does, a STATCare midlevel practitioner substitutes formulary medications for non-formulary medications without an examination or discussion with the patient? This is not, in my opinion, an appropriate process. I identified cases in my report where non-formulary medications were inappropriately withheld pending approval through the non-formulary review process. Keller Report ¶ 154 (discussing death of Raymond Dix). I identified in my report cases where inappropriate substitutions of medications were made at booking, including the case of [redacted] where sliding scale insulin was inappropriately substituted for the non-formulary medication Mounjaro. Keller Report ¶¶ 302, 543-45; *see also* Section V, *supra*.

127. Third, all of the charts reviewed by Dr. Murray for Appendix G (intake) appear to be for people who were booked into the Jail on January 1, 2024.[9] For two separate reasons, it is my opinion that an audit looking only at people booked into the Jail on January 1, 2024 provides little, if any, information regarding whether the intake process functions properly at the Jail. First, at a basic level, any such audit should examine how the intake process functioned on multiple days, not on a single day. An audit that looks at a single day will only measure whether the system worked on that day, not whether the system works in general. Second, in my experience working in jails, January 1 is a very poor day on which to conduct an audit because it is New Year's Day. The people being booked into a jail on that day

[9] Appendix G does not indicate the date on which the 75 listed individuals were booked into the Jail. Appendix H does, however, list the date on which the 75 listed individuals were booked into the Jail. All of the people listed in Appendix H were booked into the Jail on January 1, 2024. The list of people in Appendix H is identical to the list of people in Appendix G. I therefore believe that the people listed in Appendix G, who are the same as the ones listed in Appendix H, were all booked into the Jail on January 1, 2024.

are not representative of typical days, as they tend to include a higher percentage of people arrested for misbehavior on New Year's Eve, including a higher percentage of people arrested for minor offenses. In addition, because jails know that January 1 will be a day with a high volume of bookings, they tend to staff the jails accordingly. As a result, a jail's success or failure processing intakes on January 1 of any year is not likely to be reflective of its success or failure at other times of the year.

128. Fourth, it appears that very few of the people whose files Dr. Murray reviewed for the audit of intake screening remained in the Jail for any real period of time. Thirty-six people were released on January 1, 2024, the same day that they were booked into the Jail; 20 were released on January 2, 2024, the day after they were booked into the Jail; and 5 were released on January 4, 2024. Only 14 of the individuals whose records Dr. Murray reviewed remained in the Jail until January 5, 2024 or longer. The short period of time that most of the individuals spent in the Jail undermines Dr. Murray's findings. One of the items that Dr. Murray audited was whether "[a]ll positive screening findings [were] appropriately referred and subsequent evaluations completed." Murray Report at 155. Dr. Murray found that the Jail met this undefined standard for all but one of the 75 individuals. But for the 36 individuals who were released on the same day they were booked and the additional 20 who were released the following day, it is extremely unlikely that any "subsequent evaluations were completed." To conclude that this item was satisfied for these individuals is therefore misleading.

129. Fifth, Appendix G and Appendix H both indicate that Dr. Murray selected 75 files to review out of a pool of 121 files. Dr. Murray provides no explanation for how the 121 files were selected, how he determined to review only 75 files, or how those 75 files were selected.

130. Sixth, in Appendix H, Dr. Murray concludes that the County met its obligation to conduct a Health Assessment within 14 days of booking in 73 of the 75

case files he reviewed. This analysis is misleading, as 64 of the individuals were released **before** they spent 14 days in the Jail and therefore the 14-day Health Assessment deadline was not triggered. For the remaining 11, Dr. Murray concludes that "all required initial health assessments were completed within this time frame." *Id.* at 12. His own report, however, indicates otherwise, as two of the 11 individuals never had a 14-day assessment. *Id.* at 160. Also, five patients reportedly refused to have a health assessment done ([redacted] and [redacted] Besides the overarching problem of refusals in the Jail in general, it is inappropriate to count these five refusals as evidence that "all required initial health assessments were completed within this time frame."

131. I discussed in my report that both the 2017 NCCHC team and Homer Venters encouraged the SDSO to do the full Health Assessment at booking. Dr. Venters went further to recommend that any patient with a significant health history be seen be a medical practitioner as part of the intake Health Assessment. SD_215371. No other resident health facility, such as hospitals or nursing homes, delay doing an initial health assessment for 14 days. The NCCHC requires prisons to do their initial health assessments within six (6) days. The fact that the SDSO has chosen to ignore the advice of Dr. Venters is simply bad medical care. Dr. Murray, by accepting the 14-day deadline, should not excuse this.

132. Seventh, Dr. Murray's results regarding the 14-day Health Assessment are not consistent with medical files I reviewed for my initial report. Following my instructions, Plaintiffs' counsel entered information from the medical files regarding 64 bookings—all lasting at least 14 days—from dates throughout 2023 and 2024.[10]

[10] I instructed Plaintiffs' counsel to use the spreadsheet provided by Defendants at SD_1575334, which shows the booking and release dates of incarcerated people whose records were produced to Plaintiffs. I instructed them to look only at bookings between January 1, 2023 and January 15, 2024; the latter limitation is because Plaintiffs initially received medical records only through the end of January 2024. After eliminating all bookings shorter than 14 days and those outside that date range, 208 bookings remained. I then instructed Plaintiffs' counsel to enter information for every third entry, excepting the six bookings for which I was unable

The results of this analysis are contained in Appendix B to this report. Of those 64 bookings, only 38 (or 59%) were "compliant," meaning they received or were documented as having refused an initial health assessment within fourteen days. As I stated in my initial report and in this rebuttal report, I have grave concerns about the validity of the Jail's process for refusals. However, even assuming that the 15 refusals in this sample of 64 were valid, the Jail is only in compliance with its 14-day standard 59% of the time. In addition to these findings, I also found instances of non-compliance with the Health Assessment policy in my review of medical files for class members with chronic illnesses. *See* Section V, *supra*.

VII. Dr. Murray's audit of nursing sick calls is methodologically and substantively flawed.

133. Dr. Murray purported to conduct an audit to "verify the timely access to care for nurse sick call requests" as well as "whether necessary referrals were made based on clinical indications." Murray Report at 13 & Appendix I. The audit results are given in a yes/no fashion regarding whether the triage was done within 24 hours, whether the face-to-face evaluation was done within an additional 24 hours, and whether "all referrals [were] made as appropriate." *Id.*, Appendix I. Dr. Murray did not define the standards he used to decide whether a referral was "appropriate."

134. For his audit, Dr. Murray appears to have picked medical files for 25 individuals out of a pool of 120 files. *Id.*, Appendix I. Dr. Murray does not provide any explanation for how he selected the 25 files for review. For each of the 25 files Dr. Murray selected, he then reviewed a single sick call slip and related follow up, even though nearly all of the files contained more than one sick call slip. *Id.*; *see* ¶¶ 136-139, *infra*. Dr. Murray does not provide any explanation for how he selected

---

to find medical records. The end result was 64 individual bookings. After I received the information from Plaintiffs' counsel, I checked it for accuracy.

which sick call slip and related follow up to review. Dr. Murray found that the Jail met the review standards for all but one of the sick call slips he reviewed. Murray Report, Appendix I.

135. In my opinion, these methodological problems with Dr. Murray's review undermine the results of his audit of the sick call system. In particular, the fact that he only reviewed one sick call slip for each file, without providing any explanation for his process for selecting the sick call slip, is very problematic. Without a pre-defined selection process, it is possible that Dr. Murray cherry-picked sick call slips for which the Jail was compliant with its own procedures. As I discussed in my report, Ms. Rognlien-Hood, the Deputy Director who supervises the Directors of Nursing, testified in February 14, 2024 that the Jail routinely fails to meet the 24-hour face-to-face standard. *See* Keller Report ¶ 349 (citing Rognlien-Hood Tr. 87:11-14, 88:8-10, 89:8-10, 90:15-92:18); *see also* Keller Report ¶ 351 (citing SD_375922, in which Ms. Rognlien-Hood wrote that the face-to-face requirement was "hard to accomplish" because of the medical and custody staffing necessary to meet it). Similarly, the County's own audit in July 2023 found only 45-50% compliance with face-to-face evaluation requirement. *See* Keller Report ¶ 350 (citing SD_114412, SD_114467). The regular failure to meet face-to-face within 24 hours was confirmed to me by a nurse at Central Jail during my inspection.

136. Indeed, when I reviewed sick call slips and related follow up in the same files that Dr. Murray reviewed, I found substantial delays and non-compliance with the County's own policies.

137. First, the vast majority of the 25 charts included in Dr. Murray's audit contain multiple sick call requests, not all of which were timely addressed. For example, [redacted] submitted a sick call request not included in Dr. Murray's audit that was dated [redacted] 2023 and marked received by the Jail on [redacted] 2023. In the request, Mr. [redacted] wrote "very pain much" in his

knees and requested a knee brace. [redacted] Med. Rcd. at 78. The face-to-face appointment with a nurse did not happen until [redacted] 2024—a month later. *Id.* at 201 ([redacted] 2024 1:14:05 p.m. RN Note). And, in the same RN Note from [redacted] the nurse noted that she also completed a face-to-face for a sick call request that Mr. [redacted] had submitted even earlier, on [redacted] 2023. *Id.*

138. As another example, an RN note in [redacted] records states that a sick call request regarding neck and shoulder pain was received by the Jail on [redacted] 2023,[11] but the complaint was not triaged until [redacted] 2023—three weeks later. [redacted] Med. Rcd. at 471 ("24 Hr Face to Face completed within 24 hours- No").

139. As another example, [redacted] submitted a sick call request on [redacted] 2023 that was not included in Dr. Murray's audit. The request was marked received by the Jail on [redacted] 2023, reporting: "I've been vomiting contin[u]ously today. I feel dehydrated." [redacted] Med Rcd. at 125. According to the bottom (response) portion of the sick call form, Mr. [redacted] was not seen before his release on [redacted] 2023. *Id.*; *see also id.* at 67 (sick call summary, showing triage appointment cancelled due to release).

140. Second, even as to the sick call requests that Dr. Murray did evaluate (one per class member listed on the chart), Appendix I is not accurate. A review of the records cited in Appendix I shows that, in at least some examples, the sick call requests cited by Dr. Murray as having being triaged and seen face-to-face by a nurse within 24 hours (indicated by a "Yes" in Appendix I) were not actually triaged within 24 hours. For example, in Row 9 of Appendix I, Dr. Murray concludes that [redacted] was visited by a nurse within 24 hours of receipt of the sick call

[11] Although no sick call request appears in Mr. [redacted] reco[redacted]h[redacted]at date, the chart does contain[redacted]e submitt[redacted]. [redacted] on [redacted] 2023, marked received on [redacted] 2023, stating: "I am [redacted] once [redacted] bo the condition of my [redacted] hou[redacted]ase help. My health care request went unanswered." [redacted] Med. Rcd. at 158.

request that appears on page 89 of his medical records. However, Mr. [redacted] medical records say the exact opposite. Page 319 of his medical records—which Dr. Murray cites as proof of compliance—states: "24 Hr Face to Face completed within 24 hours: NO // Date of receipt – [redacted]24 // Date of Completion- [redacted]24." [redacted] Med. Rcd. at 319 ([redacted]2024 2:41:46 p.m. PST RN Note). As another example, Row 11 of Appendix I states that that Mr. [redacted] was visited by a nurse within 24 hours of receipt of the sick call request that appears on page 67 of his medical records ("I have an ab[s]cess on my right upper flank. I need to be seen ASAP and get medications."). However, that sick call request was marked received by the Jail on [redacted] 2024, and Mr. [redacted] was not seen for a face-to-face until [redacted] 2024. [redacted] Med. Rcd. at 67. Page 196 of his medical records—which Dr. Murray cites as proof of compliance—actually reflects non-compliance: "Date of receipt: [redacted]24 @ 1726 // Date of Completion: [redacted]24."

141. Finally, and most troublingly, there are multiple entries in these medical records that state that nursing staff "cancelled" sick call triage appointments simply because no face-to-face appointment had happened within 24 hours. For example, the sick call summary page of [redacted] medical records reflect multiple sick call requests (dated received on [redacted] and [redacted] 2023), regarding pain in his feet and legs and requesting a different pair of shoes. [redacted] Med. Rcd. at 49. Each of these requests is marked as "Cancelled … Reason: Over 24 hrs" by RN Ellen Tanacio on [redacted] 2023. *Id.* Although the original sick call requests do not appear in the chart, there are grievances submitted by Mr. [redacted] on this topic, in particular: On [redacted] 2023, he submitted a grievance that he's "been in pain for the last several weeks. I have a pinched nerve … I'm requesting medical attention," *id.* at 115, and in a grievance marked received on [redacted] 2023, he stated that he's "been requesting shoes … to no avail. … Why? What's taking so long?" *Id.* at 104. Mr. [redacted] was seen by a nurse (after submitting yet another sick call request on

this topic) on [redacted] 2023, more than a month after he first requested help with the issue. *Id.* at 325.

142. Another example appears in the sick call summary portion of [redacted] medical records. A [redacted] 2023 imported sick call triage entry read: "Date of Receipt – [redacted] @ 7:22 Date of Completion – Chief Complaint – thinks he has lice Disposition – Cancelled by ellen.tanacio on [redacted] 2023 Reason: Over 24 hrs." [redacted] Med. Rcd. at 73. I do not see a scan of the original sick call request in the chart, nor is there any reference to lice in the RN Progress Notes, suggesting that Mr. [redacted] was never evaluated for lice despite his complaint.

143. Another example is [redacted] (Appendix I, Row 16). Dr. Murray noted with approval that Ms. [redacted] 2024 sick call request regarding the dosage of her "transgender shots," marked received by the Jail on [redacted] 2024, was triaged by a nurse the same day. *See* [redacted] Med. Rcd. at 64 (sick call request), 320-21 ([redacted] 2024 7:02:08 p.m. RN Note). However, Ms. [redacted] had previously submitted multiple other requests regarding the dosage of that medication. According to the sick call summary portion of Ms. [redacted] medical record, the Jail received a request from Ms. [redacted] to "increase 'transgender pills'" on [redacted] 2024 at 5:53 p.m.; however, this sick call request was "[c]ancelled" on [redacted] 2024, with the stated reason: "More than 24 hrs." *Id.* at 55. I understand this to mean that the sick call request was deleted—and never even referred to a provider—because the Jail failed to conduct a face-to-face assessment within 24 hours of receipt of the sick call request. Although no request form dated [redacted] 2024 appears in Ms. [redacted] medical records, another request form on the same topic, which is marked received by the Jail on [redacted] 2024, states: "[T]his is the second one I put in." *Id.* at 65. This suggests to me that the [redacted], 2024 request form was discarded because it was not triaged within 24 hours.

144. If, as these records suggest, the Jail is disregarding sick call requests if medical staff fail to comply with policy for a face-to-face interview within 24 hours

of receipt, that would be extremely troubling. All sick call requests should be addressed.

145. Lastly, I note one additional issue ignored by Dr. Murray. He does not mention that the MSD Operations Manual requires this face-to-face assessment within 24 hours, not 48 hours. SD_065584. The SDSO reaffirmed this 24-hour standard for a face-to-face assessment in its response to the California Audit. SD_729828, SD_184484.

VIII. Dr. Murray's analysis of the timeliness of lab, x-ray, and test results ignores the Jail's repeated and documented failures to timely review those results

146. Dr. Murray states that his review showed that "[t]he average time from (lab) specimen submission to results returned to the medical record was 1.5 days." Murray Report at 16 . Similarly, he reported that "[t]he average time from (x-ray) study completion to report availability was approximately 23 hours." *Id.* at 17. Dr. Murray opines that these timeframes suggest that the healthcare system is working properly. *Id.*

147. While I agree that those timeframes for obtaining results of labs and x-rays are acceptable, Dr. Murray's analysis ignores another essential step in the process for using diagnostics to treat patients. Dr. Murray did not look at the amount of time from the receipt of study results to the time that a practitioner interpreted the results and then, if necessary, developed a treatment plan. Dr. Murray also did not assess whether the reviews and interpretation were appropriately documented in the medical record. Finally, Dr. Murray did not assess how long it took until the study results were communicated to the patients.

148. In fact, the Jail's own internal documentation shows that the review, documentation, and communication of study results has been particularly problematic. SD_114489. Moreover, in my report, I discuss a number of cases in which the lack of appropriate review, documentation, and communication of lab results resulted in actual or a risk of serious harm to patients. Keller Report ¶¶ 150-

152, 180, 207-208. Lastly, my review of medical files for some of chronic care patients discussed in Dr. Murray's report reveal failures to review test results. *See* paragraph 117, *supra*.

IX. Dr. Murray agrees with several criticisms of the medical system alleged in the *Dunsmore* complaint and found in my report.

149. Dr. Murray admits that SDSO has no Disease Management Guidelines, including guidelines for Chronic Care. Murray Report at 15. Dr. Murray excuses this lapse by saying that Dr. Freedland has promised that "CHP is in the process of developing Disease Management Guidelines (DMG) to help standardize chronic care management." *Id.* Additionally, according to Dr. Murray, Dr. Freedland said that the EHR chronic care templates are "being considered for revision to facilitate treatment goals." *Id.* This statement ignores the fact that the SDSO has known about the lack of chronic disease guidelines since at least 2017, when the NCCHC Report repeatedly pointed this out. DUNSMORE0260643, 0260676, 0260710, 0260743-44. Dr. Murray also does not mention that NaphCare's 2022 contract required NaphCare to develop chronic disease management guidelines, which NaphCare has failed to do. DUNSMORE0117611-12 (County Contract 566117) ("Naphcare Contract"). Dr. Murray also does not discuss that the contract with CHP does not obligate CHP to create chronic disease management guidelines. DUNSMORE0118502 (County Contract 563402) ("CHP Contract"). And even if CHP does create chronic disease guidelines (and I am not aware of any evidence that this has yet occurred), CHP has no way to enforce compliance with their guidelines on the NaphCare practitioners, specifically the STATCare midlevel practitioners who are providing remote care. Also, Dr. Freedland's statement to Dr. Murray that chronic disease templates are "being considered," Murray Report at 15, is an admission that the SDSO does not have such templates now. As I discussed in my initial report, problems with chronic care treatment were widespread in the medical records I reviewed. Keller Report ¶¶ 506-631. In addition, as I discussed

above, the medical files regarding chronic care that Dr. Murray's contractors reviewed, some of which I have now reviewed as well, reflect widespread failures to treat the many common chronic conditions, including hypertension and diabetes. *See* paragraph 119, *supra*. As but one example, Mr. Bach's death may have been prevented had the Jail had in place disease management guidelines for type 1 diabetes. *See* Section III.B.1, *supra*. In my opinion, the lack of chronic care guidelines at the Jail is one reason why the Jail frequently fails to provide clinically-appropriate chronic care treatment to incarcerated people in the Jail. These failures place incarcerated people at a substantial risk of serious harm.

150. Dr. Murray notes that the NCCHC Standard J-A-05 requires that "[h]ealthcare policies are reviewed annually by the medical and administrative directors." Murray Report at 26. Dr. Murray claims that the SDSO "is in the process of finishing a complete review of its current P&P manual" and that "[t]he timeline for completion of the SDSO health services P&P manual is September 2024." *Id.* at 27. Dr. Murray states that "[o]nce all policies and applicable procedures reviews are completed, they will remain on an annual review process." *Id.* Dr. Murray does not provide any basis for this speculation. He also fails to mention NaphCare's role in this revision, even though generating medical P&Ps is part of their contractual requirements. *See, e.g.*, DUNSMORE0116596 (NaphCare Contract at 2.1.1), DUNSMORE0117598 (NaphCare Contract at 2.3.2.1). And, since any Policy and Procedure Manual must include Disease Management and Chronic Care Guidelines, CHP should be involved in any effort to rewrite P&Ps. But Dr. Murray does not mention CHP in this role.

151. Dr. Murray admits that the SDSO CQI program is not compliant with NCCHC requirements. Murray Report at 32. As an example, Dr. Murray notes no CQI monitoring of the MOUD program. *Id.* at 26. I agree with this assessment. Dr. Murray does not define in exactly what way he feels the CQI program is deficient. I discuss problems with the SDSO CQI processes in my report. Keller

Report ¶¶ 762-795.

152. Dr. Murray admits that the Receiving Screen being done at the Jail is inadequate. Murray Report at 35. As I discuss at length in my initial report, I agree with this assessment. Keller Report ¶¶ 243-284. Dr. Murray criticizes the current Receiving Screening for lacking "the screener's personal observations" and "additional process monitoring." Murray Report at 35.

153. Dr. Murray approvingly quotes Dr. Freedland that the current system of death reviews will be improved because "with CHP ... directly contracting with SDSO, all mortality reviews would be done on site." *Id.* at 40. He further quotes Dr. Freedland as stating that "[t]hese on-site reviews will provide the opportunity for better contextual understanding, examination of team dynamics, and immediate access to necessary information," which, of course, implies that the current system of doing death reviews lacks these features. *Id.* The problem with Dr. Freedland and CHP fixing a broken Mortality and Morbidity Review system is that CHP's contract does not mention any responsibility for death reviews. *See generally* SD_1579715-26 (no discussion of responsibility for implementing new M&M review system). As far as I am aware, NaphCare still has the responsibility for the M&M process at the Jail, per its contract. *See* DUNSMORE0117647-48 (Naphcare Contract at 2.3.47.5). Dr. Murray also does not discuss how this future CHP M&M model would work. I agree that the SDSO's current system of doing remote death reviews is poor. I discussed this in detail in my report. Keller Report ¶ 30.

X. Dr. Murray does not address the substantial problems in the Jail's medical system related to purported refusals of treatment by class members.

154. In my initial report, I wrote at length regarding serious problems at the Jail regarding the policies and processes in place for when incarcerated people refuse medical treatment. As I explained, "it is my opinion that Sheriff's Department staff frequently record that a patient has 'refused' to attend a medical appointment, even though the patient was never informed or offered the opportunity

to attend the appointment in the first place. This practice has the effect of denying medical care to incarcerated people and therefore places them at a risk of serious harm." Keller Report ¶ 387. I offered this opinion based, *inter alia*, on my review of refusal forms in medical files, nearly all of which were signed only by two custody officers with no indication that any medical personnel informed the class members of the risks of declining treatment and on reports from named plaintiffs and other class members that officers record refusals when class members have not refused treatment. *Id.* ¶¶ 387-426.

155. In the medical file for Mr. Bach, whose death I discuss in detail above, *see* Section III.B.1, ¶ 67 *supra*, I have now found what appears to be ironclad evidence that staff at the Jail record refusals of treatment when incarcerated people have not actually refused. As I explained above, Mr. Bach's file includes a refusal of medication form timestamped at 4:48 a.m. The form is signed by two deputies, who claim that Mr. Bach refused to sign the form. However, Mr. Bach was pronounced dead at 4:09 a.m., nearly 40 minutes before the officers completed this refusal form. This form therefore strongly suggests that the deputies did not even attempt to determine whether Mr. Bach wanted to take his medication and simply marked him as a refusal.

156. In his report, Dr. Murray does not address the refusal policy and its problematic implementation. I find this troubling, as the chronic care files his reviewers examined contain many hundreds of refusals that should have been relevant to Dr. Murray's analysis because they have a substantial impact on medical care.

XI. Dr. Murray admits that the County has many nursing vacancies, did not offer an opinion on whether the County has sufficient nursing staff, and ignored evidence that the County does not.

157. Dr. Murray wrote:

> When nurses are not overwhelmed by excessive workloads, they can provide comprehensive assessments, implement care plans effectively, and engage in patient education, all of which contribute to better patient

> outcomes and enhanced recovery. Moreover, a well-staffed nursing team promotes continuity of care, reduces the risk of medical errors, and fosters a supportive environment where nurses can deliver compassionate, personalized care. By investing in a substantial nursing staffing model, healthcare organizations not only prioritize patient safety and satisfaction but also support the professional growth and job satisfaction of their nursing staff, ultimately leading to improved overall healthcare quality and efficiency.

Murray Report at 6. I agree with these statements.

158. In evaluating the adequacy of staffing in a medical system, it is critical to look at two components: (1) the number of authorized positions and (2) whether those positions are filled.

159. Nowhere in his report does Dr. Murray state that the number of authorized nursing staff positions at the Jail are sufficient to ensure adequate care for patients. Dr. Murray did not conduct any staffing analysis or cite to any staffing analyses conducted by the County. As far as I am aware, no such analysis of the current nursing staff needs exists—it is sorely needed. In addition, Dr. Murray did not independently address any of the evidence I cite in my report—including deposition testimony and other evidence—about the inadequate quantity of authorized nursing positions. *See* Keller Report ¶¶ 799-800, 802, 810.

160. The closest Dr. Murray gets to offering an opinion on whether the County has sufficient authorized nursing positions is to state that, by using overtime and contract nurses, the County "ensure[s] that IPs' care remains uninterrupted, and that the nursing workforce is supported, particularly during periods of increased demand or long-term staff vacancies." Murray Report at 8. But if the only way that the Jail can provide adequate care is through overtime and contract nurses, the system is not working properly. Dr. Murray admits that nurses who are "overwhelmed by excessive workloads"—which would include nurses required to work substantial overtime—have difficulty providing adequate care. *Id.* at 6. When staff are "overwhelmed," it results in disrupted and incomplete medical processes, stress on both nursing staff and patients and ultimately, poor medical care, and

patient harm.

161. Dr. Murray also admits that, "due to the complexity of the SDSO medical program," the contract nurses are limited in the tasks they can perform. *Id.* at 8 (the contract nurses "are assigned specific task-oriented roles to minimize orientation time"). The contract nurses therefore cannot be a solution to the Jail's failure to hire and retain adequate nursing staff.

162. Meanwhile, Dr. Murray admits that the Jail has an "average nursing vacancy rate of approximately 25%." *Id.* at 7. I have not independently verified Dr. Murray's calculations. As I discuss in my report, however, the vacancy rates have been higher in the recent past. *See* Keller Report ¶¶ 799, 802 (92 vacant positions in nursing unit as of November 1, 2023, citing SD_114288). Dr. Murray excuses the 25% nursing vacancy rate he calculated as "generally similar" to other healthcare facilities in Southern California. Murray Report at 7. Even if true (and Dr. Murray has not produced any citation to support this assertion), it is irrelevant. A nursing vacancy rate of 25% negatively impacts patient care at the Jail and is a problem that the SDSO could fix if it chose to do so. Dr. Murray admits as much by explaining that the Jail is required to resort to overtime and contract nurses to fill shifts.

163. It remains my opinion that SDSO has insufficient authorized nursing positions, has too many vacancies in nursing positions, and relies too heavily on overtime and contract staff to fill shifts. Keller Report ¶¶ 815-18.

XII. Dr. Murray did not offer any opinion on the adequacy of provider/practitioner staffing.

164. In his report, Dr. Murray notes that the County has increased its provider/practitioner staffing levels. Murray Report at 8. Though Dr. Murray commented on the scope of the increase, Dr. Murray did not opine that these new levels of provider/practitioner staffing are adequate or provide any detail regarding when and where these staff are deployed or their level of licensure (e.g., physician

or nurse practitioner). Dr. Murray did not conduct any staffing analysis or cite to any staffing analyses conducted by the County. As far as I am aware, no such staffing analysis exists.

XIII. Dr. Murray acknowledges that some nurses working in the Jail do not receive new employee orientation.

165. Dr. Murray opined that a "comprehensive" new employee orientation "is crucial for correctional healthcare professionals particularly transitioning from non-correctional settings to correctional healthcare positions." *Id.* at 8. According to Dr. Murray, such a program is also important because it "equips healthcare professionals with the knowledge of legal and ethical considerations inherent to correctional healthcare" and "facilitates the integration of new employees into interdisciplinary teams within correctional facilities." *Id.* I agree with Dr. Murray about the importance of a strong new employee orientation program.

166. Crucially, however, elsewhere in his report, he admits that at least some health care staff help to treat patients without receiving the full new employee orientation. As discussed above, it appears that the contract nurses from United Nursing International Healthcare Recruiters ("UNI") do not receive some or all of the new employee orientation. *Id.* at 8 (explaining that contract nurses only perform certain tasks "to minimize orientation time"). Having health care staff treat patients without receiving the orientation is concerning for all of the reasons that Dr. Murray stated in his report.

XIV. Dr. Murray does not address how the lack of adequate custody staff negatively impacts care for patients.

167. According to Dr. Murray, Plaintiffs alleged that "[t]he Sheriff's Department's custody staff interfere with and undermine the delivery of care by health care professionals." *Id.* at 41. In response, Dr. Murray wrote: "The security and healthcare staff we spoke to indicated that there are occasions when it is necessary for the medical and security departments to discuss the care and custody

of a particular IP." *Id.* This sentence is disingenuous because it implies (1) that these discussions actually take place each and every time there is a conflict between security concerns and medical concerns; (2) that these discussions resolve the disagreement about in the delivery of health care; and (3) that medical has an equal say in these discussions rather than being overruled by custody staff. Moreover, it does not address the evidence that I discuss in my initial report that shows that custody staff routinely interfere with medical care in ways that cause harm to incarcerated people. Keller Report ¶¶ 659-86. I found additional evidence of this problem in the chronic care medical records discussed in Dr. Murray's report. *See* paragraph 117, *supra*.

XV. Dr. Murray misrepresents the problems the Jail has with the continuity of medically-necessary medications and treatments.

168. In his report, Dr. Murray discusses the benefits of the Surescripts system, which allows the County to electronically verify class members' prescription medications in the community. Murray Report at 41. Surescripts is a valuable tool. However, Dr. Murray does not address the fact that once medications are verified through Surescripts, the Jail requires two additional steps before any patient receives their medications: The medications must be approved by a STATCare practitioner and then any nonformulary medications must go through the nonformulary review process. *See* Keller Report ¶¶ 292-303. As I discussed in my initial report, these unnecessary processes, which delay care, contributed to the death of Raymond Dix. Keller Report ¶ 154. I also identified problems with continuity of medication and, in particular, approval of non-formulary medications, in my review of the chronic care files. *See* paragraph 117, *supra*.

169. In addition, Dr. Murray does not address another, equally important component of continuity of care: continuity of medical treatments that patients were undergoing prior to coming to jail. Like requiring use of the non-formulary process before allowing continuity of medications, the SDSO requires review by the

NaphCare Utilization Management (UM) process before allowing scheduled medical treatments to take place. DUNSMORE0117617 (NaphCare Contract at 2.3.16.4). I discussed problems with this in my initial report. Keller Report ¶¶ 309-312, 458-484. I also identified problems with continuity of medical treatment in my review of the chronic care files. *See* paragraph 117, *supra.*

170. Finally, Dr. Murray did not review the process for continuity of care after off-site medical visits. This requires a practitioner to review the off-site medical records and create a treatment plan incorporating the diagnoses, studies and prescriptions from the off-site visit. This does not happen at the Jail, as exemplified by the case of [redacted] which I discuss in my initial report. Keller Report ¶¶ 309-312. Another example is [redacted] discussed in Appendix A.

XVI. Dr. Murray's opinion that incarcerated patients have adequate means for alerting medical staff of their needs is not consistent with the evidence I have reviewed.

171. Dr. Murray opines that SDSO provides incarcerated people with a reliable and timely way to alert health care staff of their medical needs. Murray Report at 42. I disagree with Dr. Murray's opinion, as the evidence I have reviewed suggests that incarcerated people often cannot obtain timely attention for their medical issues.

172. First, as I explained in my report, incarcerated people must have a way to communicate emergent medical needs, such as a heart attack, a stroke or severe injuries. This is done in many jails by having an emergency button in the housing units. However, as I detailed in my report, these intercoms at the Jail do not always work, leaving incarcerated patients with no way of alerting staff of a medical emergency. Keller Report ¶¶ 370-374. Dr. Murray does not address the problems with these intercoms, which are discussed at length in Plaintiffs' Third Amended Complaint. Dkt. 231 ¶¶ 93, 330-32, 334.

173. Second, as I discussed in my report, the Jail must have a mechanism for patients with disabilities, mental illness and/or language barriers to request and

receive medical care. Keller Report ¶ 323. Such patients often cannot effectively utilize a system of written requests. There is ample evidence that the Jail has failed these patients, as exemplified by the case of Roselee Bartolacci. Keller Report ¶¶ 193-218. Dr. Murray does not address these failings of the system.

174. Third, even the written medical request system used by the jail does not function properly, as evidenced by the Jail's own statistics. These written requests are supposed to be triaged within 24 hours and then each patient is to be seen face-to-face by a nurse within another 24 hours. As I discussed in my report, this system does not work, partly because of the chronic nursing shortage. Keller Report ¶¶ 349-50 (citing SD_114412, SD_114467, Rognlien-Hood Tr. 89:8-10). In my review of the chronic care medical records (which Dr. Murray's consultants purported to review) and in my review of Dr. Murray's sick call audit, I identified additional instances where the Jail failed to respond to sick call requests in a timely manner. *See* Sections VII, *supra.*

175. Fourth, nurses act as gatekeepers to incarcerated patient access to practitioners. If a patient wants to see a medical practitioner about a particular complaint, and would see a medical practitioner in the outside world, the gatekeeper nurse may make the decision to not allow the patient access to the practitioner. I discussed the problems with this system in my initial report. *See* Keller Report ¶¶ 430(d), 619.

XVII. Dr. Murray's opinion that the Jail has an adequate system for diagnosing and treating infectious diseases is not consistent with the evidence I have reviewed.

176. Dr. Murray states, "[a]s emphasized throughout this document, particularly with their intake processes, the SDSO has implemented all the necessary elements for a thorough and effective infectious and communicable disease surveillance program." Murray Report at 13. Dr. Murray cites no statistics to show that the system is effective. In my report, I cited several infectious diseases for which the SDSO is not screening and is not offering treatment in violation of the

standard of care. These include:

177. Chronic Hepatitis C Infection (Hep C). The SDSO does not offer opt-out screening for Hep C per national standards and as was recommended by Dr. Venters. Keller Report at ¶¶ 507-525. I cite several cases in my initial report where patients with known Hep C infections were denied treatment in violation of national standards of care. *Id.*

178. Sexually Transmitted Infections (STIs). As I discussed in my report, NaphCare is required by their contract to have an STI clinic, but they have never set this up. Keller Report at ¶¶ 594-612. This

179. Latent Tuberculosis Infection (LTBI). Dr. Murray opines that "all IPs are screened and tested for tuberculosis (TB)." Murray Report at 10. National standards require screening for LTBI in all at risk patients. The SDSO does not screen for LTBI until patients have been incarcerated for two years. Then, if a patient with LTBI is identified, the SDSO does not offer treatment unless the patient will be incarcerated for six months. This violates national standards requiring the screening of at-risk individuals and treating patients identified as having LTBI when found. Keller Report ¶¶ 581-593.

XVIII. Dr. Murray's opinion that the Jail offers sufficient access to specialty care is not consistent with the evidence I have reviewed.

180. In his report, Dr. Murray wrote: "[i]t is evident from the specialty care data provided from the medical record reviews, and corroborated by Drs. Rafi and Freedland, that SDSO has enough contracted sub-specialty, diagnostic care resources, and high acuity medical beds to provide adequate and timely access to specialty care for IPs requiring those services." Murray Report at 19.

181. The evidence I have reviewed suggests that access to specialists is not timely and adequate. *See* Keller Report at ¶¶ 470-484. In addition, the case of Mr. [redacted] who was referred to a gastrointestinal specialist for treatment of GERD but never saw one over a period of six months, shows substantial delays in access to

specialist care. *See* Appendix A.

XIX. Dr. Murray's opinion that the Jail maintains confidentiality of patient medical encounters is not consistent with the evidence I have reviewed.

182. Dr. Murray opines that the SDSO does provide confidential medical care to "the greatest extent possible." Murray Report at 43. He identifies two circumstances—when staff speak with class members cell front because they refused an appointment and where the multi-disciplinary team conducts Wellness Rounds at cell front—to highlight how the County "attempts to balance the need for IP confidentiality and access to care." *Id.* He further reports that if any class member expressed confidentiality concerns during those types of encounters, the County would see them in a confidential setting. *Id.*

183. I disagree with Dr. Murray's opinion that the County properly protects the confidentiality of medical encounters. Dr. Murray's opinion on this topic does not appear to have involved any review of patients' charts. In my review of charts, I found most cell-side encounters did not record that the patient gave consent to a non-confidential encounter. For example, none of the cases of cell-side encounters I mention in my report in paragraphs 675-679 contain any mention of the patient being asked for consent for the cell-side visit. Moreover, in a system where it can be so difficult for incarcerated people to timely access care, incarcerated people likely feel tremendous pressure to accept non-confidential encounters rather than to lose their opportunity to receive care. Patients should not be forced to choose between confidentiality and receiving care.

184. My review of charts showed healthcare staff conducting visits for intimate, private medical concerns—such as sexually transmitted diseases, inguinal hernias and hemorrhoids—at patients' cell doors. Keller Report ¶¶ 675-79. Even if the patient consented, this is not appropriate. One example is the case of [redacted] which I discussed in my report. Keller Report ¶¶ 567-72. And my conversations with incarcerated people revealed that much of the healthcare being

provided at the Jail occurs at cell front, which is not confidential.

XX. Dr. Murray's opinion that "all" patients receive adequate follow up care is not consistent with the evidence I have reviewed.

185. Dr. Murray opines that "the medical record reviews for both nursing and providers indicated that IPs receive timely follow-up care." Murray Report at 43. As I described in my initial report and in my review of some of the chronic care patients' medical files that Dr. Murray reviewed, the County often fails to provide appropriate follow up care when people return from seeing outside specialists. Keller Report ¶ 304-313; *see* paragraph 117, *supra*. I therefore disagree with Dr. Murray that the medical records establish that the Jail provides adequate follow-up care.

186. In what appear to be related findings, Dr. Murray explains that Dr. Freedland, according to Dr. Murray, stated that the County "ensures that all patients scheduled for providers are seen that day"; and that "StatCare is available to nursing staff 24/7 for all IPs that may require additional intervention." Murray Report at 43.

187. It is unclear what Dr. Murray means with respect to his statement about Dr. Freedland or how it relates to follow-up care. Perhaps Dr. Murray is stating that all patients who see an outside medical specialist are seen by onsite staff on the same day after they return to the Jail. If so, the medical files do not reflect that this is occurring. Alternatively, if Dr. Murray is stating that all patients who are scheduled to see a provider at the Jail are seen by a provider on that same day, that has no bearing on whether the Jail provides adequate follow-up care. In addition, the Jail's own CQI has documented the wait to see a provider as greater than 14 days. SD_114495. Moreover, as I discussed in my report, CHP practitioners are not in charge of scheduling their own clinics. The Jail has gatekeepers in place who decide which patients get to see a practitioner and which do not. The STATCare midlevel practitioners are one level of such gatekeepers. Nurses contact STATCare

"for permission" for an on-site practitioner to see a patient. *See* SD_754743; Appendix A, [redacted] Another level of gatekeepers are the nurses themselves. Dr. Murray admits this when he refers to the nurses seeing, diagnosing, and treating patients in accordance with check-box protocols that NaphCare developed. Murray Report at 30. Such patients are not scheduled to see a practitioner.

188. The fact that STATCare is available 24/7 could, in theory, assist in ensuring patients receive appropriate follow up care following off-site medical appointments. However, the medical files I reviewed contained serious problems with follow-up care, notwithstanding the availability of STATCare.

XXI. Dr. Murray's conclusion that the Jail provides adequate discharge planning is flawed.

189. In my report, I discussed the importance of a functioning discharge planning process and the serious problems with Defendants' system. The many problems include, but are not limited to: a lack of adequate policies regarding discharge planning; the failure of NaphCare—which is obligated, pursuant to its contract with the County, to implement a system of discharge planning that is consistent with NCCHC standards—to actually implement a system more than two years after the effective date of the contract; the failure to create a system that arranges for follow-up appointments for patients; NaphCare's failure to set forth job duties for the two people it has hired as discharge planners; the fact that, given the census in the Jail, two discharge planners are not sufficient to conduct adequate discharge planning; the fact that the system requires incarcerated people to request discharge planning, rather than providing it as a matter of course; the fact that discharge planning is not actually being provided to class members; the fact that the Jail now claims to provide a 30-day supply of discharge medications to class members, but has no official policy to enforce that practice; the failure to provide the vast majority of class members with discharge instructions; and the failure of the Jail to track any statistics regarding the provision of discharge services.

190. In Dr. Murray's report, he similarly opined that "[m]edical and mental health discharge planning is critical in correctional settings because incarcerated individuals often have complex health needs, including chronic medical conditions, mental health disorders, and substance use issues." Murray Report at 21. He then concluded that the County "ensure[s] that IPs can access social and medical services in the community in a timely manner." *Id.* at 22.

191. Dr. Murray's opinion is flawed and contradicted by the evidence I reviewed. Dr. Murray does not discuss any of the medical system policies (or lack thereof) related to discharge planning. Instead, he focuses most of his discussion on the Sheriff's Office's Reentry Services Division. But that Division is operated by custody staff and does not and could not perform any medical functions related to discharge planning. He touts the 30-day supply of medication, but does not acknowledge that there are no policies formalizing that practice. He notes that the County sometimes helps people who are receiving MAT or dialysis or have behavioral health needs. But he ignores all of the other conditions that class members have that require effective discharge planning. He does not mention the two discharge planners employed by NaphCare (who still do not have defined job duties), let alone opine regarding whether that staffing level is sufficient given the thousands of people who are discharged from the Jail each month. And his opinion regarding the adequacy of the discharge planning system at the Jail does appear to rest upon the review of any medical records; in contrast, my opinions were based upon my review of many dozens of medical files, which reflected a near-total absence of discharge planning.

192. In addition, I have been provided with a declaration from class member James Clark that is dated September 2, 2024. In it, Mr. Clark states that on the two occasions he was released from custody at the Jail in 2024, the Jail released him without any prescription drugs or prescription card. He states that, because he was not provided with a prescription medications or a prescription card, "I was unable to

obtain the medications I need in the free world." Clark Declaration ¶ 3. This declaration suggests that the Jail is not following its own policies regarding providing individuals released from the Jail with access to prescription medications.

XXII. The faux-NCCHC evaluation performed by Dr. Murray and his team is suspect, does not include adequate explanation of the ratings, and is not consistent with the evidence I reviewed.

193. In his report, Dr. Murray stated that his "team, experienced with the NCCHC accreditation process, thought it appropriate to evaluate SDSO's compliance with the current NCCHC 2018 standards for Health Services in Jails." Murray Report at 31. Dr. Murray's team concluded that SDSO was "compliant with 93% (33[sic][12]/39) of the Essential and 100% (20/20) of the Important 2018 Standards." *Id.* Dr. Murray asserted that his team's findings were based on "information obtained on facility inspections, medical record reviews, interviews with SDSO healthcare and sworn staff, review of healthcare policy procedure, institutional directives, training bulletins, and observation of health care delivery." *Id.*

194. As a starting point, however, Dr. Murray concedes that the Jail would again fail an NCCHC survey, if it was done today, because the Jail did not meet three essential standards. I agree that the Jail would fail a real NCCHC assessment if it was held right now.

195. In addition, there are a number of serious problems with Dr. Murray's "faux" NCCHC review.

196. First, though he claims his team was "experienced with the NCCHC accreditation process," the CVs for his three consultants do not mention any experience with the NCCHC accreditation process. Dr. Murray's CV states that he was certified by the NCCHC as a "Correctional Health Professional" from 1996-

[12] Dr. Murray, in the quoted portion, indicates that the Jail met 33 of 39 Essential standards. In his actual analysis, however, he determined that the Jail complied with 36 of 39 Essential standards. Murray Report at 31-38.

2000, but he has no association with NCCHC listed since 2000. Instead, Dr. Murray's experience is with the ACA, the NCCHC's rival in the correctional health care accreditation market.

197. Second, Dr. Murray's review did not include a number of essential components of an NCCHC accreditation survey. He and his team did not interview any incarcerated people, even though they had the opportunity to do so. He and his team did not interview the site Health Services Administrator (Angela Nix); the SDSO medical director (Dr. Montgomery); the Deputy Director supervisor of the Directors of Nursing (Serina Rognlien-Hood), or any of the Directors of Nursing themselves. In contrast, when NCCHC conducted its review in 2017 (and found that the County was compliant with only 31% of Essential and 24% of Important standards), it interviewed the staff members occupying those positions. DUNSMORE0260623 (NCCHC Report at 6) ("We interviewed the jail commander, command staff with the sheriff, responsible physician, director of nursing, CQI nurse, infection control/training nurse, psychiatrist, psychologist, mental health clinicians, dentist, medical records clerk, 11 health staff, six COs, and 11 inmates selected at random.").

198. Third, Dr. Murray's conclusions regarding each of the standards includes no analysis. He simply states for all but three of the essential standards that the Jail complies with the standard because it meets all of the compliance indicators for each of the standards. But Dr. Murray does not list any of the compliance indicators, nor his basis for concluding that the Jail met the indicators. His conclusions that the Jail complies with various standards are therefore completely untethered from the actual NCCHC standards and the compliance indicators that underlie them. He and his team did not show any of their work, which makes it impossible to determine the basis they had for deciding regarding compliance.

199. Because Dr. Murray's faux-NCCHC review is so methodologically flawed, I will not attempt to address each of his purported findings. I can say,

however, that some of his findings of compliance are surprising to me given the evidence I have reviewed. Examples include:

A. J-A-02 Responsible Health Authority – *Essential* Standard: The responsible health authority (RHA) ensures that the facility maintains a coordinated system for health care delivery.

200. Dr. Murray concluded that the Jail met this standard. I disagree. Since the NCCHC found in 2017 that the Jail had not complied with this standard, the SDSO has fragmented health care to the point that there is no longer "a coordinated system for health care delivery." Instead, the Jail now has three independent "silos." 1. The SDSO nurses and medical administrators, including Dr. Montgomery, and Serina Rognlien-Hood. 2. NaphCare, which supplies the STATCare midlevel practitioners, the mental health personnel, and the MOUD practitioners. NaphCare also has responsibility for the medical Policies and Procedures, Chronic Care Guidelines, enforcement of the non-formulary process and the Utilization Management process, and Mortality and Morbidity committee, among others. 3. Correctional Health Partners, which supplies the on-site physicians and midlevel practitioners, including the Jail medical director. There is now even less of a "coordinated system for health care delivery" than in 2017 when the Jail failed to meet this standard.

201. From what I can tell, all three silos at the Jail overlap. CHP practitioners and NaphCare practitioners independently make diagnoses and prescribe treatments to patients. CHP has no authority to supervise NaphCare practitioners and vice-versa. In the case of a death, Dr. Montgomery, SDSO security and the SDSO Director of Nursing conduct some kind of death reviews. Separately, NaphCare, by contract, runs the formal Mortality and Morbidity committee. Dr. Freedland (per Dr. Murray's report) wants CHP to do their own on-site death reviews, all of which are or will be uncoordinated. Murray Report at 40. As another example of fragmentation, Dr. Murray states that Dr. Freedland is developing Disease Management Guidelines, *id.* at 15, but Dr. Freedland has no

authority to enforce those guidelines on the NaphCare practitioners and this project is not included in the scope of work for the CHP contract.

B. J-A-07 Privacy of Care – *Important*

202. Dr. Murray concludes that the Jail meets this standard, which requires that "[h]ealth care encounters and exchanges of information remain in private." *Id.* at 32. However, the NCCHC Report in 2017 pointed out that "The areas of privacy and confidentiality of care need to be addressed." DUNSMORE0260627. As far as I am aware, the SDSO has not changed *any* of its privacy practices since then. As I discussed in my initial report and above, much of the care in the Jail is improperly provided in non-confidential settings.

C. J-A-9 Procedure in the Event of an Inmate Death – *Important*

203. Dr. Murray concluded that the Jail "conducts a thorough review of all deaths in custody in an effort to improve care and prevent future deaths." Murray Report at 32. I have pointed out in my initial report that the death review process at the SDSO is seriously flawed. Keller Report ¶¶ 86-239. My further discussion of the death of Mr. Bach in this report reinforces my initial opinions; that the Jail took no steps following his preventable death from diabetic ketoacidosis suggests that the CQI process for death reviews at the Jail is profoundly broken. *See* Section III.B.1, *supra*; Keller Report ¶¶ 108-114. Dr. Murray implicitly acknowledges problems with the death review process by explaining that CHP will be doing on-site death reviews in the future. This change suggests that the County recognized that the reviews conducted by NaphCare are not adequate. I therefore find it not credible that Dr. Murray concluded that the Jail satisfied this standard.

D. J-F-01 Patients with Chronic Disease and Other Special Needs – *Essential*

204. Dr. Murray opined that the Jail met this standard, which requires that "[p]atients with chronic disease, other significant health conditions, and disabilities receive ongoing multidisciplinary care aligned with evidence-based standards."

Murray Report at 36. However, the NCCHC criticized the Jail in 2017 for not having chronic disease guidelines or policies and procedures for a chronic disease program. DUNSMORE0260643-0260644. Dr. Murray admits in his report that the SDSO still does not have these essential documents. Murray Report at 15. In my initial report, I discussed serious inadequacies in how the Jail practitioners deal with Asthma and Type 2 Diabetes. Keller Report ¶¶ 526-551, 613-631. I also identified many problems with chronic care, including for asthma, diabetes, and hypertension, in my review of the chronic care files, discussed above.

205. The opinions contained in this rebuttal are based on the documents, evidence, and/or observations made available to me to date. I reserve the right to revise or expand my opinions should additional information become available to me. Together with my report disclosed on August 21, 2024, the information contained in this report and the accompanying appendices are a fair and accurate representation of the subject of my anticipated testimony in this case.

Dated: November 1, 2024

Jeffrey E. Keller, M.D.