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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

v.

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

Defendants.

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

REBUTTAL EXPERT REPORT OF KELLY S. RAMSEY, M.D.

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

Trial Date: None Set

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I. INTRODUCTION

I, Kelly S. Ramsey, MD, MPH, MA, FACP, DFASAM, declare:

1. Plaintiffs' counsel asked me to prepare this Rebuttal Expert Report to respond to the opinions regarding substance use management and substance use disorder treatment in the August 21, 2024, reports of Defendants' experts Owen J. Murray (medical, "Murray Report"), Joseph Penn (mental health, "Penn Report")), and Lenard Vare (jail management and operations, "Vare Report") (collectively, "Defendants' Reports").

2. I have reviewed the analyses, opinions, and conclusions of Dr. Murray, Dr. Penn, and Mr. Vare in Defendants' Reports regarding substance use management and substance use disorder treatment in the San Diego County jails (the "Jail"). Each of those experts opines briefly on some of the elements of substance use treatment detailed in my August 20, 2024 report, but their opinions are strongly contradicted by the evidence I have reviewed, in particular medical records that Dr. Murray and Dr. Penn relied on in their reports. Those medical records, along with the rest of the evidence I have reviewed, underscore the conclusions in my initial report that the Jail's systems for substance use management and substance use disorder treatment expose incarcerated persons to a substantial risk of serious harm. *See* Expert Report of Kelly S. Ramsey, MD (hereinafter, the "Ramsey Rpt.") at ¶ 17.

3. Based on the curricula vitae provided by Dr. Murray and Dr. Penn, the physicians have neither specific training nor expertise in addiction medicine or addiction psychiatry, respectively. Dr. Penn mentions that he has treated persons with substance use disorder in incarcerated settings but does not specify that he ever received any dedicated training to do so. Dr. Murray does not mention any specific training or experience related to treating substance use or substance use disorder. The fact that neither physician has identified any specific training regarding the treatment of substance use or substance use disorder is concerning. Most current medical school and residency programs do not include much, if any, substantive

training on substance use and substance use disorder. When Dr. Murray and Dr. Penn received their training in the 1980s and 1990s respectively, medication for addiction treatment for opioid use disorder, other than methadone in opioid treatment programs (OTPs), was not common or widely available.

4. Based on the curriculum vitae and the report of Mr. Vare, it is my understanding that he has no background in medicine, let alone addiction medicine.

5. I find it concerning that none of the experts Defendants have hired to opine on substance use management or substance use disorder treatment specialize in or appear to have much, if any, experience with this area of practice. As I discuss in more detail below, the opinions they offer regarding the adequacy of the Jail's system for treating substance use and substance use disorder are not consistent with the evidence in this case, including medical records on which they purport to rely. The dissonance between their opinions and the evidence further suggests that they lack the expertise to opine on substance use management and substance use disorder treatment in the Jail.

II. THE MEDICAL RECORDS SUMMARIZED IN THE MURRAY AND PENN REPORTS DEMONSTRATE THAT THE SHERIFF'S DEPARTMENT FAILS TO PROTECT INCARCERATED PERSONS AT RISK OF SERIOUS HARM DUE TO SUBSTANCE USE INTOXICATION, WITHDRAWAL. SUBSTANCE USE DISORDER, AND OVERDOSE

6. Both Dr. Murray and Dr. Penn based certain opinions in their reports on reviews of incarcerated persons' medical records. Dr. Murray and Dr. Penn did not review the medical records themselves. Instead, they relied on consultants to review the records for them.

7. Consultants for Dr. Murray reviewed 81 medical records regarding chronic care and drafted summaries of those records that are included in Appendix J to his report. *See* Murray Rpt. at 14-15, 164-224. The consultants were either nurse practitioners, physician assistants, or physicians, although Dr. Murray did not provide any curricula vitae or descriptions of the experience for any of these

consultants. It is therefore impossible for me to determine whether these consultants have any experience with addiction medicine, let alone sufficient experience to provide adequate reviews of medical records. I also could not determine whether they have any experience practicing addiction medicine in a correctional environment. Each summary includes a conclusion as to whether the care reflected in the medical record met the standard of care. Dr. Murray concluded that "the standard of care was followed in 93% of cases reviewed," which is 75 of the 81 cases. Murray Rpt. at 15.

8. Dr. Murray also reviewed medical records related to five in-custody deaths in Appendix Q to his report, but he did not provide any opinion as to whether the standard of care was met for those patients. *See* Murray Rpt. at 39, 253-55.

9. Consultants for Dr. Penn also reviewed 81 medical records regarding mental health care and drafted summaries of those records that are included in Appendix D to his report. *See* Penn Rpt. at 9, 156-205. Dr. Penn explained that these consultants were each "correctional forensic psychiatrists" with "recent experience in jail correctional systems as treating psychiatrists," *id.* at 9, which is more information than Dr. Murray provided about his consultants, but Dr. Penn also did not provide any curricula vitae for these consultants or information about whether they have experience in addiction psychiatry. Thus, I cannot determine whether they have sufficient experience to provide adequate reviews of substance use management and substance use disorder treatment in these medical records. Dr. Penn stated that these experts "assessed through medical record reviews" "the quality of care, access to, and continuity of mental health services for SDSO incarcerated persons" and explained that "[t]heir individual summaries, comments, and findings were reviewed and incorporated into my overall analysis and expert opinions." *Id.* For each of the 81 records, either "Yes" or "No" is checked in response to the prompt: "This incarcerated person had access to care (e.g., *access to care means that, in a timely manner, seen by a qualified M[ental] H[ealth]*

professional, is rendered a clinical judgment, and receives M[ental] H[ealth] care that is ordered) for their serious or non-serious medical needs." *See generally* Penn Rpt. at 156-205. "Yes" is checked for 96% of those records, or 78 of the 81 cases reviewed. *Id.*

10. I reviewed the medical records for each incarcerated person whose medical records were summarized in either Dr. Murray's or Dr. Penn's report, and where the summary indicated that the person may have had substance use or substance use disorder. Notably, in the reviews in their reports that mention substance use or substance use disorder, Dr. Murray and Dr. Penn did not identify any problems with the care that incarcerated persons received for substance use or substance use disorder.

11. I did not receive any of these medical records until September 20, 2024. I began reviewing them immediately. The files were very large and time consuming to review and write up the issues with substance use care that I identified. My review likely would have gone more quickly if I had been provided access to TechCare, the Jail's electronic medical record system. I was, however, informed that I could not have access to TechCare.

12. I reviewed those medical records to evaluate whether the descriptions and conclusions in those summaries regarding the Jail's treatment of substance use and substance use disorder were reliable and whether Dr. Murray's and Dr. Penn's opinions predicated on those summaries were reliable. I reviewed 24 medical records summarized in Appendix J to Dr. Murray's report regarding chronic care, 3 medical records summarized in Appendix Q to Dr. Murray's report regarding in-custody deaths, and 13 medical records summarized in Appendix D to Dr. Penn's report regarding mental health care. In total, I reviewed 39 medical records because Dr. Murray's consultants and Dr. Penn's consultants both reviewed the medical record for [redacted].

13. My review was limited to the care provided for substance use and

substance use disorder. It is my understanding that the Plaintiffs' other experts will be addressing other components of the medical care provided to the class members whose files Dr. Murray's and Dr. Penn's consultants reviewed.

14. I drafted my own analysis of each of the medical records I reviewed, which are included in Appendix A and discussed throughout this report. A list of the materials I reviewed since August 21, 2024 is in Appendix B. Based on my review of those records, explained in further detail below, I found serious problems with the treatment the Jail provided to class members, including failures to meet the standard of care for treating substance use and substance use disorder. My review of those records strongly reinforced the conclusions in my initial report, which I describe in each relevant section below. My conclusions also call into question the reliability of the reviews performed by Dr. Murray's and Dr. Penn's consultants, as well as any of Dr. Murray's and Dr. Penn's conclusions predicated on the relevant consultant summaries.

III. DEFENDANTS' REPORTS FAIL TO MEANINGFULLY ANALYZE WHETHER THE SHERIFF'S DEPARTMENT ADEQUATELY TREATS PERSONS EXPERIENCING WITHDRAWAL AND THE MEDICAL FILES DEFENDANTS' EXPERTS PURPORTED TO REVIEW SHOW THAT WITHDRAWAL MANAGEMENT FREQUENTLY DID NOT MEET THE STANDARD OF CARE

15. As explained in my initial report, incarcerated persons experiencing withdrawal are at risk of serious harm, including death, but that harm is preventable if the Jail provides adequate care. Ramsey Rpt. at ¶¶ 20-21. To provide that care, the Jail "must screen persons entering the jail to identify those at risk of acute withdrawal syndromes, assess incarcerated persons at risk of withdrawal to determine if they are experiencing withdrawal, house persons experiencing withdrawal in a setting where adequate treatment can be delivered, and then deliver that treatment." Ramsey Rpt. ¶ 21. I concluded that the Jail failed to adequately screen, assess, house, and treat persons at risk of experiencing withdrawal.

16. As detailed below, Defendants' Reports do not show that the Jail

adequately screens, assesses, houses, or treats persons at risk of experiencing withdrawal. Instead, the medical records that Dr. Murray and Dr. Penn relied on demonstrate several systemic failures in the Jail's management of withdrawal, which I expand on below. Those failures are:

- The Jail's intake screening process regularly misses substance use;
- When an incarcerated person's substance use is not identified at intake, they generally are not assessed, monitored, and treated for withdrawal from that substance, even if the Jail later identifies that substance use;
- Though the Jail has policies in place to monitor and treat withdrawal from opioids, alcohol, and benzodiazepines, in practice, it fails to follow those policies and procedures and to meet the standard of care;
- The Jail lacks treatment protocols regarding stimulant intoxication and withdrawal, which generally goes untreated;
- The Jail does not provide individualized withdrawal treatment, which often leads to inadequate withdrawal management, including insufficient dosing of medication for opioid withdrawal; and
- The Jail does not appropriately house persons experiencing withdrawal;

17. These failures, which are well documented in the medical records relied upon by Dr. Murray and Dr. Penn, reinforce my conclusion that the Jail fails to provide adequate withdrawal management.

A. The Jail's intake screening process regularly misses substance use

18. As I explained in my initial report, the first step in treating withdrawal is identifying people at risk for withdrawal. People are at risk for withdrawal if they have a history of using substances that have an associated withdrawal syndrome. Therefore, identifying incarcerated persons at risk for withdrawal requires screening persons entering the Jail to identify their substance use history.

19. The standard of care for identifying substance use is using a validated screening tool. A validated screening tool is a series of questions that have been empirically tested and shown to reliably identify substance use. When someone's responses to those questions indicates substance use, the next step is to assess them for withdrawal symptoms using COWS, CIWA-Ar, and other tools. Screening and

assessments are two different elements of withdrawal management.

20. Using a validated screening tool is the standard of care because it increases the likelihood that the Jail will identify substance use at intake. It would of course be unreasonable to expect that using a validated screening tool would result in a 100% success rate in identifying substance use. Screening for substance use necessarily relies on asking someone about their substance use, and there will inevitably be some persons who decline to reveal their substance use for myriad reasons, including fear of being stigmatized within the Jail for their substance use.

21. In my initial report, I concluded that the Jail's intake screening process did not meet the standard of care because the Jail did not use a validated screening tool. Instead, staff asked a series of yes or no questions regarding substance use during booking that have not been empirically tested, so there was no basis to conclude that those questions would reliably identify substance use. The responses to those questions are generally logged in the "Receiving Screening" section of an incarcerated person's medical record. If an incarcerated person gave a response to those questions that indicates they have used substances, or if a urine drug screen tests positive for recent substance use, the Jail would then ask them a second set of questions about substance use. The responses to this second set of questions are generally logged in the "Comprehensive Detox Screen" section of the medical record. Based on the responses to those questions, a decision would be made as to whether or not the person would be assessed for withdrawal. The questions in the "Comprehensive Detox Screen" have not been empirically validated either. *See* Ramsey Rpt. at ¶ 41. Someone will only be assessed for withdrawal based on their responses to that second set of screening questions in the Comprehensive Detox Screen. *Id.* at ¶ 40.

22. This multi-step screening process fails to meet the standard of care because, as I explained in my initial report, by the time a person is asked the questions in the Comprehensive Detox Screen, they have already screened positive

for substance use in response to questions in the Receiving Screening or from a urine drug screen. *Id.* By that point, the Jail should be assessing that person for withdrawal, not subjecting them to more screening questions that could disqualify that person from a withdrawal assessment.

23. The practical difference between the Jail's two-step screening process and a validated screening tool is that the questions in the validated screening tool are more likely to prompt the respondent to indicate that they have used substances. I outline this in detail using an example below, but generally speaking, a validated screening tool involves questions that identify dozens of substances by name and asks the incarcerated person if they have used them. For example, one of the validated screening tools identified in my initial report, the Tobacco, Alcohol, Prescription medication, and other Substance use Tool ("TAPS"),[1] includes specific questions that the Jail's receiving screening lacks. TAPS includes questions specifically asking the patient if they have used "any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy MDMA," if they have used "prescription medications just for the feeling, more than prescribed or that were not prescribed for you," and if they have used "a medication for anxiety or sleep (for example: Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you." *Id.*

24. In contrast, the Jail's standard intake screening is more general, asking about "use of alcohol, heroin, prescription pain medications or sedatives" and "any other illegal drugs," along with a history of "alcohol or drug withdrawal" and participation in "a detox program or substance abuse treatment program." [redacted] Med. Rcd. at 7-8. The vagueness of these questions increases the likelihood that the person answering those questions will not realize that the question is asking about a

[1] *See* National Institute of Drug Abuse, TAPS Tobacco, Alcohol, Prescription medication, and other Substance use Tool, https://nida.nih.gov/taps2 (last visited Oct. 23, 2024).

substance that they use. Those questions also include language that could discourage an incarcerated person from admitting to substance use as they are entering a Jail, including asking them if they use "illegal drugs" as they are being booked into a jail facility.

25. The medical records that Dr. Murray and Dr. Penn relied upon demonstrate that the Jail's intake screening questions routinely fail to identify substance use at intake that is identified later in a person's incarceration.[2] This means that persons who should be assessed for withdrawal are instead screened out and receive no monitoring, management, or treatment for withdrawal.

26. Dr. Murray and Dr. Penn both opine on the adequacy of the Jail's intake screening process regarding substance use, but they make no effort to evaluate the effectiveness of that screening process in practice. Neither expert even considers the content of the questions the Jail uses in its screening tool. This is somewhat surprising given that Dr. Murray is aware of the importance of using validated tools when it comes to *assessing* people for withdrawal symptoms. *See* Murray Rpt. at 10-11 ("the CIWA is a validated tool used extensively in clinical settings").

27. Dr. Murray discusses the intake screening done at the Jails on pages 9-11 and evaluates its effectiveness on page 41 of his report. He opines, "The

[2] *See* Appendix A, [redacted]e identified, but opioid and methamp[redacted] ([redacted]zepine use missed); [redacted] (opio[redacted] (metham[redacted]pioid use missed); [redacted]opioid use missed); [redacted] (opioid use mi[redacted]pioid use identified [redacted]nt[redacted]e identified but opioid us[redacted]missed); [redacted] (opioid use misse[redacted]pheta[redacted]f use missed); [redacted]issed); [redacted] (alcohol use identified but opioi[redacted] (stimul[redacted]se, alcohol use, and PCP [redacted]ol use[redacted]mine use missed); [redacted]use missed); [redacted] (opioid use and stimulant [redacted] (alcohol and s[redacted]ed); Eric Wolf (opioid use missed)

inspection of the current intake and screening process revealed that the SDSO practices meet or exceed an acceptable correctional standard. The SDSO utilizes the latest in body scanning technology to detect contraband such as drugs" and "IPs identified with substance use histories are evaluated and are monitored using COWS/CIWA." Murray Rpt. at 41. I disagree with Dr. Murray's evaluation of the thoroughness of the Jail's intake process with respect to substance use and substance use disorder.

28. Dr. Murray and I agree that intake screening, when done correctly, should "provide valuable insights into . . . substance use disorders . . . that may require ongoing management or treatment within the correctional facility." Murray Rpt. at 9. But I disagree with Dr. Murray's opinion that the Jail's intake process "adequately assesses and dispositions IPs entering the jail under the influence of alcohol and drugs." Murray Rpt. at 41. Dr. Murray's opinion on the intake process regarding substance use and substance use disorder is not grounded in any discernible methodology. He appears simply to summarize some of the Jail's policies regarding intake screening, without actually citing to any policies, and then asserts those policies are actually implemented in practice based on his review of 75 records without any explanation of which (if any) of those records involved patients screened for substance use or assessed for substance use disorder. *Id.* at 11-12, 155-61. But the medical records summarized in Dr. Murray's expert report show repeated failures in the intake screening and assessment process.

29. Dr. Penn discusses the intake screening on pages 13-16 of his report, but he only mentions substance use or SUD in his discussion of the intake process once, "During booking, if any IP exhibits changes in mental status, signs of intoxication, substance influence, psychosis, disorientation, or other acute medical or mental health issues, this information is promptly communicated to the SDSO booking deputies. The deputies then relay this information to the intake registered nurse." Penn Rpt. at 14. Like Dr. Murray, Dr. Penn merely summarizes his

understanding of what the Jail's intake screening policies are supposed to be, without actually citing those policies or using any methodology to determine if they are followed in practice.

30. The medical records, however, include numerous examples of persons who were willing to admit to substance use, but the intake screening failed to identify the entirety of their substance use. Records where the intake screening identified the use of some, but not all, substances show that the Jail's screening process misses substances even when incarcerated persons are willing to admit to substance use. In those instances, a validated screening tool is more likely to have identified substance use that the Jail's screening tool missed because it ensures that incarcerated persons will be asked specifically about a wide range of substances. There are also records where the intake screening did not identify any substance use, but the incarcerated person readily admitted to substance use shortly thereafter, indicating the problem was the screening tool.

31. For example, [redacted]' medical record illustrates how the questions the Jail uses in its standard intake screening can fail to identify substance use that likely would have been identified by a validated screening tool. The Jail's standard intake screening failed to identify Mr. [redacted] cocaine use at booking, although daily cocaine use was identified during an Inmate Safety Program (ISP) follow-up three hours later. [redacted] Med. Rcd. at 7-8 (intake screening conducted on [redacted] 2020, at [redacted] p.m.), 282 (ISP assessment conducted on [redacted] 2020, at [redacted] p.m.). The following month, medical staff identified a history of benzodiazepine use as well, specifically alprazolam [Xanax]. *Id.* at 1342-43. The intake screening's failure to identify Mr. [redacted] substance use cannot be explained away on the basis that he was unwilling to disclose it because he admitted to cocaine use the night that he was booked and he admitted to benzodiazepine use one month later.

32. Instead, Mr. [redacted] medical record indicates that the use of a validated

screening tool at intake may have identified his cocaine use and benzodiazepine use. Mr. [redacted] answered "no" to all the questions on the standard intake screening, but three hours later he confirmed daily cocaine use in response to a more specific question in the ISP assessment that asked about "recent substance use," specifically "amphetamines, THC, EtOH, Opiates, Cocaine, or Other." *Id.* at 282. And one month later, he confirmed his "past Xanax" use only "[w]hen prompted" by a medical provider. *Id.* at 1343. This indicates that the Jail's standard intake screening questions may have missed Mr. [redacted] substance use because they did not specifically mention "cocaine" or "Xanax" by name, instead asking about "other illegal drugs" and "sedatives" more generally. The validated TAPS tool may have been more effective because its questions identify "cocaine" and "Xanax" by name. The form of the questions also may have made a difference given the note that Mr. [redacted] only acknowledged benzodiazepine use "[w]hen prompted." The validated TAPS tool's questions regarding prescription medication use involve detailed prompts identifying various types of prescription medication use that may have caused Mr. [redacted] to recall his past alprazolam [Xanax] use.

B. When an incarcerated person's substance use is not identified at intake, they generally are not assessed, monitored, and treated for withdrawal from that substance, even if the Jail later identifies that substance use

33. Because even validated screening tools cannot be expected to have a 100% success rate, it is critical that the Jail have policies and procedures in place to refer people to substance use treatment in the event their substance use is missed at intake but identified later. A history of substance use indicates that the person may be at risk of withdrawal, return to use, and overdose. To mitigate that risk, when a history of substance use is identified, it is critical to promptly assess that person for substance use disorder so that treatment can be initiated. The Jail has policies and procedures in place to refer persons for withdrawal monitoring and substance use disorder treatment when their substance use is identified during the standard intake

screening. But it lacks similar policies and procedures when an incarcerated person's substance use is identified for the first time after the intake screening, even when it is identified on the same day that the intake screening occurred. The medical records show that the Jail's lack of any policy, procedure, or practice to refer those persons for assessment and treatment for substance use disorder has resulted in the Jail failing to provide timely care – or any care at all – to incarcerated persons that it knows may be at risk of withdrawal, return to use, and overdose.[3]

34. [redacted]s medical record is a clear example of the Jail's practice of failing to provide care to patients that medical providers know, or should know, may be at risk for withdrawal, return to use, and overdose. Mr. [redacted]'s methamphetamine use was identified during the standard intake screening on [redacted] 2023, but his opioid use was missed. However, his opioid use was identified later that day when Mr. [redacted] was referred for an ISP assessment/follow-up for mental health care ("MHC"). [redacted] Med. Rcd. at 48-58. During that follow-up, Mr. [redacted]'s daily amphetamine and opioid use was identified. *Id.* at 56. At this point, Jail medical staff knew that Mr. [redacted] used opioids daily and should have started him on opioid withdrawal protocols with COWS assessments, then promptly diagnosed OUD, and provided him with MOUD. None of that happened. It appears that, because Mr. [redacted]'s opioid use was identified outside of the regular intake screening process – even though it was identified on the day that he was booked – the Jail's opioid withdrawal protocols were not initiated.

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C. Though the Jail has policies and procedures in place to monitor and treat withdrawal from opioids, alcohol, and benzodiazepines, in practice, it fails to follow those policies and to meet the standard of care

35. As I explained in my initial report, once someone screens positive for substance use, the next step in providing withdrawal management is to assess that person to determine if they are experiencing withdrawal. *See* Ramsey Rpt. at ¶ 51. I described four tools that are the standard of care for withdrawal assessments of the substances for which the Jail has policies and procedures in my initial report, COWS for opioids, CIWA-Ar and PAWSS for alcohol, and CIWA-B for benzodiazepines. *Id.* at ¶¶ 52-55. The Jail uses all those tools except for PAWSS. I also described the standard of care for monitoring stimulant intoxication and withdrawal, which the Jail does not manage or treat and is discussed in greater detail in the following section.

36. Each of these tools works similarly in practice – a nurse observes a patient and responds to a series of prompts regarding the patient's condition. Each prompt involves an observation of a symptom of withdrawal and has a set of pre-defined responses. Each of those responses is assigned a score. Generally speaking, the higher the score, the more severe the symptom of withdrawal.

37. Each of these tools is intended to be used by a nurse trained in addiction withdrawal management. *Id.* at ¶ 56. That training is important because the tools assess for withdrawal based on a mix of objective and subjective observations. An example of an objective prompt is the patient's resting heart rate. On the COWS assessment, a resting heart rate of 80 or below scores 0, 81-100 scores 1, 101-120 scores 2, and over 120 scores 4.[4] An example of a subjective prompt is the extent to which a patient has "gooseflesh skin," which has three

[4] *See* Clinical Opiate Withdrawal Scale, National Institute on Drug Abuse, https://nida.nih.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf.

possible responses: "Skin is smooth," which scores 0; "piloerection of skin can be felt or hairs standing up on arms," which scores 3; or "prominent piloerection," which scores 5. *Id.* That subjective prompt requires training so that the observer can tell the difference between a "piloerection of skin" that scores 3 and a "prominent piloerection" that scores 5. In my initial report, I concluded that the Jail does not use adequately trained nurses to complete these assessments. If the Jail used certified addiction registered nurses ("CARNs") to complete these assessments or used a CARN to train the nurses, I likely would have concluded they were adequately trained because CARNs have to complete an addiction-specific certificate. But the Jail uses registered nurses (RNs) not CARNs, so I reviewed evidence regarding the trainings that those RNs received and concluded the trainings were inadequate. *Id.* at ¶¶ 62-69. Several medical records reviewed for this report support that conclusion because they include COWS and CIWA-Ar assessments that were completed inadequately.

38. A fundamental component of the standard of care for these assessments is completing these assessments serially at regular intervals. The frequency of the assessments is critical because symptoms of withdrawal can change rapidly, particularly during the several days after their last consumption of the substance when the risk of complications from withdrawal is highest. Ramsey Rpt. at ¶ 59. Often, the first withdrawal assessment is completed while the patient is still intoxicated, or post-intoxication but before withdrawal symptoms have started, leading to a low score. Symptoms of withdrawal begin to present after intoxication wears off (which varies by the substance and its half-life), necessitating frequent assessments to monitor the evolving severity of the withdrawal.

39. I outlined the standard of care for the frequency of withdrawal assessments in my initial report, explaining the Bureau of Justice Assistance (BJA) Guidelines are "monitoring for alcohol withdrawal at least every 6 hours for the first 72 hours after arrival to a facility; for opioid withdrawal at least every 4 hours for

the first 72 hours after arrival to a facility; for sedative (benzodiazepine) withdrawal at least every 6 hours for the first week after arrival to a facility; and for stimulant withdrawal at least twice daily for the first 72 hours after arrival to a facility." *See* Ramsey Rpt. at 22-23, ¶ 59. I generally agree with these guidelines, although I noted in my initial report that some variance in that timing is appropriate for alcohol and opioid withdrawal. Ramsey Rpt. at 22-23, ¶¶ 59-60. CIWA-Ar assessments for alcohol withdrawal should be completed "minimally every 4 hours initially; for a score less than 8 on three consecutive assessments, monitoring may be spaced to every 8 hours, but for a score greater than 8, a patient should be monitored and reassessed every 1-2 hours." *Id.* COWS assessments should be completed "every 6 hours for scores less than 13," but should be completed "hourly for scores greater than or equal to 13." *Id.* at ¶ 60. The evidence I reviewed in connection with my initial report demonstrated that the Jail did not conduct these assessments with sufficient frequency because it had a practice of conducting these assessments just once every 24 hours.

40. Defendants' expert reports note that the Jail uses COWS, CIWA-Ar, and CIWA-B assessments, but they make no attempt to evaluate whether those assessments were completed adequately. Dr. Murray notes that the Jail has policies for using COWS, CIWA-Ar, and CIWA-B, but he failed to evaluate whether staff properly use those tools in practice. Murray Rpt. at 10-11. Moreover, Dr. Murray acknowledges that the Jails only use COWS and/or CIWA "once daily," which is not the standard of care. *Id.* at 10. Dr. Penn states "individuals with substance use histories are evaluated and monitored using COWS/CIWA," but also does not attempt to evaluate the adequacy of that monitoring in practice. Penn Rpt. at 56.

41. The medical records I reviewed for this report show the Jail's practices do not meet the standard of care. The Jail's practice is to only *attempt* assessments once per day, but those assessments are regularly not completed. When an assessment is not completed, the Jail's practice does not involve attempting the

assessment again before another 24 hours have passed. This results in patients regularly going days between completed assessments, including during the pivotal first days after cessation of use, when withdrawal symptoms may emerge and the risk of complications from withdrawal are heightened.

42. Many of the 39 medical records reviewed in connection with this rebuttal report and summarized in Appendix A contain evidence of the Jail's practice of attempting COWS, CIWA-Ar, and CIWA-B assessments just once per day and actually completing them less frequently.[5] [redacted] medical record is worth breaking down in detail here because all three types of assessments were conducted for Mr. [redacted] over the course of an eleven-day period in line with the Jail's practice of attempting assessments only once per day, regardless of whether or not they are actually completed.

43. Mr. [redacted] was first assessed for opioid withdrawal using COWS on [redacted], 2023, at [redacted] resulting in a score of 1 and a notation to "[r]eassess in 8 hours." The next assessment did not come until more than 15 hours later, on [redacted], 2023, at [redacted] a.m., when the score jumped to 14, which indicates he was experiencing moderate opioid withdrawal symptoms and should have been reassessed again within one hour. [redacted] Med. Rcd. at 199-200. Instead, that assessment included a notation to "[r]eassess in 6 hours." *Id.* at 199. But no attempt was made to conduct another COWS assessment until more than 27 hours later on [redacted], 2023, at [redacted] p.m., and that assessment was not even completed. *Id.* at 205-06. Instead of completing the assessment, a nurse noted Mr. [redacted] was unavailable due to a court appearance. *Id.* That incomplete assessment included a

[5] The following summaries in Appen[redacted]e this practice: [redacted] (COWS, C[redacted]A-B); [redacted]Ar); R[redacted]ford (COW[redacted] (C[redacted] (C[redacted]WA-[redacted]). [redacted]WA-B); [redacted]OWS); [redacted]WS); [redacted] (COW[redacted] (COW[redacted]r); [redacted] CIWA-Ar)

notation to "[r]eassess in 8 hours." *Id.* at 205. But it took more than 24 hours (over 47 hours since the last completed assessment) before staff attempted to complete another COWS assessment on [redacted] 2023, at [redacted] p.m., at which point the assessment produced a score of 4 with another notation to "[r]eassess in 8 hours." *Id.* at 217.

44. From there, the Jail waited over 25 hours to attempt an assessment on [redacted] 2023 at [redacted] p.m., which was completed with a score of 7 and a note to reassess in 8 hours. *Id.* at 225-26. The next attempt came more than 25 hours later on [redacted], 2023, at [redacted] p.m., with a score of 3 and a note to reassess in 8 hours. *Id.* at 233-34. That was followed by multiple unsuccessful attempts to complete COWS assessments, with the next attempt coming more than 21 hours later on [redacted], 2023, at [redacted] p.m. during which Mr. [redacted] was unavailable and a notation was made to reassess in four hours, *id.* at 239-40, then a delay of more than 23 hours until the next attempt on [redacted], 2023, at [redacted] p.m., when he was again unavailable with a note to "[r]eassess in 4 hours." *Id.* at 245-46. Medical staff waited more than 24 hours before the next attempt on [redacted], 2023, at [redacted] p.m., which was successfully completed and resulted in a score of 5 and a note to reassess in 8 hours. *Id.* at 253-54. As a result, there was a gap of more than 69 hours between completed assessments. Staff then delayed nearly 48 hours until the next attempt on [redacted], 2023, at [redacted] p.m., which was completed with a score of 3 and a note to reassess in 8 hours. *Id.* at 259-60. Staff made a final attempt over 18 hours later on [redacted], 2023, at [redacted] a.m., which was completed with a score of 3 and note to reassess in 8 hours. No further COWS assessments were attempted.

45. The repeated and substantial delays in assessments fell far below the standard of care. Moreover, medical staff also were clearly aware that Mr. [redacted] needed to be assessed more frequently—every assessment included a notation to reassess in either 4, 6, or 8 hours—but failed to do so.

46. The Jail's failure to conduct Mr. [redacted]s COWS assessments with

adequate frequency exposed him to a substantial risk that he would experience complications from opioid withdrawal, but medical staff would not know and therefore would not be able to provide adequate treatment. This risk was particularly pronounced in the nearly 52-hour period between Mr. [redacted]'s first completed assessment that scored 14, indicating he was experiencing moderate withdrawal, and his second completed assessment.

47. The Jail also failed to assess Mr. [redacted]'s alcohol and benzodiazepine withdrawal with adequate frequency. CIWA-Ar assessments for alcohol withdrawal should be completed every 4 hours until three consecutive assessments produce a score of less than 8, at which point they can be spaced out to every 8 hours. Ramsey Rpt. at 23, ¶ 60. CIWA-Ar scores of more than 8 should prompt reassessment within 2 hours. *Id.* Mr. [redacted]'s CIWA-Ar assessments were only attempted once per day and actually completed less frequently.[6] The repeated and substantial delays in these assessments fell far below the standard of care.

[6] The CIWA-Ar assessments occurred on the following dates and times:

- [redacted]., completed, score 2, reassess in 8 hours), *id.* at
- [redacted](15+ hours later, [redacted] a.m., completed, score 20, reassess in 95-96;
- [redacted], 2023 (25+ hours later, [redacted] p.m., not completed, reassess in 4 at 201-02;
- [redacted]ust 19, 2023 (24+ hours later, 51+ hours since last completed assessment, [redacted] completed, score 3, reas[redacted] in 8 hours), *id.* at 209-10;
- [redacted], 2023 (25+ hours later, [redacted] p.m., completed, score 5, reassess in 8 at 221-22;
- [redacted], 2023 (25+ hours later, [redacted] p.m., completed, score 1, reassess in 8 at 229-30;
- [redacted] 2023 (21+ hours later, [redacted] p.m., not completed, reassess in 4 at 235-36;
- [redacted], 2023 (23+ hours later, [redacted] p.m., not completed, reassess in 4 at 241-42;
- [redacted], 2023 (24+ hours later, 69+ hours since last completed assessment, [redacted] completed, score 0, reas[redacted] in 8 hours), *id.* at 249-50;
- [redacted], 2023 (47+ hours later, [redacted] p.m., completed, score 3, reassess in 8 at 255-56;
- [redacted], 2023 (18+ hours later, [redacted] a.m., completed, score 1, reassess in 8 . at 263-64.

48. CIWA-B assessments should be completed at least every 6 hours, *see* Ramsey Rpt. at 23-24, ¶ 60, but Mr. [redacted]'s CIWA-B assessments also were attempted and completed far less frequently.[7]

49. As with Mr. [redacted]'s COWS assessments, the delays in completing his CIWA-Ar and CIWA-B assessments exposed Mr. [redacted] to a potential risk of substantial harm from untreated complications of withdrawal.

D. The Jail lacks treatment protocols regarding stimulant intoxication and withdrawal, which generally go untreated

50. Persons entering the Jail under the influence of stimulants are at risk of harm, but the Jail lacks any defined protocols for treating stimulant intoxication and withdrawal. That risk of harm includes overamping from stimulant intoxication, which can lead to severe complications including stroke, seizure, and cardiac arrest. *See* Ramsey Rpt. at ¶¶ 57, 121. In my initial report, I outlined the "standard of care for identifying and monitoring persons overamping on stimulants or withdrawing from stimulants." Ramsey Rpt. at ¶ 57-58. I explained that there are no validated

[7] The CIWA-B assessments occurred on the following dates and times:

- [redacted] ([redacted] p.m., completed, score 0, reassess in 8 hours), *id.* at 197-
- [redacted], 2023 (15+ hours later, 10:22 a.m., completed, score 19, reassess in *d.* at 203-04;
- [redacted], 2023 (27+ hours later, [redacted] p.m., not completed, reassess in 4 at 213-214;
- [redacted], 2023 (24+ hours later, 51+ hours since last completed assessment, completed, score 4, rea[redacted] in 8 hours), *id.* at 223-24;
- [redacted], 2023 (25+ hours later, [redacted] p.m., completed, score 5, reassess in 8 at 231-32;
- [redacted], 2023 (25+ hours later, [redacted] p.m., completed, score 3, reassess in 8 at 237-38;
- [redacted], 2023 (21+ hours later, [redacted] p.m., not completed, reassess in 4 at 243-44;
- [redacted], 2023 (23+ hours later, [redacted] p.m., not completed, reassess in 4 at 251-52;
- [redacted], 2023 (24+ hours later, 69+ hours since last completed assessment, completed, score 1, reas[redacted] in 8 hours), *id.* at 257-58;
- [redacted], 2023 (47+ hours later, [redacted] p.m., completed, score 3, reassess in 8 at 265-66;
- [redacted], 2023 (18+ hours later, [redacted] a.m., completed, score 4, reassess in 8

tools equivalent to COWS and CIWA for monitoring stimulant intoxication or withdrawal, but that monitoring is still necessary via clinical examination and assessments of several symptoms associated with stimulant intoxication or withdrawal. *Id.* I noted that the BJA guidelines on the frequency of withdrawal monitoring state "for stimulant withdrawal at least twice daily for the first 72 hours after arrival to a facility." *Id.* at ¶ 59. I also outlined the standard of care for treating stimulant withdrawal, which includes behavioral management and medication when necessary. *Id.* at ¶ 95. I concluded that the Jail lacks any "protocol for stimulant withdrawal." *Id.* at ¶ 62.

51. Defendants' Reports do not include any opinions specific to stimulant intoxication and withdrawal. But several medical records relied on by Dr. Murray and Dr. Penn show incarcerated persons entering the Jail under the influence of stimulants without receiving any monitoring or treatment for stimulant intoxication and withdrawal.[8] These records show that the Jail's lack of policies, procedures, and protocols for stimulant intoxication and withdrawal results in the Jail regularly failing to treat stimulant intoxication and withdrawal.

E. The Jail does not provide individualized withdrawal treatment, which often leads to inadequate withdrawal management, including insufficient dosing of medication for opioid withdrawal

52. The standard of care for providing treatment to persons experiencing withdrawal requires "'frequent, individualized, clinical assessments'" with "'patient-specific orders from the provider.'" Ramsey Rpt. at ¶ 100 (quoting BJA Guidelines). Individualized withdrawal treatment is necessary because "'it is very difficult even for trained medical providers to predict withdrawal severity for any particular patient.'" *Id.* This is particularly important when it comes to dosing medication for withdrawal. To use an obvious example, a person experiencing

[8] [redacted]

opioid withdrawal who had been consuming 2mg of fentanyl per day for three years would likely need a higher dose of medication than a person experiencing opioid withdrawal who had been consuming 1mg of fentanyl per day for three months.

53. In my initial report, I concluded that "the Jail's approach to addressing withdrawal is reactive, rather than proactive, with no indication of individualized care, assessment, or dosing." Ramsey Rpt. at 40, ¶ 101. I pointed out that the Sheriff's Department "treated patients in opioid, alcohol, or benzodiazepine withdrawal with the same doses of medication for that specific withdrawal syndrome, contrary to the standard of care." *Id.* ¶ 102. I highlighted an email that the Jail's Chief Medical Officer Dr. Jon Montgomery sent in September 2023 in which he wrote "docs/providers felt constrained that they were only able to prescribe 8/2 milligrams for Suboxone (buprenorphine/naloxone) … no more, no less" and detailed why I was not convinced by testimony in his April 26, 2024 deposition (two months before Mr. Woodford's death) in which he stated that buprenorphine/naloxone dosing had become more flexible. *Id.* at 42, ¶¶ 106-07. I concluded that the Jail "fails to provide individualized care for individuals with opioid use disorder who are experiencing acute opioid withdrawal syndrome," in part because of the Jail's practice of using a "fixed medication dose" strategy for all patients, which is inconsistent with the "much safer option" of "low dose buprenorphine initiation strategies." *Id.* at 43, 46, ¶¶ 109, 117. I quoted the BJA guidelines, which state that "[a]ll patients at risk for opioid withdrawal should have rapid access to treatment," and I advised that "[o]pioid withdrawal syndrome could be avoided entirely if the Jail provided low dose initiations of buprenorphine rather than waiting for patients to experience symptoms of opioid withdrawal syndrome and then starting medication." *Id.* at 47, ¶ 119.

54. Defendants' Reports did not discuss these issues. But the medical records that Dr. Murray and Dr. Penn relied on include several examples of incarcerated persons receiving inadequate withdrawal management under the Jail's

standardized withdrawal protocols. Several persons subjected to the Jail's policy of not starting buprenorphine/naloxone until receiving a COWS score of more than 6 either received buprenorphine/naloxone later than they should have,[9] or never received buprenorphine/naloxone at all.[10] Persons withdrawing from opioids also were generally prescribed buprenorphine/naloxone based on standardized doses rather than individualized assessments.[11] The serious risks of underdosing buprenorphine/naloxone, including return to use and overdose, are discussed in greater detail in the below section on individualized treatment for opioid use disorder.

F. The Jail does not appropriately house persons experiencing withdrawal

55. Dr. Murray and Dr. Penn offer brief opinions regarding housing that are worth addressing from a substance use management and substance use disorder treatment perspective. In the section of his report on intake, Dr. Murray states that "the RN's assessment findings" at intake "ensur[e] that IPs . . . are placed in safe housing based on their health status." Murray Rpt. at 10. Dr. Penn notes that custodial staff from the JPMU "determine the most appropriate housing for the individual, whether it be PSU, watch status, EOH, protective custody, general population, or outpatient stepdown." Penn Rpt. at 50. He opines that the various "Policies, Procedures, and Standards utilized by SDSO . . . are designed to mitigate risks and ensure the well-being of incarcerated individuals across housing settings." *Id.* at 51. Neither expert discusses the reality that incarcerated persons are frequently housed in holding cells for extended periods of time while going through the intake process, which I noted in my initial report poses serious risks to

[9] *See* Appendix A, [redacted].

[10] *See* Appendix A, [redacted].

[11] *See* Appendix A, [redacted]; Richard Woodford.

incarcerated persons with acute intoxication or at risk for experiencing withdrawal. Ramsey Rpt. at 30-35, ¶¶ 77, 83-84, 121-23. They also fail to acknowledge that custody staff, not medical staff, have ultimate control over housing, *id.* at 31, 32, ¶¶ 80-81, which as noted in the discussion of medical records below has led to patients experiencing withdrawal being placed in unsafe housing units with disastrous consequences, including the death of Richard Woodford in June 2024.

G. The Death of Richard Woodford Illustrates the Harm that Can Be Caused by Defendants' Inadequate System for Treating Withdrawal

56. Mr. Woodford's death at Central Jail on June 26, 2024, is worth evaluating in detail because it illustrates the catastrophic harm that can result from the Jail's systemic failure to provide withdrawal management. I discussed Mr. Woodford's death in my initial report based on an interview I conducted with an incarcerated person housed in the unit where Mr. Woodford died. *See* Ramsey Rpt. at 34-35, ¶ 86. At the time, Defendants had not made his medical records available. My understanding is that Defendants did not produce the records to the Plaintiffs until September 20, 2024, after which they were provided to me. The records reveal stunning failures in withdrawal management that likely resulted in Mr. Woodford's death.

57. At intake on the morning of June 25, 2024, Mr. Woodford's fentanyl use and history of withdrawal were identified, *see* Woodford Med. Rcd. at 7-8, and a comprehensive detox screen was completed noting daily recent opioid use, *see id.* at 31. Shortly thereafter, at 10:47 a.m., a STATCare provider ordered "[i]nitiate Suboxone treatment with 8/2mg Suboxone daily starting the day after incarceration." *Id.* at 21. In the same note, that STATCare provider wrote "[n]o clinical assessment performed on this p[a]t[ient]." *Id.*

58. The STATCare provider never assessed Mr. Woodford and did not provide individualized treatment. Instead, at 10:47 a.m. on June 25, 2024, he ordered the Jail's standard buprenorphine/naloxone 8/2mg dose to be started the

following day at 8:00 a.m., which was more than 21 hours away. *Id.* at 22. A COWS assessment performed just six minutes prior at 10:41 a.m. resulted in a score of 1 based only on Mr. Woodford's pulse, which had it been 1 bpm lower would have resulted in a score of 0. *Id.* at 28-29. This score reflects that Mr. Woodford was not yet experiencing many, if any, symptoms of withdrawal.

59. The Jail did begin COWS assessments for Mr. Woodford, but those assessments also reflect many of the exact failures that I identified with the Jail's withdrawal assessment policies, procedures, and practices in my initial report. Three COWS assessments were completed by three different nurses while Mr. Woodford was incarcerated. As noted above, the first assessment was conducted by an RN at 10:41 a.m. on June 25, 2024, within minutes of Mr. Woodford's booking and resulted in an overall score of 1. *Id.* at 28-29. As explained above and in my initial report, the standard of care required that the second assessment be conducted within at most 4-6 hours. Ramsey Rpt. at 23, ¶¶ 59-60. The record of the first COWS assessment includes a note to "[r]eassess in 8 hours," which is longer than that standard of care but would have at least ensured Mr. Woodford was assessed again the same day. However, Mr. Woodford's second assessment did not occur until nearly 18 hours later at 4:29 a.m. on June 26, 2024. This assessment resulted in a score of 10. Woodford Med. Rcd. at 41-42. By that point, Mr. Woodford was experiencing symptoms of withdrawal, including "[m]ultiple episodes of diarrhea or vomiting," *id.* at 42, which is consistent with what was described to me by the incarcerated person in Mr. Woodford's housing unit, *see* Ramsey Rpt. at 34-35, ¶ 86. That score prompted a STATCare provider to order "[g]ive morning dose of [S]uboxone now" at 4:37 A.M. and to "[a]lert S[TAT]C[are] with any increase or worsening of symptoms." Woodford Med. Rcd. at 22. This order by the STATCare provider was appropriate. However, if the Jail had followed the standard of care for COWS assessments, Mr. Woodford would have already been assessed at least two additional times by that point (no later than

4:41 p.m. and 10:41 p.m. on June 25, 2024). Those assessments may have prompted the STATCare provider to order his medication to start sooner.

60. At 5:16 a.m., an RN noted that Mr. Woodford refused the buprenorphine/naloxone and said he would take it later. *Id.* The STATCare provider responded to this note at 6:04 a.m., but did not direct nursing staff on-site to take any action to ensure Mr. Woodford received his withdrawal medication, instead noting the refusal and again writing "[a]lert SC with any changes." At 10:22 a.m., Mr. Woodford took his first dose of buprenorphine/naloxone 8/2mg. *Id.* at 52.

61. That RN also performed a timely COWS assessment at 10:29 a.m. Unfortunately, this third assessment likely was not performed properly. *See* Ramsey Rpt. at 24-27 (discussing inadequate training practices for withdrawal assessments). The third assessment resulted in an overall score of 5. Murray Med. Rcd. at 45-46. It notes "[n]o GI symptoms." But as I discussed in my report, incarcerated persons in the Jail reported that Mr. Woodford was defecating on himself throughout his incarceration. *See* Ramsey Rpt. 34-35, ¶ 86.

62. At the same time as the COWS assessment, the RN also took vital signs that showed Mr. Woodford was experiencing potentially dangerous complications of withdrawal, including a sharp dip in blood pressure (from 128/78 at 4:29 a.m. to 98/63 at 10:29 a.m.) that indicated Mr. Woodford was becoming hypotensive. Murray Med. Rcd. at 24. He also had an elevated heart rate and rapid respirations, which combined with his low blood pressure indicate he likely had hypovolemia due to excessive vomiting and diarrhea. This should have prompted an alert from the nurse to the STATCare provider, but there is no record that such an alert was sent.

63. After the third COWS assessment, the standard of care was to perform another assessment within 6 hours (by 4:29 p.m.). *Id.* Mr. Woodford never received another COWS assessment. He was not seen by medical staff again until a "man down" call at around 5:56 p.m. on June 26, 2024, by which point Mr. Woodford was found breathing but non-responsive. He died shortly thereafter.

64. The Jail has not provided a medical examiner's report on Mr. Woodford's death at time of writing, so no official cause of death is available yet. His medical record indicates that Mr. Woodford was experiencing withdrawal symptoms at the time he died. As noted above, the last vital signs taken about eight hours before his death indicate that he likely had hypovolemia due to excessive vomiting and diarrhea, which are symptoms of withdrawal. His pupils also were dilated to 5-6mm in the minutes before he died, which is consistent with opioid withdrawal and inconsistent with opioid intoxication. *Id.* at 23. He also reported a lengthy history of opioid use at intake. It is very likely that Mr. Woodford died from inadequately managed withdrawal while in the care of the Sheriff's Department.

IV. DEFENDANTS' REPORTS FAIL TO SHOW THAT THE SHERIFF'S DEPARTMENT ADEQUATELY TREATS PERSONS WITH SUBSTANCE USE DISORDER

65. In my initial report, I concluded that the Sheriff's Department fails to provide adequate treatment for incarcerated persons with substance use disorder ("SUD"). For those with opioid use disorder ("OUD"), the Department does not provide adequate access to medication for opioid use disorder ("MOUD"). Defendants' Reports' discussions of OUD, described below, fail to show the Department provides adequate access to MOUD. For those with alcohol use disorder and/or stimulant use disorder, I concluded the Department did not have any policies or procedures to provide treatment post-withdrawal. Defendants' Reports offer no conclusions as to alcohol or stimulant use disorder whatsoever. In fact, the medical records that Dr. Murray and Dr. Penn relied on not only reinforced my opinion as to alcohol and stimulant use disorder, but also prompted me to expand that opinion and conclude that the Department fails to provide treatment for any non-opioid use disorder post-withdrawal.

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A. The Sheriff's Department Fails to Meet the Standard of Care for Persons with Opioid Use Disorder

66. I repeatedly emphasized in my initial report that the standard of care for treating OUD is providing MOUD adequately. This is the standard of care because medication is the only treatment that is associated with decreased mortality in persons with OUD. The most obvious risk from failing to treat OUD is also the most dangerous – that the patient will return to using opioids from the unregulated drug supply, which can result in severe consequences, including overdose and death. MOUD can mitigate that risk, but only if it is provided consistently and at a sufficient dose to address opioid cravings for the patient to avoid returning to use.

67. Defendants' Reports do not show that the Jail is providing adequate treatment for OUD. Dr. Murray, Dr. Penn, and Mr. Vare all opine that the Jail's treatment of OUD is adequate based largely on the overall number of persons that the Jail claims have received some amount of medication for opioid use at some point. None of the experts attempted to evaluate whether the provision of that medication was adequate. But the medical records relied on by Dr. Murray and Dr. Penn show that the Jail systemically fails to treat OUD adequately. Those failures are discussed in greater detail below, and they include:

- The Jail fails to promptly diagnose OUD and deliver MOUD once it learns that an incarcerated person likely has OUD
- The Jail fails to provide adequate care to those with OUD, including by failing to provide sufficient doses of MOUD and failing to ensure MOUD is not discontinued when treatment is still needed

68. Dr. Murray and Dr. Penn both explain that the Jail differentiates between MAT and MOUD. Dr. Murray and Dr. Penn state that the MAT program involves "patients receiving both medication and counseling/behavioral therapy," Murray Rpt. at 25, *see also* Penn Rpt. at 59, while they define MOUD as involving "patients receiving medication for OUD but have declined the counseling/behavioral therapy component." *Id.* Based on those definitions, both Dr. Murray and Dr. Penn

claim that on May 7, 2024, there were 193 incarcerated persons in the MAT program and 436 incarcerated persons receiving MOUD who were *not* in the MAT program. They also each introduced a third category of OUD treatment – "buprenorphine for detox management" – defined as persons receiving buprenorphine/naloxone who were "awaiting a face-to-face visit with a MAT provider." *Id.* They disagreed on just how long this waitlist was as of May 7, 2024, with Dr. Murray stating 706 persons were on this waitlist while Dr. Penn stated 77 persons were on the waitlist. *Id.* Mr. Vare had completely different numbers, claiming that "[t]he numbers of IPs in the MAT program currently are far larger" than "875 per month." Vare Rpt. at 66.

69. Defendants' experts' reliance on the overall numbers of persons receiving MOUD is an insufficient basis to conclude that the Jail provides adequate treatment for persons on MOUD. To start, Defendants' experts provide no baseline with which to compare the Jail's data. Without that context, it is not possible to determine whether the MOUD program is adequate. More importantly, none of the experts conducted any assessment to evaluate whether the persons purported to be receiving medication via MAT, MOUD, or "buprenorphine for detox management" actually are receiving care consistent with the standard of care. My review of the medical records that Defendants' experts' consultants reviewed showed that the MOUD program at the Jail is deficient in many aspects that expose incarcerated persons to a substantial risk of serious harm, including overdose and death.

1. The Jail fails to promptly diagnose OUD and deliver MOUD once it learns that an incarcerated person likely has OUD

70. As explained in my initial report, anyone "identified as likely having OUD should be seen by a medical provider immediately to establish a diagnosis and should be started on medication with buprenorphine or methadone . . . with dose adjustments as needed for protracted opioid withdrawal syndrome or for ongoing cravings, from the outset." Ramsey Rpt. at ¶ 158. Diagnosing OUD quickly is

important because "[i]ndividuals with OUD not treated appropriately are more likely to return to use." *Id.* As I explained earlier in this report, the Jail's standard intake screening routinely misses substance use that is identified by Jail medical staff at a later date. But the Jail lacks policies, procedures, and protocols to ensure that when an incarcerated person's substance use is identified for the first time after the receiving screening, that person is promptly referred for diagnosis and treatment of OUD. Several medical records relied on by Dr. Murray and Dr. Penn show Jail medical staff identifying substance use that indicates an incarcerated person likely has OUD but making no attempt to refer that person for diagnosis and treatment of OUD. This can result in lengthy delays (often months or longer) between the Jail becoming aware that someone likely has OUD and that person receiving MOUD – with some instances of the person never receiving any treatment.[12]

71. For example, [redacted] had received buprenorphine/naloxone prior to his incarceration, but his history of opioid use was not identified at his intake on [redacted] 2023. *See* [redacted] Med. Rcd. at 10-11. The following day, Mr. [redacted] submitted an inmate request noting that he used fentanyl and wanted to be in the MAT program to keep him safe from "overdosing on fentanyl if it enters the jail." *Id.* at 235. Three weeks after intake, Mr. [redacted]'s partner began calling the Jail asking for Mr. [redacted] to be placed on the MAT program. Staff repeatedly informed Mr. [redacted]'s partner that he was "on the MAT interest queue" but "there is not a timeframe to be given on how soon he will be seen." *Id.* at 30. Mr. [redacted]'s partner called the Jail at least five times over the course of two weeks from [redacted] 2023 to [redacted] 2023, and consistently received the same response. *Id.* at 30-31. Mr. [redacted] finally was evaluated for the MAT program on

[12] [redacted]

November 8, 2023, more than one month after his initial request.

72. In another example, [redacted]'s methamphetamine use was identified during the standard intake screening, but her opioid use was missed and not identified until a psychiatric evaluation two weeks later. [redacted] Med. Rcd. at 54 ([redacted] 2023, receiving screening), 745 ([redacted], 2023, psychiatric evaluation). During that psychiatric evaluation, Ms. [redacted] "expresse[d] interest in the MAT program." *Id.* At that point in time, the standard of care in the Jail should have been to assess and diagnose Ms. [redacted]'s OUD promptly so she could be started on MOUD immediately. Instead, it took more than three months before Ms. [redacted] eventually was diagnosed with OUD on [redacted], 2023. *Id.* at 206.

73. In yet another example, on [redacted], 2023, [redacted] requested MOUD seven weeks after he was booked into the Jail. The following day, a psychiatric evaluation identified that Mr. [redacted] had daily or every other day opioid use. [redacted] Med. Record at 89-90. After receiving no response, Mr. [redacted] had to request buprenorphine/naloxone again on [redacted] 2023, at which point he was told he was on the MAT interest queue. Mr. [redacted] waited almost two months and again requested buprenorphine/naloxone on [redacted] 2024, at which point he was assessed and diagnosed with OUD on [redacted], 2024, which finally led to treatment with buprenorphine/naloxone. The Jail's four-month failure to treat Mr. [redacted]'s OUD is a violation of the standard of care and placed him at risk during that time period.

74. One group of persons who likely have OUD that the Jail should have no trouble identifying is persons who are in opioid withdrawal and already receiving buprenorphine/naloxone from the Jail. Under the standard of care, "[a]ll persons with opioid use and/or OUD should be monitored medically for acute opioid withdrawal syndrome and offered MOUD ***as an ongoing treatment***." Ramsey Rpt. at ¶ 173 (emphasis added). But the medical records relied on by Dr. Murray and Dr. Penn include multiple instances where the Jail failed to continue incarcerated

persons with OUD on MOUD without interruption after they were no longer monitored for withdrawal.[13]

75. On page 28 of his report, Dr. Penn asserts that "StatCare is a specialized division within NaphCare, which currently provides MAT, mental health, and utilization management services to SDSO. StatCare specifically focuses on offering urgent and emergent healthcare services" and "StatCare provides: **24/7 Availability**: STATCare operates around the clock, providing immediate medical consultation and support to SDSO facilities whenever urgent care is needed. This immediate support includes medication management for chronic care or MAT patients upon intake or during their time in SDSO." Penn Rpt. at 28. From the medical records I have reviewed, including several noted in footnote 14 above and described in the Appendix, STATCare does not provide immediate medical consultation and immediate support for patients with OUD. *See also* Ramsey Rpt. at 49, ¶ 124. Patients in the SD Jail often wait days to start buprenorphine for acute opioid withdrawal.

76. On page 26 of Dr. Murray's report, he states, "The SDSO MSD is currently working to draft policies, treatment guidelines, training, standardized note templates, and an improved flagging system. Recommendations would also include the establishment of a CQI program for monitoring the MAT/MOUD program for ongoing improvement." I am unaware of any evidence that the Jail has implemented "an improved flagging system" since Dr. Murray's report. Another reason that I doubt these claims is that NaphCare was supposed to create a CQI program with regularly scheduled quarterly meetings under its contract with the Jail, which was not happening as of April 16, 2024, *see* Nix Depo. Tr. at 146:20-147:4, and is apparently still not happening given that Dr. Murray recommended such a program be created for MAT/MOUD, Murray Rpt. at 26.

[13] *See* Appendix A, [redacted]

77. Dr. Murray raises one issue in his report relevant to providing MOUD for those the Jail knows likely have OUD that I did not see reflected in the medical records. He states that patients already "receiving treatment for OUD at the time of incarceration are offered continuation of their medication, often in partnership with their Opioid Treatment Program (OTP) in the community when possible." Murray Rpt. at 25. But he provides no data as to how many times this has occurred. As discussed in my initial report, based on deposition testimony from Dr. Montgomery and NaphCare personnel, the only reliable number available appears to be the "probably 50 or less" patients identified during NaphCare's 30(b)(6) deposition. Nix Depo. Tr., Vol. II, at 66:1-22.

78. Dr. Murray also states that NaphCare has 7 staff in the MAT program: two NPs, one physician, and four mental health counselors. Murray Rpt. at 25. Group counseling occurs only at two sites. Only one site has a dedicated MAT housing unit. Given the volume of patients in the Jails with substance use and SUD, I question whether this is an adequate number of personnel to staff the MAT program effectively. My review of medical records revealed there are often substantial delays in assessing persons for and providing persons with MOUD. These delays strongly suggest that the Jail does not have sufficient personnel to provide incarcerated persons with timely evaluations and treatment for OUD.

2. The Jail fails to provide adequate care to those with OUD, including by failing to provide sufficient doses of MOUD and failing to ensure MOUD is not discontinued when treatment is still needed

79. As I explained in my initial report, the standard of care for treating OUD is providing opioid agonist medication (with methadone or buprenorphine) at a sufficient dose to address opioid cravings so that the patient does not return to use. Cravings are one of the DSM-5-TR criteria for SUD, which is why the standard of care is to provide a sufficient dose of methadone or buprenorphine to eliminate opioid cravings and prevent the risk that the patient returns to use.

80. Dosing must be individualized, as "[s]ome patients with high opioid tolerance may require buprenorphine doses above 24 mg/day during treatment stabilization," and that "[h]igher doses of buprenorphine (≥ 16 mg daily) appear necessary for rapid stabilization in individuals with" exposure to highly potent synthetic opioids, such as fentanyl. Ramsey Rpt. at ¶ 192. It remains difficult to pin down exactly what the Jail's policies, procedures, and practices are regarding dosing buprenorphine/naloxone. The operative NaphCare MAT policy "states that buprenorphine 16 mg daily is the maximum dose unless there is a 'verified dosage from the community' not to exceed 24 mg." *Id.* at ¶ 195. This policy limits the ability of a medical provider in the Jail to provide an adequate dose of buprenorphine/naloxone if their medical judgment is that an incarcerated person needs a dose higher than 24mg but an equivalent community dose cannot be verified. This verification step risks preventing persons who need that dose but never received MOUD in the community from getting access to an adequate dose. It also blocks persons who did receive such a dose but are unable to get that dose verified for any reason.

81. In addition, an allegation of diversion should not prevent an incarcerated person from receiving an adequate dose of MOUD. I noted in my initial report that "persons on M[OUD] sometimes divert medications, but that reality does nothing to change whether those persons still need M[OUD]." *Id.* at ¶ 202. NaphCare's operative written policy "includes a zero tolerance policy for diversion," *id.* at ¶ 202, which violates the standard of care because it exposes an incarcerated person accused of diversion to the risk of return to use and overdose. I outlined several mitigation strategies for diversion that do not involve reducing medication. *Id.* at ¶ 205. One allegation that an incarcerated person diverted buprenorphine/naloxone should not result in exposing that person to a risk as severe as an overdose, which can (and has) caused deaths in the Jail. The medical records that Dr. Murray and Dr. Penn relied on show that the Jail's practice is to cut an

incarcerated person's dose of MOUD following an allegation of diversion. This is a harsh, punitive response that violates the standard of care by preventing an incarcerated person from receiving an adequate dose for their OUD for non-medical reasons. In my initial report, I outlined several options the Jail could follow to discourage diversion without risking return to use. *Id.* at ¶ 205.

82. Several medical records relied on by Dr. Murray and Dr. Penn include evidence of the Jail's failure to provide adequate MOUD, including insufficient dosing,[14] incidents where an incarcerated person's access to MOUD was impacted due to allegations of diversion,[15] evidence of NaphCare's zero tolerance diversion policy specifically being active in the Jail,[16] and incarcerated persons' MOUD being discontinued because of inadequately treated side effects.[17]

83. [redacted] medical record illustrates the harms that arise from the Jail's failure to provide individualized care for OUD and its punitive response to suspected diversion. The Jail promptly identified that Mr. [redacted] had an active community-based prescription for buprenorphine/naloxone, specifically buprenorphine/naloxone 8/2 mg twice daily (BID), and began providing it to Mr. [redacted] the day after he was booked. [redacted] Med. Rcd. at 26.

84. The Jail started Mr. [redacted] on buprenorphine/naloxone 16/4 mg, the dose that he was prescribed in the community, but dosed it once daily rather than split twice daily. *Id.* at 28. After three days at this dose, Mr. [redacted] submitted a sick call request complaining that the dose was too strong, and he requested to

[14] [redacted]

[15] *See* Appendix A, [redacted]

[16] *See* Appendix A, [redacted]

[17] [redacted],

"taper off slowly" on [redacted], 2023. *Id.* at 18. Unfortunately, the Jail's typical practice of providing buprenorphine/naloxone at either 16/4 mg or 8/2 mg, with no dosing in between, prevented Mr. [redacted] from being reduced slowly, and his dose was reduced to 8/2 mg. *Id.* at 28. More nuanced dosing, reducing his dose to 14/3.5 mg or 12/3 mg or 10/2.5 mg, were all feasible options that were not utilized. Nineteen days later, on [redacted], 2023, Mr. [redacted] submitted another sick call request complaining that the dramatic reduction in his buprenorphine/naloxone led to symptoms of opioid withdrawal, and he requested a small increase "to 10/2.5 or 12/3 mg." *Id.* at 18. This request was denied, with progress notes on [redacted], 2023, and [redacted] 2023, noting that he would be maintained on the "standard dose of 8/2 mg daily." *Id.* at 30. Mr. [redacted] continued to file sick call requests for the next four months because his 8/2 mg dose was insufficient, ultimately requesting that he be returned to his initial 16/4 mg dose, but instead, the Jail maintained Mr. [redacted] at 8/2 mg. *Id.* at 19.

85. The dosing issue came to a head in [redacted] 2023. On [redacted] 2023, medical staff finally decided to "increase[] his dose from 8[/2] mg to 16[/4] mg." *Id.* at 37. But two days later, on [redacted], 2023, Mr. [redacted] was accused by custodial staff of hoarding buprenorphine/naloxone. *Id.* Two days after that, on [redacted], 2023, a court ordered the Jail to "address his prescription and medication." *Id.* At this point, the medical record makes clear that decisions about Mr. [redacted] OUD treatment were no longer solely in the hands of medical staff. On [redacted], 2024, in response to the court order, a nurse practitioner assessed Mr. [redacted]'s medical care. *Id.* at 37-38. In response to the hoarding allegation, the NP noted, "if I don't have written documentation to back up hoarding, I will increase his dose back to 16[/4] mg. If there is written proof, then I will talk to IP to explain why his dose was cut in half." *Id.* at 38. This note is concerning because it indicates the NP's medical judgment was that a 16/4 mg dose was appropriate, but that medical judgment would be overridden, and Mr. [redacted] would instead be given

half the adequate dose if custody staff provided a written report alleging hoarding. Ultimately, custody staff produced a written report alleging that Mr. [redacted] was caught with methamphetamine and fentanyl, but notably not buprenorphine/naloxone, so the NP ordered his dose increased back to 16/4 mg. She noted, however, that "[o]nce we are presented with proof of hoarding we will cut the dose in half." *Id.* at 39. One week later, however, a physician reversed that decision and cut Mr. [redacted]'s dose in half on [redacted], 2023, based on allegations of diversion. *Id.*

86. This sequence of events is deeply concerning. I explained in my initial report that "continued opioid use while on MOUD . . . likely indicates that the person is not being treated with an adequate dose of medication, underscoring their need to stay on MOUD." Ramsey Rpt. at 92, ¶ 213. The reason that sufficient dosing of MOUD is so critical is that, when persons with OUD do not receive sufficient medication, they are at risk of returning to use and potentially overdosing. Custody staff's allegation that Mr. [redacted] was caught with fentanyl is evidence of this risk coming to fruition. At this point, it should have been clear to Jail medical staff that they had failed to provide Mr. [redacted] with an adequate dose of buprenorphine/naloxone, and they should have sought to protect Mr. [redacted] by ensuring he received a sufficient dose to prevent his return to use. But the Jail's policies, procedures, and practices dictated the opposite outcome, leading to a physician cutting Mr. [redacted]'s dose in half and exposing him to the substantial risk of serious harm from returning to fentanyl use.

87. After his dose was decreased, Mr. [redacted] continued to request that his dose be increased for months. This request was denied on [redacted], 2023, based on his "history of cheeking/hoarding his medication." *Id.* at 45. Eventually, on [redacted], 2023, a physician finally "[u]ptitrated patient [S]uboxone to achieve a more therapeutic dose to reduce cravings and prevent fentanyl OD." *Id.* This record shows that Jail medical staff knowingly exposed Mr. [redacted] to a risk of

"fentanyl OD" based on alleged diversion for more than three months. Even once his dose was increased, Mr. [redacted] remained at risk of having his medication reduced due to an allegation of diversion, as demonstrated by a [redacted], 2024, note in which a physician describes "educating him" about "the ZERO tolerance policy for diversion." *Id.* at 88.

88. Defendants' Reports make a number of claims regarding the provision of care to persons with OUD that are divorced from the reality in the medical records and other evidence in the case, which I respond to below. One overarching theme in Defendants' Reports is that their own experts provide different descriptions of the MAT program at the Jail. In my initial report, I explained in detail my understanding of how the Jail's MAT program evolved over time, including walking through the discrepancies between the MAT program as defined in NaphCare's currently operative policies, Dr. Montgomery's deposition testimony regarding changes the Jail might make to the program in the future, and the evidence of how the MAT program has in fact been operated in the past. Ramsey Rpt. at ¶¶ 151-97. I ultimately concluded that "it is unclear what the Jail is actually doing in practice." *Id.* at ¶ 195.

89. Defendants' experts submitted reports with fundamentally different descriptions of what the MAT program actually entails. Dr. Murray's report comes the closest to at least describing the core elements of the standard of care for treating persons with OUD – specifically through MOUD by providing "[m]edications such as methadone, buprenorphine, and naltrexone" to incarcerated persons with opioid use disorder. He states that incarcerated persons with OUD that "refuse psychosocial treatment" are instead "designated as part of the Medication for Opioid Use Disorder (MOUD) program." But he does not explain this "MOUD program" in any detail. It is unclear from Dr. Murray's report what process the Jail uses to start persons on MOUD, the standards the Jail applies to determine doses of buprenorphine/naloxone, and the Jail's practices regarding patients suspected of

diversion – all of which are critical elements of providing MOUD. The medical records on which Dr. Murray relied demonstrated that the Jail is not meeting the standard of care in these areas. *See also* Ramsey Rpt. at 62-98.

90. Dr. Penn defines the MAT program somewhat differently than Dr. Murray, describing it as "[a] specialized behavioral health treatment programming module for those who meet the DSM-[5] criteria for opioid use disorder," and that it involves "intensive services such as weekly individual therapy, group therapy and medication management." Penn Rpt. at 34. He states that the "goal of the program is to mitigate overdose, promote recovery, reduce recidivism, and support a healthy lifestyle." *Id.* Based on this definition, Dr. Penn appears not to understand that MOUD, in and of itself, is the standard of care for the treatment of OUD. Dr. Penn does not engage in any assessment of the Jails' provision of care to persons receiving MOUD who are not enrolled in MAT, other than restating the numbers explained above. As for the persons in the MAT program, Dr. Penn asserts that the Jail "provides comprehensive MAT treatment," although he does not define his understanding of the standard of care for "comprehensive MAT treatment" other than generally stating it involves both medication and therapy.

91. On page 44 of his report, Dr. Penn evaluates the educational and therapeutic programming in the Jail stating, "[i]deally, individual and group counseling, self-help groups, residential programs, and clinical management are well-coordinated. Policies and procedures clearly define the roles and collaborative areas of the treatment and healthcare teams. Community self-help initiatives, like Alcoholics Anonymous and Narcotics Anonymous, can serve as valuable supplements or alternatives to staff-provided counseling." Again, at no point in his report does Dr. Penn actually assess the use of MOUD in the Jail. He spends much more time evaluating therapy and educational programming rather than focusing on MOUD, which is the standard of care because it is actually associated with meaningful outcomes for persons with OUD, including decreased mortality. As

with Dr. Murray's report, the medical record summaries that Dr. Penn relied on show inadequate provision of MOUD.

92. Mr. Vare's definition of MAT is far broader than the definitions in Dr. Murray's or Dr. Penn's reports. He states "Medication-Assisted Treatment (MAT) provides screening of individuals at the time of booking and then provides them with resources through medical providers to alleviate withdrawal symptoms and provide ongoing treatment." Vare Rpt. at 63. Mr. Vare appears to think that "MAT" is equivalent to the entire process of providing substance use treatment to persons in the Jail, which is not how Dr. Murray or Dr. Penn (or, indeed, the Jail's own policies) describe the program.

93. Mr. Vare ultimately concludes that "Plaintiffs' claims that the Sheriff's Office failed to provide adequate medical care including medicated assisted treatment for incarcerated persons with substance [ab]use disorders" are inaccurate. I disagree with his conclusion. Mr. Vare makes his lack of expertise regarding substance use treatment apparent throughout opinion 5 of his report. Mr. Vare appears to think that screening and assessments are part of the MAT program, stating that "by implementing the MAT program, the jails are screening individuals at the point of entry through drug testing, body scanners, and assessments for providing medications to help treat those who need medical intervention." Screening and assessment are not part of the MAT program, they are steps in withdrawal treatment that come before patients are placed in the MAT program. Mr. Vare lacks knowledge on what CIWA and COWS are, apparently thinking they are "services" for patients. They are assessment tools to determine whether a patient is in withdrawal and it needs management, not services themselves.

94. Mr. Vare's analysis of the Jail's MAT program is limited to "copies of several hand-written letters from incarcerated persons who had participated in the MAT program and had positively benefited from the experience." He includes excerpts from five letters in his report. Only one letter has a person's name attached

to it. None of the medical charts of these five individuals have been produced by Defendants. Though three of the letters use the term "MAT," none of the letters reference that the writers received MOUD. Even assuming these testimonies from unnamed individuals are legitimate, they do not provide substantive, quantitative evidence of the efficacy of the MAT.

95. Mr. Vare states on page 63, "My opinion in this section is not focused on the treatment itself and I have not considered whether MAT is medically necessary or appropriate as I am not a medical expert. This opinion only considers the existence of treatment programs and whether incarcerated persons have access to such services." He goes on, however, to opine for seven pages on the MAT program. To state the obvious, Mr. Vare has no qualifications to provide a reliable opinion on any aspect of the MAT program. He has no clinical or medical expertise, let alone expertise in addiction medicine. His opinions regarding the Jail's MAT program are not reliable.

B. The Sheriff's Department Lacks Policies and Procedures Focused on Treating, and Therefore Fails to Provide Treatment for, Non-Opioid Substance Use Disorder

96. The medical records summarized in Dr. Murray's and Dr. Penn's reports reinforce my opinion from my initial report that the Sheriff's Department lacks policies and procedures focused on treating alcohol use disorder or stimulant use disorder post-withdrawal.[18] *See* Ramsey Rpt. at ¶ 220-23. Those medical records also demonstrate that the Jail lacks policies and procedures focused on treating other non-opioid substance use disorders post-withdrawal, including tobacco use disorder ("TUD") and other substance use disorders.[19] Prompted by my

[18] [redacted] ulant); [redacted] ([redacted] ; [redacted] ([redacted] (alc [redacted] ; [redacted] (st [redacted] ulant).

[19] *See* App [redacted] (diagnosed with TUD); [redacted] (history of PCP use); [redacted] PCP use).

review of those records, my conclusion now is broader than the conclusion in my initial report. The Sheriff's Department lacks policies and procedures focused on treating *any non-opioid substance use disorder* post-withdrawal, including alcohol, stimulants, tobacco, and other substances.

97. Tellingly, none of Defendants' experts conducted any analysis of the Jail's policies and procedures for treating non-opioid substance use disorders after withdrawal, because no such policies or procedures exist. Indeed, the term "stimulant use disorder" appears just once in Murray's report when it is briefly noted in one of the summaries of the medical records in Appendix J. Murray Rpt. at 169 (summary of [redacted] Med. Rcd.). Similarly, the term "alcohol use disorder" appears just once in Murray's report as a brief note in another summary. Murray Rpt. at 173 (summary of [redacted] Med. Rcd.). Neither summary includes any discussion of treatment for stimulant use disorder or alcohol use disorder. Those terms do not appear in Penn's report at all. And neither report mentions tobacco or other substances. These disorders are noted in several of the underlying medical records, but those records make clear that the Jail does not have any practice in treating either alcohol use disorder or stimulant use disorder.

V. DEFENDANTS' REPORTS FAIL TO SHOW THAT THE SHERIFF'S DEPARTMENT ADEQUATELY PROTECTS PERSONS AT RISK OF OVERDOSE

98. All three of Defendants' Reports acknowledge that treating substance use disorder reduces the risk of overdose, a point with which I agree. Murray Rpt. at 24-25; Penn Rpt. at 34; Vare Rpt. at 58; Ramsey Rpt. at ¶ 224. The opposite is also true; failure to adequately treat an incarcerated person's withdrawal and/or substance use disorder exposes that person to a risk of return to use and overdose (as I explained in my initial report, the sections above, and in the Appendix below). If the system fails to adequately treat withdrawal and substance use disorder, incarcerated persons with substance use disorder will remain at risk of serious harm from overdoses, including death.

99. The death of Eric Wolf, summarized briefly in Dr. Murray's report, is a tragic example of the risk of overdose created by the Jail's failure to promptly diagnose and treat OUD. Mr. Wolf was booked on July 26, 2023, but his substance use was not identified at intake that day. Wolf Med. Rcd. at 18-19. His history of opioid, stimulant, and alcohol use was identified during an Inmate Safety Program assessment on July 28, 2023, based on Jail staff's review of his medical records. *Id.* at 70. By that point, Mr. Wolf was still at risk of withdrawal, so he should have been referred for COWS and CIWA-Ar monitoring, and then assessed for any OUD and prescribed MOUD. None of that happened.

100. Mr. Wolf's substance use was identified many additional times during his incarceration. *See id.* at 74, 92 (July 29, 2023); *id.* at 202 (October 19, 2023); *id.* 257 (October 23, 2023, self-reporting that he "wore the drugs," using opioids multiple times per week as well as alcohol and stimulant use daily). Nevertheless, the Jail never assessed him to whether he met the DSM-5-TR criteria for OUD so he could be provided with MOUD to avoid a return to use.

101. On January 5, 2024, staff found Mr. Wolf face down and unresponsive on the floor of his cell. *Id.* at 1272. Staff deployed naloxone ten times with no effect, and Mr. Wolf was pronounced dead shortly thereafter. *Id.* at 1272-73. While an official cause of death is still pending, staff found baggies of fentanyl in Mr. Wolf's cell and an autopsy the following day returned a presumptive positive test for fentanyl. *See* Wolf 3-Day ICD Review at 21. This evidence strongly indicates that Mr. Wolf died of a fentanyl overdose.

102. Had the Jail acted on his reports of frequent opioid use, assessed him for OUD, and provided him with MOUD, it is possible that Mr. Wolf would not have overdosed fatally on fentanyl. As I discussed above, one of the purposes of MOUD is to prevent the opioid cravings. Had Mr. Wolf been receiving an adequate dose of MOUD, he may not have had opioid cravings and sought out opioids in the Jail. Without MOUD, Mr. Wolf experienced cravings, returned to use, overdosed,

and died.

103. The widespread risk of overdose caused by the Jail's failure to adequately treat withdrawal and OUD makes it all the more important for the Jail to provide adequate treatment when incarcerated persons inevitably overdose. The symptoms of an overdose, and therefore the standard of care for treating overdoses, vary depending on the substance that caused the overdose. For that reason, the Jail's overdose intervention practices must regularly adapt in response to changes in the substances prevalent in the unregulated drug supply in the Jail. Ramsey Rpt. at ¶ 226.

104. In my initial report, I reviewed the Jail's written policies as well as records documenting its practices for treatment of persons experiencing overdose, concluding that its policies, procedures, and practices fail to meet the standard of care. *Id.* at ¶¶ 225-27. I explained that the Jail has a practice of over-relying on naloxone when providing emergent care. Deploying naloxone in response to a suspected overdose is part of the standard of care, but it is not the *entire* standard of care. I explained that the standard of care has changed due to the increasing presence of highly potent synthetic opioids ("HPSOs") in the unregulated drug supply. Overdoses from the unregulated drug supply require treatment with more than just naloxone because sedatives (such as synthetic benzodiazepines, xylazine, and medetomidine) are frequently added to HPSO. Naloxone can help normalize breathing in someone who overdosed on HPSO, but the sedatives in the unregulated drug supply can prevent that person from returning to consciousness after naloxone is deployed. When someone's breathing is normalized but they remain unconscious, the standard of care is not to continue deploying naloxone, but rather to place that person in the recovery position and then engage in additional supportive measures outlined in my initial report. Ramsey Rpt. at ¶ 228. I noted how the death of Vianna Granillo illustrated the harms from Jail staff's overreliance on naloxone, as staff repeatedly deployed doses of naloxone long after they could have possibly had

any effect while failing to put Ms. Granillo in the recovery position and attempting additional life-saving treatment. *Id.* at ¶ 233.

105. Defendants' Reports fail to show that the Jail meets the standard of care in providing overdose treatment.

106. Dr. Murray does not evaluate or opine on the adequacy of the treatment that the Jail has provided to incarcerated persons experiencing overdose. The only notable element of Dr. Murray's report regarding overdose treatment is the medical record of Majid Almajid, one of the deaths summarized in Appendix Q. *See* Murray Rpt. at 253-254. That summary notes that "on May 5, 2024, medical was called for a man down. CPR was in progress upon the medical staff's arrival. Multiple doses of Narcan were given. He already had some livor mortis and rigor mortis. Care was transferred to EMS upon arrival, and the patient was pronounced deceased a few minutes later." I reviewed Mr. Almajid's medical record because of the naloxone deployment, but the record is mostly irrelevant for purposes of this report. What is relevant is that the deployment of naloxone here reinforces that the default response to any "man down" situation in the SD Jail is to deploy multiple doses of naloxone even when it is not the most effective treatment. Mr. Almajid's death is a case where the "man down" had clear signs of death (livor mortis and rigor mortis) that naloxone could never reverse. I would hope that Jail personnel are trained on an appropriate assessment process (assess airway, breathing, circulation) *before* deploying naloxone. No autopsy was performed in this case and the cause of death and manner of death are pending. I reserve the right to supplement this report if I receive additional records indicating that substance use played a role in Mr. Almajid's death.

107. Dr. Penn's discussion of overdose treatment is limited to an anecdote about one overdose he purportedly witnessed during an inspection, but he does not identify the patient involved and a lawyer for Defendants later confirmed that "no medical records were pulled" "regarding the person that Dr. Penn witnessed

overdose." September 23, 2024 Email from Counsel for Defendants to Counsel for Plaintiffs re Materials Relied Upon by Experts per Court Order (Dkt. 718)." This means no medical records have been produced that confirm the overdose, and no urine toxicology report has been produced that demonstrates if substances were indeed present. Dr. Penn also gives an anecdotal comment from an SDSO physician who described the Jail staff's actions as "spot on." But the response to one overdose (if it occurred) and one reported comment from a physician are not sufficient to show that the Jail responds to overdoses appropriately. Given the number of overdose deaths that have occurred in the SD Jail, I do not concur with Dr. Penn's approval of their overdose intervention response.

108. Mr. Vare discusses overdoses at greater length, but he does not have medical expertise, so he does not offer an opinion on the adequacy of the treatment provided to persons who overdosed in the Jail. Mr. Vare's experience is in operations and security, so his opinion focuses on the Jail's efforts to prevent substances that might cause an overdose from entering the Jail in the first place. I understand a different expert retained by Plaintiffs will respond to Mr. Vare's opinions regarding overdoses from an operations and security perspective.

VI. DR. MURRAY'S AND DR. PENN'S OPINIONS ON DISCHARGE PLANNING FAIL TO SHOW THAT THE SHERIFF'S DEPARTMENT HAS ADEQUATE DISCHARGE PLANNING FOR INCARCERATED PERSONS WITH SUD

109. In my initial report, I explained that "an imperative step in providing adequate care" to incarcerated persons with substance use disorder is "[e]nsuring that persons with OUD have access to MOUD at discharge." Ramsey Rpt. at ¶ 246. As noted repeatedly above, the risks associated with discontinuing MOUD are severe, including a return to use and overdose. Those risks do not go away at discharge. In fact, the risks can be even greater at discharge given the unique barriers persons with SUD face upon reentry. *Id.* at ¶ 243-45.

110. In that report, I noted numerous instances where an incarcerated person

with OUD was released without MOUD in hand, struggled to access MOUD, and experienced disruption in treatment as a result. The Sheriff's Department's practice for providing MOUD at discharge is to send a prescription to a community-based pharmacy where the patient can then access the medication on their own. *Id.* at ¶¶ 251-53. But this proved difficult for several persons leaving custody, so to address those difficulties, I recommended that the Sheriff's Department provide naloxone, buprenorphine/naloxone, or methadone in hand at discharge. *See id.* at § IV (Recommendations Regarding Discharge Planning and Services).

111. Dr. Murray and Dr. Penn both insist that the Jail provides adequate discharge planning for persons with substance use disorder, but they simply assert that the Jail engages in discharge planning without attempting to assess that the discharge planning is adequate in practice.

112. Dr. Murray mentions that patients are supposed to be given a prescription card at discharge that they can redeem at a local pharmacy for a 30-day supply of medications, along with a voucher for naloxone. Murray Rpt. at 22-23. But he does not assess whether the Jail actually gives those prescription cards out for MOUD in practice. He also states that persons are provided with "a list of community resources" to help facilitate care and that the Jail "attempts to make connections for MAT patients with community-based programs," but he does not assess how frequently those attempts are successful.

113. Further, for patients with substance use other than opioid use disorder, there does not appear to be any meaningful discharge planning. There are missed opportunities to link persons to community-based supports, such as recovery centers, mutual support groups (including non-12-step programs, such as SMART Recovery), peers, and harm reduction programs (such as syringe services programs).

114. Dr. Penn's discussion of discharge planning is nearly identical to Dr. Murray's. He mentions that persons are supposed to receive a voucher for naloxone, a 30-day supply of medications at a community-based pharmacy, and that

Jail discharge planners *attempt* to make connections for MAT patients in community-based programs. My responses to Dr. Penn's assertions are the same as those I expressed above with respect to Dr. Murray's assertions.

115. Unlike the elements of substance use treatment discussed above, the medical records I reviewed for this rebuttal report lack information useful to assess the effectiveness of discharge planning for people with SUD. Neither Dr. Murray nor Dr. Penn identified any methodology that they used to evaluate discharge planning for people with SUD in practice. So my conclusion remains unchanged – the Jail should provide MOUD in hand at discharge to the extent legally possible, including using the hospital/clinic designation from 42 CFR Part 8 to stock and dispense methadone and the DEA's 72-hour rule to discharge patients with methadone.

VII. CONCLUSION

116. The information and opinions contained in this report are based on the evidence, documentation, and/or observations available to me. I reserve the right to modify or expand these opinions should additional information become available to me. The information contained in this report and the accompanying exhibits are a fair and accurate representation of the subject of my anticipated testimony in this case.

Dated: November 1, 2024

Kelly S. Ramsey, M.D.

Appendix A

[redacted]

1. The Jail's provision of withdrawal management to Mr. [redacted] did not meet the standard of care. The Jail failed to provide timely assessments of Mr. [redacted]'s withdrawal symptoms. The Jail also failed to provide individualized treatment by basing the dose of Mr. [redacted]'s medication on a standardized, non-individualized taper regimen rather than basing the dose on the scores of the withdrawal assessments.

2. Mr. [redacted]'s substance use was identified during the intake screening, which triggered COWS, CIWA-Ar, and CIWA-B assessments. [redacted] Med. Rcd. at 9-10. But these assessments were not performed with sufficient frequency, underscoring the conclusion in my initial report that the Jail fails to meet the standard of care for these assessments by attempting them just once per day, even if the patient is unavailable for the attempted assessment. Mr. [redacted]'s medical record contains extensive evidence of that practice. COWS Assessments for opioid withdrawal should generally be completed every 4 hours for the first 72 hours of incarceration, although I noted in my initial report that some variance in that timing is appropriate. Ramsey Rpt. at ¶¶ 59-60. COWS assessments can be completed "every 6 hours for scores less than 13," but should be completed "hourly for scores greater than or equal to 13." *Id.* at ¶ 60. Mr. [redacted]'s COWS assessments were instead attempted just once per day and actually completed even less frequently.

3. Mr. [redacted] was first assessed for opioid withdrawal using the COWS on [redacted], 2023, at [redacted] p.m., resulting in a score of 1 and a notation to "[r]eassess in 8 hours." The next assessment did not occur until more than 15 hours later, on [redacted], 2023, at [redacted] a.m., when the score jumped to 14, which indicates he was experiencing moderate opioid withdrawal symptoms and should have been assessed again within one hour. [redacted] Med. Rcd. at 199-200. Instead, that assessment included a notation to "[r]eassess in 6 hours." *Id.* at 199. But no attempt was made to conduct another COWS assessment until more than 27 hours later on

[redacted] 2023, at [redacted] p.m., and that assessment was not even completed. *Id.* at 205-06. Instead of completing the assessment, a nurse noted Mr. [redacted] was unavailable due to a court appearance. *Id.* That incomplete assessment included a notation to "[r]eassess in 8 hours." *Id.* at 205. But it took more than 24 hours (over 47 hours since the last completed assessment) before staff attempted to complete another COWS assessment on [redacted] 2023, at [redacted] p.m., at which point the assessment produced a score of 4 with another notation to "[r]eassess in 8 hours." *Id.* at 217.

4. From there, the Jail waited over 25 hours to attempt an assessment on [redacted] 2023, at [redacted] p.m., which was completed with a score of 7, and a note to reassess in 8 hours. *Id.* at 225-26. The next attempt occurred more than 25 hours later on [redacted] 2023, at [redacted] p.m., with a score of 3, and a note to reassess in 8 hours. *Id.* at 233-34. That was followed by multiple unsuccessful attempts to complete COWS assessments, with the next attempt coming more than 21 hours later on [redacted], 2023, at [redacted] p.m., during which Mr. [redacted] was unavailable and a notation was made to reassess in four hours, *id.* at 239-40, then a delay of more than 23 hours until the next attempt on [redacted], 2023, at [redacted] p.m., when he was again unavailable with a note to "[r]eassess in 4 hours." *Id.* at 245-46. Nursing staff waited more than 24 hours before the next attempt on [redacted] 2023, at [redacted] p.m., which was completed successfully, and resulted in a score of 5 and a note to reassess in 8 hours. *Id.* at 253-54. As a result, there was a gap of more than 69 hours between completed assessments. There was then a delay of nearly 48 hours until the next attempt on [redacted] 2023, at [redacted] p.m., which was completed with a score of 3 and a note to reassess in 8 hours. *Id.* at 259-60. Staff made a final attempt over 18 hours later on [redacted], 2023, at [redacted] a.m., which was completed with a score of 3 and a note to reassess in 8 hours. No further COWS assessments were attempted.

5. The repeated and substantial delays in assessments fell far below the standard of care. Moreover, nursing staff also were clearly aware that Mr. [redacted]

needed to be assessed more frequently—every assessment included a notation to reassess in either 4, 6, or 8 hours—but failed to do so.

6. The Jail's failure to conduct Mr. [redacted]'s COWS assessments with adequate frequency exposed him to a substantial risk that he would experience complications from opioid withdrawal without receiving adequate treatment. This risk was particularly pronounced in the nearly 52-hour period between Mr. [redacted]'s first completed assessment that scored 14, indicating he was experiencing moderate acute opioid withdrawal, and his second completed assessment.

7. The Jail also failed to assess Mr. [redacted]'s alcohol and benzodiazepine withdrawal with adequate frequency. CIWA-Ar assessments for alcohol withdrawal should be completed every 4 hours until three consecutive assessments produce a score of less than 8, at which point they can be spaced out to every 8 hours. Ramsey Rpt. at 23, ¶ 60. CIWA-Ar scores of more than 8 should prompt reassessment within 2 hours. *Id.* Mr. [redacted]'s CIWA-Ar assessments were only attempted once per day, and successfully completed even less frequently.[1] The repeated and

[1] The CIWA-Ar assessments occurred on the following dates and times:

- [redacted]

substantial delays in these assessments fell far below the standard of care.

8. CIWA-B assessments should be completed at least every 6 hours, *see* Ramsey Rpt. at 23-24, ¶ 60, but Mr. [redacted]'s CIWA-B assessments also were attempted and successfully completed far less frequently.[2]

9. As with Mr. [redacted]'s COWS assessments, the delays in completing his CIWA-Ar and CIWA-B assessments exposed Mr. [redacted] to a potential risk of substantial harm from untreated complications of withdrawal.

10. The Jail also failed to provide individualized treatment to Mr. [redacted]. His medical record reflects the Jail's policy of not initiating buprenorphine/naloxone until the patient reaches a COWS score of at least 6, *see* [redacted] Med. Rcd. at 126 (noting criteria for buprenorphine/naloxone initiation is "score of 6 or greater"), 199 (initiating buprenorphine/naloxone once a COWS score went over 6). Such treatment is not consistent with the standard of care, which as per BJA Guidelines

[2] The first CIWA-B assessment was comple[redacted]t [redacted]p[redacted] and the last CIWA-B assessment was completed at [redacted]a.[redacted]n[redacted] at time, a total of at least 43 assessments should have [redacted]comple[redacted]e Jail attempted just 11, completing only 8, with gaps of two and three days between completed assessments.

- [redacted]

8

for Managing Substance Withdrawal in Jails, recommends initiating treatment for opioid withdrawal at a COWS of 3. As I stated in my initial report, using a low dose initiation strategy for buprenorphine/naloxone would eliminate a need for any opioid withdrawal before initiating treatment with buprenorphine/naloxone. *See* Ramsey Rpt. at 40-47, ¶¶ 102-119. The Jail also put Mr. [redacted] on a standardized buprenorphine/naloxone taper defined by a broadly applicable policy, not by Mr. [redacted]'s COWS scores and his individualized symptoms, which should be the basis for individualized dosing of buprenorphine/naloxone. *Id.*

11. The Jail also failed to provide adequate treatment for Mr. [redacted]'s OUD after withdrawal. Once the Jail began providing MOUD to Mr. [redacted], he repeatedly requested an increase in his buprenorphine/naloxone dose due to opioid cravings for months from [redacted] 2023 to [redacted] 2024, indicating that the Jail did not provide a sufficient dose of medication. *See* [redacted] Med. Rcd. at 412-17, 421, 422, 424, 426-27, 482, 486, 488-92, 496, 499-500, 504-12, 518, 525. Instead of increasing his dose, the Jail *decreased* Mr. [redacted]'s buprenorphine/naloxone dose in response to an allegation of diversion. *Id.* at 412. As explained in my initial report and discussed in much more detail in the MOUD section above, denying sufficient medication based on allegations of diversion violates the standard of care and harms patients by denying them the treatment they need. Without that treatment, they are at increased risk of a return to use, which is a distinct possibility due to the availability of substances in the jail, and overdose. *See* Ramsey Rpt. at 86-92, ¶¶ 202-13.

[redacted]

12. The Jail did not identify all the substances that Mr. [redacted] used at intake, and it did not provide adequate treatment for the substance use that was identified. During intake, a history of alcohol use was identified, and CIWA-Ar assessments were initiated, but they were done only once daily despite notations in Mr. [redacted]'s electronic record that re-assessments were supposed to be completed

every four, six, or eight hours. *See* [redacted] Med. Rcd. at 18-19, 147, 154, 158, 162, 166, 170, 172, 176. A psychiatrist also eventually identified a history of methamphetamine use as Mr. [redacted]'s substance of choice, indicating that the intake screening process failed to identify Mr. [redacted]'s methamphetamine use. *Id.* at 242-43. As with his alcohol use, no attempt was ever made to treat Mr. [redacted]'s methamphetamine use. Mr. [redacted]'s opioid use disorder also was missed at intake, with an LMFT identifying it seven months later. *Id.* at 34.

13. There is no indication in the medical record that Mr. [redacted] was ever offered treatment for alcohol use disorder (medication for alcohol use disorder/MAUD) post-withdrawal or for methamphetamine use disorder once it was identified. This reinforces my conclusion in my initial report, discussed further earlier in this report, that the Jail does not have any policies or procedures for treating alcohol use disorder or stimulant use disorder.

[redacted]

14. The Jail's standard intake screening failed to identify Mr. [redacted]' cocaine use at booking, although daily cocaine use was identified during an Inmate Safety Program (ISP) follow-up three hours later. [redacted] Med. Rcd. at 7-8 (intake screening conducted on [redacted] 2020, at [redacted] p.m.), 282 (ISP assessment conducted on [redacted], 2020, at [redacted] p.m.). The following month, medical staff identified a history of benzodiazepine use as well, specifically Xanax (alprazolam). *Id.* at 1342-43. It is concerning that the Jail's standard screening process did not identify Mr. [redacted]' cocaine use given that he disclosed it a few hours later.

15. Mr. [redacted]' medical record indicates that the use of a validated screening tool at intake may have identified his cocaine use and benzodiazepine use. One of the validated screening tools identified in my initial report, the Tobacco, Alcohol, Prescription medication, and other Substance use Tool ("TAPS"),[3]

[3] *See* National Institute of Drug Abuse, TAPS Tobacco, Alcohol, Prescription

includes specific questions that the Jail's receiving screening lacks which may have prompted different responses from Mr. [redacted]. TAPS includes questions specifically asking the patient if they have used "any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy (MDMA)," if they have used "prescription medications just for the feeling, more than prescribed or that were not prescribed for you," and if they have used "a medication for anxiety or sleep (for example: Xanax, Ativan, or Klonopin) not as prescribed or that was not prescribed for you." *Id.* The Jail's standard intake screening is more general, asking about "use of alcohol, heroin, prescription pain medications or sedatives" and "any other illegal drugs," along with a history of "alcohol or drug withdrawal" and participation in "a detox program or substance abuse treatment program." [redacted] Med. Rcd. at 7-8.

16. Mr. [redacted] answered "no" to all the questions on the standard intake screening, but three hours later he confirmed daily cocaine use in response to a more specific question in the ISP assessment that asked about "recent substance use," specifically "amphetamines, THC, EtOH, Opiates[opioids], Cocaine, or Other." *Id.* at 282. And one month later he confirmed his "past Xanax" use only "[w]hen prompted" by a medical provider. *Id.* at 1343. This indicates that the Jail's standard intake screening questions may have missed Mr. [redacted]' substance use because they did not specifically mention "cocaine" or "Xanax" by name, instead asking about "other illegal drugs" and "sedatives" more generally. The validated TAPS tool may have been more effective because its questions identify "cocaine" and "Xanax" by name. The form of the questions also may have made a difference given the note that Mr. [redacted] only acknowledged benzodiazepine use "[w]hen prompted." The validated TAPS tool's questions regarding prescription medication use involve

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medication, and other Substance use Tool, https://nida.nih.gov/taps2 (last visited Oct. 23, 2024).

detailed prompts identifying various types of prescription medication use that may have caused Mr. [redacted] to recall his past alprazolam (Xanax) use.

17. The Jail violated the standard of care again when it made no attempt to diagnose and treat Mr. [redacted] for any stimulant use disorder once his cocaine use was identified, which is unsurprising given the Jail's lack of policies and procedures to treat stimulant use disorder.

Richard Woodford

18. Mr. Woodford's death is an alarming example of the harm that results from the Jail's inadequate provision of withdrawal management. I discussed Mr. Woodford's death in my initial report based on an interview I conducted with an incarcerated person housed in the unit where Mr. Woodford died. *See* Ramsey Rpt. at 34-35, ¶ 86. At the time, Defendants had not made his medical records available. My understanding is that Defendants did not produce the records to the Plaintiffs until September 20, 2024, after which they were provided to me. The records reveal stunning failures in withdrawal management that likely resulted in Mr. Woodford's death.

19. At intake on the morning of June 25, 2024, Mr. Woodford's fentanyl use and history of withdrawal were identified, *see* Woodford Med. Rcd. at 7-8, and a comprehensive detox screen was completed noting daily recent opioid use, *see id.* at 31. Shortly thereafter, at 10:47 a.m., a STATCare provider ordered "[i]nitiate Suboxone treatment with 8/2mg Suboxone daily starting the day after incarceration." *Id.* at 21. In the same note, that STATCare provider wrote "[n]o clinical assessment performed on this p[a]t[ient]." *Id.*

20. That STATCare note reflects several key failures in the Jail's withdrawal management policies, procedures, and practices that I highlighted in my initial report. In that report, I explained that "the Jail's approach to addressing withdrawal is reactive, rather than proactive, with no indication of individualized care, assessment, or dosing." Ramsey Rpt. at 40, ¶ 101. I pointed out that the

Sheriff's Department "treated patients in opioid, alcohol, or benzodiazepine withdrawal with the same doses of medication for that specific withdrawal syndrome, contrary to the standard of care." *Id.* ¶ 102. I highlighted an email that the Jail's Chief Medical Officer Dr. Jon Montgomery sent in September 2023 in which he wrote "docs/providers felt constrained that they were only able to prescribe 8/2 milligrams for Suboxone (buprenorphine/naloxone) …no more, no less" and detailed why I was not convinced by testimony in his April 26, 2024, deposition (two months before Mr. Woodford's death) in which he stated that buprenorphine/naloxone dosing had become more flexible. *Id.* at 42, ¶¶ 106-07. I concluded that the Jail "fails to provide individualized care for individuals with opioid disorder who are experiencing acute opioid withdrawal syndrome," in part because of the Jail's practice of using a "fixed medication dose" strategy for all patients, which is inconsistent with the "much safer option" of "low dose buprenorphine initiation strategies." *Id.* at 43, 46, ¶¶ 109, 117. I quoted the BJA guidelines, which state that "[a]ll patients at risk for opioid withdrawal should have rapid access to treatment," and I advised that "[o]pioid withdrawal syndrome could be avoided entirely if the Jail provided low dose initiations of buprenorphine rather than waiting for patients to experience symptoms of opioid withdrawal syndrome and then starting medication." *Id.* at 47, ¶ 119.

21. The STATCare provider never assessed Mr. Woodford and did not provide individualized treatment. Instead, at 10:47 a.m., on June 25, 2024, he ordered the Jail's standard buprenorphine/naloxone 8/2mg dose to be started the following day at 8:00 a.m., which was more than 21 hours away. *Id.* at 22. A COWS assessment performed just six minutes prior at 10:41 a.m. resulted in a score of 1 based only on Mr. Woodford's pulse, which had it been 1 bpm lower would have resulted in a score of 0. *Id.* at 28-29. This score reflects that Mr. Woodford was not yet experiencing many, if any, symptoms of withdrawal.

22. The Jail did begin COWS assessments for Mr. Woodford, but those

assessments also reflect many of the exact failures that I identified with the Jail's withdrawal assessment policies, procedures, and practices in my initial report. Three COWS assessments were completed by three different nurses while Mr. Woodford was incarcerated. As noted above, the first assessment was conducted by an RN at 10:41 a.m. on June 25, 2024, within minutes of Mr. Woodford's booking and resulted in an overall score of 1. *Id.* at 28-29. As explained above and in my initial report, the standard of care required that the second assessment be conducted within at most 4-6 hours. Ramsey Rpt. at 23, ¶¶ 59-60. The record of the first COWS assessment includes a note to "[r]eassess in 8 hours," which is longer than that standard of care but would have at least ensured Mr. Woodford was assessed again the same day. However, Mr. Woodford's second assessment did not occur until nearly 18 hours later at 4:29 a.m. on June 26, 2024. This assessment resulted in a score of 10. Woodford Med. Rcd. at 41-42. By that point, Mr. Woodford was experiencing symptoms of withdrawal, including "[m]ultiple episodes of diarrhea or vomiting," *id.* at 42, which is consistent with what was described to me by the incarcerated person in Mr. Woodford's housing unit, *see* Ramsey Rpt. at 34-35, ¶ 86. That score prompted a STATCare provider to order "[g]ive morning dose of [S]uboxone now" at 4:37 A.M. and to "[a]lert S[TAT]C[are] with any increase or worsening of symptoms." Woodford Med. Rcd. at 22. This order by the STATCare provider was appropriate. However, if the Jail had followed the standard of care for COWS assessments, Mr. Woodford would have already been assessed at least two additional times by that point (no later than 4:41 p.m. and 10:41 p.m. on June 25, 2024). Those assessments may have prompted the STATCare provider to order his medication to start sooner.

23. At 5:16 a.m., an RN noted that Mr. Woodford refused the buprenorphine/naloxone and said he would take it later. *Id.* The STATCare provider responded to this note at 6:04 a.m., but did not direct nursing staff on-site to take any action to ensure Mr. Woodford received his withdrawal medication,

instead noting the refusal and again writing "[a]lert SC with any changes." At 10:22 a.m., Mr. Woodford took his first dose of buprenorphine/naloxone 8/2mg. *Id.* at 52.

24. That RN also performed a timely COWS assessment at 10:29 a.m.. Unfortunately, this third assessment likely was not performed properly. *See* Ramsey Rpt. at 24-27 (discussing inadequate training practices for withdrawal assessments). The third assessment resulted in an overall score of 5. Murray Med. Rcd. at 45-46. It notes "[n]o GI symptoms." But as I discussed in my report, incarcerated persons in the Jail reported that Mr. Woodford was defecating on himself throughout his incarceration. *See* Ramsey Rpt. 34-35, ¶ 86.

25. At the same time as the COWS assessment, the RN also took vital signs that showed Mr. Woodford was experiencing potentially dangerous complications of withdrawal, including a sharp dip in blood pressure (from 128/78 at 4:29 a.m. to 98/63 at 10:29 a.m.) that indicated Mr. Woodford was becoming hypotensive. Murray Med. Rcd. at 24. He also had an elevated heart rate and rapid respirations, which combined with his low blood pressure indicate he likely had hypovolemia due to excessive vomiting and diarrhea. This should have prompted an alert from the nurse to the STATCare provider, but there is no record that such an alert was sent.

26. After the third COWS assessment, the standard of care was to perform another assessment within 6 hours (by 4:29 p.m.). *Id.* Mr. Woodford never received another COWS assessment. He was not seen by medical staff again until a "man down" call at around 5:56 p.m. on June 26, 2024, by which point Mr. Woodford was found breathing but non-responsive. He died shortly thereafter.

27. The Jail has not provided a medical examiner's report on Mr. Woodford's death at the time of writing, so no official cause of death is available yet. His medical record indicates that Mr. Woodford was experiencing withdrawal symptoms at the time he died. As noted above, the last vital signs taken about eight hours before his death indicate that he likely had hypovolemia due to excessive vomiting and diarrhea, which are symptoms of opioid withdrawal. His

pupils also were dilated to 5-6mm in the minutes before he died, which is consistent with opioid withdrawal and inconsistent with opioid intoxication. *Id.* at 23. He also reported a lengthy history of opioid use at intake. It is very likely that Mr. Woodford died from inadequately managed withdrawal while in the care of the Sheriff's Department.

[redacted]

28. Mr. [redacted]'s alcohol use was identified at intake, [redacted] Med. Rcd. at 9-10, and a STATCare provider ordered CIWA-Ar assessments, *id.* at 27, but those assessments were never actually performed. At [redacted] p.m. on [redacted] 2022, a nurse filled in "Not Assessed" on every line of a CIWA-Ar assessment, *id.* at 350-51, but completed a comprehensive detox screen at the exact same time that noted some of the symptoms that are measured in a CIWA-Ar assessment, including shaking hands and a headache, *id.* at 352-53. On [redacted] and [redacted], 2022, other nurses also filled in "Not Assessed" on every line of the CIWA-Ar assessment, but noted they had seen Mr. [redacted] in the "Additional Comments" section, generally claiming he was doing fine. *Id.* at 358-59, 362-63. No other CIWA-Ar assessments were attempted. Three days later, on [redacted] 2023, an NP noted "CIWA discontinued, REASON: Patient clinically stable on chart review. No use of GI comfort meds in the last 24 hours." *Id.* at 34. The fact that three different nurses on three different days all decided to fill in "Not Assessed" on every line of the CIWA-Ar assessment, and then the assessments were discontinued, indicates that staff had a practice of not performing the CIWA-Ar assessments. This practice meant that Mr. [redacted]'s alcohol withdrawal was not monitored adequately, exposing him to a potential risk of harm from complications of withdrawal.

29. Moreover, Mr. [redacted] was never offered treatment for alcohol use disorder (medication for alcohol use disorder/MAUD) post-withdrawal, reflecting the Jail's lack of policies and procedures for providing treatment for AUD.

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[redacted]

30. Mr. [redacted]'s medical record is alarming because it shows multiple medical staff at the Jail neglecting to monitor his withdrawal from opioids and alcohol. Mr. [redacted] was booked on [redacted], 2023, at [redacted] a.m.. [redacted] Med. Rcd. at 2. His opioid and alcohol use the day prior to his booking were identified at intake, *id.* at 8-9, although his methamphetamine use was not identified until the following month during a psychiatric evaluation, *id.* at 116. A STATCare provider ordered initiation of COWS and CIWA-Ar assessments the day of his intake, *id.* at 192, but assessments were only completed that day. On [redacted], 2023, nurses completed COWS and CIWA-Ar assessments at [redacted] a.m., *id.* at 240-41, 245-46, and [redacted] a.m., *id.* at 252-53, 256-57, but no further assessments were completed. On [redacted] 2023 and [redacted], 2023, nurses did not complete COWS or CIWA-Ar assessments, instead noting on [redacted] 2023, that Mr. [redacted] "refused to be seen for detox rounds, stated that he was no longer detoxing and was fine, no s[igns]/s[ymptoms] of detox, informed p[a]t[ient] to let staff know if condition changes," *id.* at 258-61, and on [redacted], 2023, that he "refused detox assessment and medications. Refused to come out of cell but replied when called . . . No indications of acute distress," *id.* at 262-65. No further attempts to assess Mr. [redacted] were made, and a physician ordered that the COWS and CIWA-Ar assessments be discontinued on [redacted], 2023, *id.* at 193-94. In the end, Mr. [redacted]'s risk of withdrawal was monitored adequately for less than 9 hours after he was booked.

31. Medical staff's failure to conduct assessments of Mr. [redacted]'s opioid and alcohol withdrawal after the first nine hours of his incarceration demonstrates a practice of alarming disregard for the potential risks of withdrawal. Two different nurses failed to complete the assessments on [redacted] 2023 and [redacted], 2023 and a physician signed off on ceasing the assessments the following day, meaning three medical staff members all independently decided that the COWS and CIWA-Ar

assessments did not need to be completed. These staff members either did not understand the importance of these assessments, indicating they were trained inadequately, *see* Ramsey Rpt. at ¶¶ 62-69, or they did understand, and they all disregarded the potential risks of harm from failing to monitor an incarcerated person at risk of withdrawal from opioids and alcohol.

32. The Jail also made no attempt to diagnose and treat Mr. [redacted] for opioid use disorder, alcohol use disorder, or stimulant use disorder. At no point did any medical professional complete a comprehensive substance use history or attempt to make a diagnosis as to whether Mr. [redacted] had a substance use disorder. No treatment (MOUD or MAUD) was offered to Mr. [redacted] for any substance use disorder he may have had. Ultimately, the Jail ceased efforts to treat Mr. [redacted]'s substance use after just nine hours, at which point he was left to fend for himself, exposing him to a risk of complications from withdrawal, return to use, and potential overdose.

[redacted]

33. Ms. [redacted]' primary substance use issue was that she was prescribed Percocet (oxycodone/acetaminophen), a prescription opioid pain medication, prior to her incarceration and then experienced opioid withdrawal and a recurrence of pain when she did not receive that medication in the Jail. The intake screening from [redacted], 2023, did not identify any substance use, [redacted] Med. Rcd. at 9-10, but later that day a STATCare provider learned that Ms. [redacted] had a recent history of prescribed opioid pain medication use and ordered initiation of COWS assessments, *id.* at 26. That order noted that the Jail's policy of only initiating buprenorphine/naloxone treatment once a COWS score went higher than 6 was in effect. *Id.* Although the standard of care is to complete COWS assessments at least every 6 hours, assessments were attempted just once per day for the next ten days, even if the assessment was not completed successfully, which led to a gap of more than 72 hours between assessments completed on [redacted], 2023 and [redacted], 2023.

See id. at 103-156. At no point did those assessments reach a score of 6 or higher (the highest score was 3), and Ms. [redacted] was never ordered buprenorphine/naloxone. *See id.* at 103-156. The Jail never attempted to take a substance use history that could have revealed any other substance use that needed treatment, including opioid use disorder. Ms. [redacted] also repeatedly complained that the pain management medications the Jail prescribed were not sufficient for the pain she experienced from a prior bilateral hip replacement. *See id.* at 23-24. Providing buprenorphine/naloxone to Ms. [redacted] may have been more effective in treating her pain, as well as assisting with her opioid withdrawal and OUD (if she met criteria), but it was never ordered.

[redacted]

34. Mr. [redacted]'s history of alcohol use was identified at intake, [redacted] Med. Rcd. at 19-20, CIWA-Ar assessments were ordered, *id.* at 90-92, but only two CIWA-Ar assessments were ever completed and they were done over 48 hours apart, *id.* at 85-86 [redacted] 2023, at [redacted] a.m., one hour after booking), 95-96 ([redacted] 2023, at [redacted] p.m.). The second CIWA-Ar assessment indicates that an alert was sent to StatCare regarding abnormal vital signs, but there is no indication a StatCare provider ever reviewed the abnormal vital signs. *Id.* at 96. On [redacted], 2023, a physician ordered that the CIWA-Ar assessments be discontinued. *Id.* at 192. This reflects the Jail's inadequate training of medical staff regarding the importance of CIWA-Ar assessments in reducing the risk of complications from withdrawal.

35. Eventually, staff identified that Mr. [redacted] smoked a pack of cigarettes per day, indicating he likely had tobacco use disorder ("TUD"), *id.* at 131, but no attempt was ever made to diagnose and treat either his alcohol use disorder or his tobacco use disorder, reflective of the Jail's lack of policies and procedures for treating non-opioid substance use disorders.

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[redacted]

36. The Jail's treatment of Ms. [redacted]'s substance use was inadequate for several reasons. Her substance use was not identified during intake on June 6, 2023. [redacted] Med. Rcd. at 9-10. Just over two weeks later, on June 22, 2023, a behavioral health assessment indicated that Ms. [redacted] had a history of "daily methamphetamine use for the past 25 years," indicating she likely had stimulant use disorder. *Id.* at 48. But due to the Jail's lack of policies regarding treatment for stimulant use disorder, there is no indication that she was ever assessed or treated. On [redacted] 2024, three months after intake, Ms. [redacted] requested that she be placed in the MAT program. *Id.* at 35. That prompted an assessment and diagnosis of OUD ten days later, on [redacted] 2024, which was the first time that staff at the Jail completed a full substance use history for Ms. [redacted]. *Id.* at 365.

37. Three days after Ms. [redacted]'s OUD diagnosis, the Jail provided her with MOUD for the first time, *id.* at 428, but the medical record makes clear that the dose of buprenorphine/naloxone provided to Ms. [redacted] was inadequate to treat her OUD. Ms. [redacted] requested an increase in her buprenorphine/naloxone dose multiple times, consistently reporting opioid cravings despite being on buprenorphine/naloxone. *See id.* at 319, 320, 322-23, 325, 336-37, 34. Ms. [redacted]'s reports of opioid cravings made sense because she had been prescribed the Jail's standard buprenorphine/naloxone 8/2mg dose, which is quite low for someone with an extensive history of opioid use. Treating OUD effectively necessitates addressing ongoing opioid cravings with higher doses of buprenorphine/naloxone or methadone, otherwise the patient is at risk of returning to use because of those cravings. Rather than provide Ms. [redacted] with an adequate dose of buprenorphine/naloxone, medical staff told Ms. [redacted] that "MAT is to prevent withdrawal and that [her][4] cravings are part of addiction and managing them is a life

[4] Ms. [redacted] is transgender, the Jail consistently misgenders her in the record.

long process that goes with addiction." *Id.* at 40. That is not effective management of opioid use disorder and does not meet the standard of care for treating opioid use disorder. Buprenorphine/naloxone is meant to do more than just treat opioid withdrawal, it is also meant to minimize or eliminate opioid cravings, which can only be accomplished via a dose that is sufficiently high to address opioid cravings.

38. Mr. [redacted]' substance use was not identified at intake on [redacted] 2023. [redacted] Med. Rcd. at 66-67. Four weeks after Mr. [redacted] was incarcerated, he requested MAT and reported an extensive history of five overdoses, including two incidents where he "flat-lined" before being resuscitated. *Id.* at 121, 515. Two weeks after that, he was seen by a licensed clinical social worker ("LCSW"), who took a detailed substance use history noting heavy use of fentanyl every other day that had built up his tolerance over time, resulting in cravings and withdrawal symptoms when he did not use. *Id.* at 123 The social worker determined he "meets criteria for OUD" and scheduled a sick call for a medical provider to diagnose him. The medical provider made that diagnosis one week later and started Mr. [redacted] on buprenorphine/naloxone at a dose of 8/2 mg daily on [redacted], 2023. *Id.* at 508. Unsurprisingly considering Mr. [redacted]' extensive history of heavy opioid use, the Jail's standard 8/2mg dose was insufficient, and he had to request an increased dose. *Id.* at 3.

39. Given his extensive history of opioid use, including several overdoses, Mr. [redacted] was at a substantial risk of serious harm from return to use and overdose. The standard of care for starting medication after a patient reports opioid use

indicative of opioid use disorder is the same day,[5] [6] [7] not two weeks later. The Jail also failed to provide individualized treatment to Mr. [redacted] when it started him on a standard buprenorphine/naloxone 8/2 mg dose that was obviously insufficient given his opioid use history. The notes regarding his MAT treatment are also sparse, with just one note two lines long, which indicates that medical staff were not routinely evaluating Mr. [redacted] to determine if the treatment was effective.

[redacted]

40. Ms. [redacted]'s substance use was identified at intake, [redacted] Med. Rcd. at 9-10, which prompted COWS and CIWA-B assessments, but they only were conducted once daily. *Id.* at 221. Ms. [redacted] was started on buprenorphine/naloxone initially, which was the correct course of treatment, but her buprenorphine/naloxone was set on a standardized taper (no individualized care). *Id.* at 213. Instead, Ms. [redacted] had to request that her buprenorphine/naloxone be continued and then she was assessed for the MAT program. *See id.* at 226. The standard of care is to continue a patient's buprenorphine/naloxone uninterrupted, so the Jail's MAT assessment protocol placed unnecessary barriers to the seamless continuation of Ms. [redacted]'s treatment. There also were multiple concerning psychiatric notes in Ms. [redacted]'s record stating that if she diverts buprenorphine, the psychiatrist would recommend tapering and discontinuation of her buprenorphine/naloxone treatment. *See id.* at 194. As explained in my initial report and discussed further in the MOUD section above, this is an inappropriate response to diversion and exposes patients to a substantial risk of serious harm, including

[5] Jakubowski, Andrea MD; Fox, Aaron MD. Defining Low-threshold Buprenorphine Treatment. Journal of Addiction Medicine 14(2):p 95-98, March/April 2020. | DOI: 10.1097/ADM.0000000000000555

[6] The Role of Low-Threshold Treatment for Patients with OUD in Primary Care | The Academy

[7] SAMHSA Advisory: Low Barrier Models of Care for Substance Use Disorders

return to use and overdose. The record also indicates that Ms. [redacted] was not receiving a sufficient dose of buprenorphine/naloxone for four months before her dose was reassessed. *Id.* at 223.

[redacted]

41. The Jail did not identify Mr. [redacted]' opioid use at intake, [redacted] Med. Rcd. at 18-19, despite records from prior incarcerations indicating that he had a history of OUD and use of MOUD. *Id.* at 233, 235. Although the Jail ultimately provided MOUD to Mr. [redacted], the delay prompted by the failure to identify OUD at intake leads me to disagree with the conclusion in Dr. Penn's report that Mr. [redacted] received access to care.

42. Notably, the summary in Dr. Penn's report states that the reviewer was "not assessing MAT," Penn Rpt. at 180, indicating that Dr. Penn's reviewers were not instructed to evaluate MAT while reviewing medical records. If this is true, then it calls into question why Dr. Penn offered any opinions on the Jail's MAT program, as well as his conclusions regarding the MAT program, which are discussed further in the MOUD section above.

[redacted]

43. Opioid use was identified at intake, but Mr. [redacted]'s stimulant use was not identified at intake. [redacted] Med. Rcd. at 10-11. That stimulant use was only identified during a later evaluation of Mr. [redacted], but he was never offered treatment for stimulant use disorder. *Id.* at 42. Overall, substance use was evaluated at Mr. [redacted]'s intake screening, *id.* at 10-11, his psychiatric evaluation, *id.* at 42, and in a behavioral health assessment, *id.* at 45, but all those evaluations produced different substance use histories. Those inconsistencies are reflective of the Jail's failure to use a validated screening tool that could provide more consistent and reliable results regarding substance use.

44. While Mr. [redacted] ultimately was placed in the MAT program, he asked to be removed from the MAT program so he could be a trustee worker, indicating

that the Jail barred people on MAT from being trustee workers. *Id.* at 30. There is no medical reason why someone receiving MOUD would be unable to work on that basis alone. Denying opportunities to someone receiving MOUD indicates that the Jail may be discriminating against persons with substance use disorder.

[redacted]

45. Mr. [redacted]'s lengthy medical record spans an incarceration of more than seven years, although the most relevant portion of his medical record does not begin until 2023 when he began requesting MAT. Mr. [redacted] informed staff in [redacted] 2023 that he had been using fentanyl in the Jail, was experiencing opioid withdrawal symptoms, and that he wanted to be placed in the MAT program. [redacted] Med. Rcd. at 24. The jail began monitoring Mr. [redacted]'s opioid withdrawal symptoms, but he was denied MAT because the program was not available at Vista at the time. *Id.* Eventually, it appears Mr. [redacted] was started on buprenorphine/naloxone about two months later in [redacted] 2023. *Id.* at 27-28. That delay did not meet the standard of care and was dangerous because Mr. [redacted] was using fentanyl at the time, which could have led to an overdose. Because of this months-long delay in providing Mr. [redacted] with buprenorphine/naloxone after he reported active fentanyl use, I do not agree with the conclusion in Dr. Penn's report that he had timely access to care.

46. Even if I had not seen Mr. [redacted]'s medical records, I would not agree with the conclusion that Mr. [redacted] had access to care based on the summary in Dr. Penn's report alone. That summary states that Mr. [redacted] was prescribed multiple medications at one point that, if he had taken the medications as prescribed, amounted to a "quantity sufficient to cause death." Penn Rpt. at 175. The reviewer concluded that Mr. [redacted]'s failure to take those medications as prescribed "may have been life-saving." *Id.* Those medications are not related to substance use treatment, and I understand another expert retained by the Plaintiffs will comment on Mr. [redacted]'s overall treatment. But as a medical professional, I

could never conclude that a patient who was prescribed a potentially fatal combination of medications received access to care. The summary of Mr. [redacted]'s medical care in Dr. Penn's report directly contradicts the conclusion in the report that Mr. [redacted] had access to care. This contradiction makes me highly skeptical of the other conclusions in Dr. Penn's report that patients had access to care.

[redacted]

47. The intake screening identified Mr. [redacted]'s methamphetamine use, but it missed his opioid use. [redacted] Med. Rcd. at 9-10. The Jail never followed up on Mr. [redacted]'s methamphetamine use to determine if he should be monitored for overamping due to stimulant intoxication or stimulant withdrawal or receive treatment for stimulant use disorder. As for his opioid use, medical staff eventually identified Mr. [redacted]'s opioid use eight months after intake. *Id.* at 23. He was placed in the MAT program and received MOUD for a short period of time, but he began to complain about side effects from buprenorphine/naloxone and his MOUD was discontinued. *Id.* at 24, 203.

48. The Jail's handling of Mr. [redacted]'s complaints of side effects from buprenorphine/naloxone did not meet the standard of care. It is to be expected that a patient may experience side effects from buprenorphine/naloxone, particularly constipation, which was Mr. [redacted]'s primary complaint. But side effects like those Mr. [redacted] experienced should not lead to discontinuation of MOUD. Instead, side effects should be addressed at the outset by educating the patient on the potential side effects they may experience. It is not uncommon for patients on either methadone or buprenorphine to be on a scheduled bowel regimen (not ordered as needed but rather scheduled). The benefits a patient derives from continued use of MOUD far outweigh the possible risks of its use.

49. The reviewer that drafted the summary in Dr. Murray's report did not apply this standard of care, instead noting that Mr. [redacted] refused medication without

exploring whether the Jail adequately followed up on those refusals. Murray Rpt. at 194-95. The medical record shows that Mr. [redacted] refused medication because he was experiencing side effects that were not adequately treated. Had those side effects been adequately treated, he may not have refused medication and been able to stay on the MOUD that he needed. I disagree with the conclusion in Dr. Murray's report that Mr. [redacted]'s treatment met the standard of care.

[redacted]

50. Ms. [redacted]'s medical record was summarized in both Dr. Murray's and Dr. Penn's reports, with each concluding that her treatment met the standard of care. While Ms. [redacted]'s opioid use was identified at intake, [redacted] Med. Rcd. at 9-10, the Jail waited six weeks to start Ms. [redacted] on buprenorphine/naloxone. *Id.* at 25. That delay is too long, and it exposed Ms. [redacted] to a risk of returning to use given the availability of opioids in the Jail. The Jail did conduct COWS assessments after identifying Ms. [redacted]'s opioid use, but they were completed only once daily. *See, e.g.*, *id.* at 281, 288, 290, 294, 298. Ms. [redacted]'s methamphetamine use also was identified at intake, *id.* at 9-10, but there is no evidence the Jail monitored her for overamping due to stimulant intoxication or stimulant withdrawal or offered her treatment for stimulant use disorder.

[redacted]

51. Mr. [redacted]'s medical record reflects many of the inadequacies in the Jail's MAT program. Mr. [redacted] had received buprenorphine/naloxone prior to his incarceration, but his history of opioid use was not identified at his intake on [redacted] 2023. *See* [redacted] Med. Rcd. at 10-11. The following day, Mr. [redacted] submitted an inmate request noting that he used fentanyl and wanted to be in the MAT program to keep him safe from "overdosing on fentanyl if it enters the jail." *Id.* at 235. Three weeks after intake, Mr. [redacted]'s partner began calling the Jail asking for Mr. [redacted] to be placed in the MAT program. Staff repeatedly informed Mr. [redacted]'s partner that he was "on the MAT interest queue" but "there is not a

timeframe to be given on how soon he will be seen." *Id.* at 30. Mr. [redacted] partner called the Jail at least five times over the course of two weeks from [redacted] to [redacted] 2023, and consistently received the same response. *Id.* at 30-31.

52. Mr. [redacted] finally was evaluated for the MAT program on [redacted] 2023, more than one month after his initial request, and he was started on buprenorphine/naloxone the following day. Unfortunately, he was not provided with an adequate dose. The Jail started Mr. [redacted] on a dose of just buprenorphine/naloxone 8/2 mg for one month before increasing his dose to buprenorphine/naloxone 16/4 mg on [redacted] 2023. *Id.* at 31-33. On [redacted] 2024, his dose was increased to buprenorphine/naloxone 20/5 mg. But Mr. [redacted] repeatedly requested an increase above that dose because he had been on a dose of buprenorphine/naloxone 24/6 mg in the community (12/3 mg in the morning and 12/3 mg in the evening) and was still experiencing cravings. *Id.* at 42, 47, 235. Mr. [redacted] made these requests from at least [redacted], 2023, through [redacted] 2024. *Id.*

53. There also was concerning evidence of the Jail's practice of denying medication to those suspected of diversion and stigmatizing persons on MOUD. On [redacted] 2024, Mr. [redacted] filed a grievance because the nurse dispensing medications was threatening to take persons off MOUD if they cheeked medication, despite no evidence that anyone had been cheeking medication. Rather than addressing the nurse's behavior, the Jail's response to Mr. [redacted]'s grievance was to remind him of the "zero tolerance policy of Naphcare" and request that he "follow our policy and cooperate with [the] medication nurse. It will be much appreciated." *Id.* at 268. The behavior of the nurse, and the Jail's response apparently endorsing that behavior, underscore my conclusion in my initial report that the Jail failed to meet the standard of care when it comes to diversion. *See generally* Ramsey Rpt. at 86-92, 115-120.

54. Mr. [redacted]'s treatment failed to meet the standard of care for multiple reasons. It took the Jail more than one month to start Mr. [redacted] on buprenorphine/naloxone after he reported prior fentanyl use and prior buprenorphine/naloxone treatment, where the standard of care would have been to start him on the same day as his request. The Jail also failed to provide adequate individualized treatment for MOUD by taking months to increase Mr. [redacted]'s dose of buprenorphine/naloxone and never providing the dose that he had received in the community, which failed to meet the goal of eliminating Mr. [redacted]'s opioid cravings, thereby exposing him to a risk of return to use and potential overdose. The Jail endorsed stigmatizing behavior by one of its nurses while reinforcing NaphCare's zero tolerance policy for diversion, which does not meet the standard of care.

[redacted]

55. Ms. [redacted][8] entered the Jail under the influence of substances on [redacted], 2023, and had numerous medical issues throughout her incarceration, including substance use, which were treated inconsistently. Some of Ms. [redacted]'s substance use was identified at intake, although the medical record does not include a comprehensive detox screen, which I would expect to see given that use of alcohol/sedatives/opioids was identified at intake. *See* [redacted] Med. Rcd. at 1. The Jail did identify methamphetamine use at intake, but it does not appear any follow-up was done to identify, monitor, and/or treat potential stimulant use disorder.

56. Four months after entering the Jail, on [redacted] 2023 and [redacted], 2023, Ms. [redacted] reported that "I am a fetty [fentanyl] addict and I need to be placed on the MAT . . . I will do fetty everytime it lands here help me please," and that she had "recently overdose[d] off flently [sic.] by someone else bring[ing it] in[to] SDCJ. I

[8] The medical record indicates that Ms. [redacted] is transgender and identifies as a woman, but staff at the Jail repeatedly m[redacted]dered her throughout the medical record.

[am] having black out withdrawal." *Id.* at 4. This report of fentanyl use in the Jail immediately should have led to an evaluation for OUD and treatment with MOUD, but instead medical staff informed Ms. [redacted] that she was "not qualified" for the "existing MAT program" "at the moment." *Id.* at 1308. She eventually was assessed for and diagnosed with opioid use disorder more than two months later on [redacted], 2023. *Id.* at 718. It appears she was added to the MAT program and started receiving buprenorphine/naloxone eight days after that diagnosis. *Id.* at 1318.

57. It is difficult to evaluate the effectiveness of Ms. [redacted]'s treatment once she was in the MAT program and receiving buprenorphine/naloxone because, as the summary in Dr. Penn's report notes, many of the progress notes in the medical records are "cut and paste" notes. Penn Rpt. at 156. The medical record does not include any substantive description of her response to buprenorphine/naloxone, although there is no evidence of ongoing opioid use after Ms. [redacted] entered the MAT program, so it may have been effective.

58. Ultimately, I disagree with the conclusion in Dr. Penn's report that Ms. [redacted] had access to care. Though she may have received adequate treatment for OUD once she entered the MAT program, the Jail failed to provide access to care in the months prior to Ms. [redacted]'s enrollment in the MAT program. Ms. [redacted] reported having an opioid use disorder and to previously using fentanyl in the Jail but was not assessed for OUD for more than two months after making that report, exposing her to a risk of continued fentanyl use, overdose, and death. Once she was diagnosed with OUD, it still took the Jail eight days to start her on MOUD, where the standard of care is initiating medication on the same day. In addition, despite evidence of substantial substance use at intake, the Jail failed to complete a comprehensive detox screen. And though the Jail identified her as a person who uses methamphetamine, it never assessed, monitored, or treated her for methamphetamine use disorder.

[redacted]

59. Mr. [redacted]'s medical record reflects several of the failures in the Jail's treatment for substance use identified in my initial report. Mr. [redacted]'s treatment got off to a positive start when his fentanyl use was identified at intake on [redacted] 2023, and COWS assessments were initiated, but his care declined after that. *See* [redacted] Med. Rcd. at 10-11, 304. Various RNs completed COWS assessments for Mr. [redacted] from [redacted] 2023 to [redacted], 2023. *See id.* at 301-335. These assessments were only completed once daily despite each assessment noting "[r]eassess in 8 hours." The record also reflects the Jail's policy of not starting buprenorphine/naloxone until a patient's COWS score reaches 6, *id.* at 24, which I explained in my initial report is not the standard of care. Ramsey Rpt. at 45-46. Mr. [redacted] never had a COWS assessment that reached a score of 6 or higher, but he did have three assessments that reached a score of 5. Two of those assessments included categories that the nurse marked "not assessed" – if they had been assessed, it may have increased Mr. [redacted]'s score to 6 and triggered buprenorphine/naloxone treatment. [redacted] Med. Rcd. at 301-302, 319-320. In the third COWS assessment with a score of 5, the nurse marked that Mr. [redacted]'s resting pulse rate was between 101 and 120, which added 2 to the COWS score, but the actual measured pulse on the following page was 125, which should have added 4 to the COWS score, raising the overall score to 7 and triggering buprenorphine/naloxone treatment. *Id.* at 323-24.

60. Even though Mr. [redacted] reported extensive fentanyl use at intake, the Jail did not diagnose him with OUD until [redacted] 2023. *Id.* at 376. Unfortunately, once he was started on buprenorphine/naloxone, he was given an inadequate dose of buprenorphine/naloxone 8/2 mg once daily for months. Jail medical staff repeatedly refused to increase Mr. [redacted]'s dose despite repeated requests from him for a dose increase because he was still experiencing opioid cravings. *See id.* at 160, 169, 170, 172, 394, 409. Opioid cravings are one of the

DSM-5-TR criteria for OUD, which is why the standard of care is to provide a sufficient dose of methadone or buprenorphine to eliminate opioid cravings and prevent the risk that the patient returns to use. But medical staff ignored his requests, instead reminding Mr. [redacted] that he would face consequences for any diversion of medication, which is the opposite of the standard of care. *Id.*

[redacted]

61. Mr. [redacted]'s fentanyl, methamphetamine, and PCP use were all identified at intake. [redacted] Med. Rcd. at 19-20. Consistent with the Jail's lack of policies and procedures regarding substance use treatment outside of opioid use disorder, the medical record does not indicate any follow-up was done to monitor him for or treat his methamphetamine and PCP use. A comprehensive detox screen was performed, but it only focused on Mr. [redacted]'s opioid use.

62. The Jail provided Mr. [redacted] with buprenorphine/naloxone six days after intake. The standard of care for withdrawal management was to start Mr. [redacted] on buprenorphine/naloxone immediately, but the record reflects that the Jail's policy of only beginning buprenorphine/naloxone after a COWS score of 6 prevented initiation of buprenorphine/naloxone for Mr. [redacted], whose COWS scores were consistently 0 or 1. *Id.* at 113, 129-145. Consistent with the Jail's COWS practice, Mr. [redacted] was only assessed once every 24 hours, despite notations on each COWS assessment to reassess after either 4 or 8 hours. *Id.* Once Mr. [redacted] began to receive buprenorphine/naloxone, the record indicates that he responded positively to treatment.

63. Mr. [redacted]'s treatment did not meet the standard of care due to the lack of monitoring and treatment for his methamphetamine and PCP use, the insufficiently frequent COWS assessments, and the delay in starting him on buprenorphine/naloxone.

[redacted]

64. Mr. [redacted]'s substance use was missed at intake and only identified

seven weeks later during a behavioral health assessment. *See* [redacted] Med. Rcd. at 18-19, 37. The most notable part of Mr. [redacted]'s medical record from a substance use treatment perspective was the Jail's handling of an allegation that he had diverted buprenorphine/naloxone. On [redacted], 2024, a nurse reported that Mr. [redacted] had removed powdered buprenorphine/naloxone from his mouth and placed it in a magazine, which a deputy then inspected and found "a good am[oun]t of Suboxone wrapped in plastic" in the magazine. *Id.* at 181. Fortunately, this incident did not result in the discontinuation of buprenorphine/naloxone, as Mr. [redacted] was instead "counseled regarding Cheeking/Hoarding/Diverting Suboxone" and his buprenorphine/naloxone was continued "as previously prescribed." *Id.* at 182. However, Mr. [redacted] was cautioned that "continued/repeated noncompliance" with medications "may lead to discontinuation of Suboxone." *Id.* Counseling is an appropriate response to diversion rather than decreasing a patient's dose or discontinuing the medication.

[redacted]

65. At intake, Ms. [redacted]'s methamphetamine use was identified, but her opioid use was missed and not identified until a psychiatric evaluation two weeks later. [redacted] Med. Rcd. at 54 ([redacted], 2023, receiving screening), 745 ([redacted], 2023, psychiatric evaluation). During that psychiatric evaluation, Ms. [redacted] "expresse[d] interest in the MAT program." *Id.* At that point in time, the standard of care in the Jail should have been to assess and diagnose Ms. [redacted]'s OUD promptly so she could be started on MOUD immediately. Instead, it took more than three months before Ms. [redacted] eventually was diagnosed with OUD on [redacted], 2023. *Id.* at 206.

66. The Jail then started Ms. [redacted] on buprenorphine/naloxone but failed to provide adequate individualized treatment. Ms. [redacted] was started on the Jail's standard buprenorphine/naloxone 8/2 mg dose on [redacted], 2023, but began complaining of side effects, including constipation, within one month. *Id.* at 14, 23.

Her buprenorphine/naloxone dose then was decreased to just 2/0.5 mg per day on [redacted], 2024, which prompted Ms. [redacted] to complain that she felt like she was experiencing opioid withdrawal symptoms just eight days later. *Id.* at 23-24. Ms. [redacted]'s dose was then increased to 4/1 mg per day on [redacted], 2024, then 6/1.5 mg per day on [redacted], 2024, then all the way back to 8/2 mg per day on [redacted] 2024. *Id.* at 24. By the following month, Ms. [redacted] was complaining of both opioid cravings and constipation, indicating that her dosing was insufficient to treat her OUD and that the Jail failed to adequately treat her side effects. *Id.* at 33-34. This roller coaster could have been avoided if the Jail had provided Ms. [redacted] with individualized treatment from the outset, including better education about potential side effects when she was started on MOUD, providing medication (a scheduled bowel regimen) early on to address those side effects, and more responsive adjustments to dosing as Ms. [redacted] adjusted to buprenorphine/naloxone.

67. Ms. [redacted]'s treatment did not meet the standard of care due to the months-long delay in starting Ms. [redacted] on buprenorphine/naloxone, the inadequate dosing of buprenorphine/naloxone and side effect management once Ms. [redacted] began receiving it.

[redacted]

68. Mr. [redacted]'s medical record is a clear example of the Jail's practice of failing to provide MOUD to patients that medical providers know, or should know, have symptoms of OUD. Here, Mr. [redacted]'s methamphetamine use was identified at intake on [redacted] 2023, but his opioid use was missed. However, his opioid use was identified on the same day of his intake when Mr. [redacted] was referred for an Inmate Safety Program ("ISP") assessment/follow-up for mental health care ("MHC"). [redacted] Med. Rcd. at 48-58. During that follow-up, Mr. [redacted]'s daily amphetamine and opioid use was identified. *Id.* at 56. At this point, Jail medical staff knew that Mr. [redacted] used opioids daily and should have

started him on opioid withdrawal protocols, with COWS assessments, then promptly diagnosed OUD and provided him with MOUD. None of that happened. It appears that, because Mr. [redacted]'s opioid use was identified outside of the regular intake screening process – even though it was identified on the day that he was booked – the Jail's opioid withdrawal protocols were not initiated. This indicates that the Jail has a practice of medical providers failing to communicate a patient's need for substance use treatment with other medical providers who could provide that treatment.

69. Mr. [redacted] eventually requested MOUD seven weeks later on [redacted], 2023. The following day, a psychiatric evaluation identified that Mr. [redacted] had daily or every other day opioid use. *Id.* at 89-90. But he was not diagnosed promptly with OUD and started on buprenorphine/naloxone, even though a medical provider knew that he had a history consistent with OUD. Instead, Mr. [redacted] had to request buprenorphine/naloxone again on [redacted], 2023, at which point he was told he was in the MAT interest queue. [redacted] waited almost two months and again requested buprenorphine/naloxone on [redacted] 2024, at which point he was assessed and diagnosed with OUD on [redacted], 2024, which finally led to treatment with buprenorphine/naloxone.

70. The Jail's four-month failure to treat [redacted]'s OUD is a clear-cut violation of the standard of care, but the summary in Dr. Murray's report ignores that delay completely and concludes his treatment met the standard of care. Murray Rpt. at 202 ("Opioid Use Disorder. He was enrolled in the MAT program and was compliant.").

[redacted]

71. Mr. [redacted]'s substance use was missed at intake on [redacted], 2023, and he was not monitored with any withdrawal protocols. [redacted] Med. Rcd. at 9-10. About three weeks later, on [redacted], 2023, Mr. [redacted] requested to join the MAT program. *Id.* at 16. Ultimately, he was diagnosed with OUD and started

on buprenorphine/naloxone about one month later on [redacted], 2023. *Id.* at 94. From the time he was booked until he was started on OUD more than six weeks later, Mr. [redacted] was exposed to a risk of return to use and overdose.

[redacted]

72. During intake on [redacted], 2023, Mr. [redacted]'s substance use was initially not identified on the receiving screening, but a comprehensive detox screen was performed anyway. It is unclear from the medical record what prompted this comprehensive detox screen, but it identified opioid withdrawal symptoms and triggered the opioid withdrawal protocol. [redacted] Med. Rcd. at 142. Nursing staff then performed COWS assessments over the course of the next 16 days. *See id.* at 139-199.

73. There were several issues with the COWS assessments. Consistent with the Jail's general practice, assessments were attempted only once per day, despite notations in the medical record to reassess after four or eight hours. The first COWS assessment was completed on [redacted] 2023, at [redacted] p.m., resulting in a score of 5 and the second COWS was completed roughly twelve hours later on [redacted], 2023, at [redacted] p.m., with a score of 2. *Id.* at 146. The second assessment noted that Mr. [redacted] should be reassessed in eight hours, but no attempt was made to assess him again until [redacted] p.m. on [redacted], 2023, 25 hours later. At that time, no assessment was performed as Mr. [redacted] was purportedly unavailable. *Id.* at 148. Because no assessment was performed, the record indicates that Mr. [redacted] was supposed to be reassessed in 4 hours, but no attempt was made to reassess until [redacted], 2023, at [redacted] p.m., 22 hours later. That assessment produced a score of 6, which triggered initiation of buprenorphine/naloxone. *Id.* at 158. By this point, it had been more than 48 hours since Mr. [redacted] was last assessed. He should have been assessed at least 40 hours earlier, and had he been assessed, he may have been started on buprenorphine/naloxone treatment sooner, as his score may have been 6 or higher. Regardless, the Jail's policy of refusing

buprenorphine/naloxone treatment until a COWS score of 6 failed to meet the standard of care. Mr. [redacted] should have been started on buprenorphine/naloxone after the first COWS assessment the day he was booked. Instead, buprenorphine/naloxone was not initiated until two-and-a-half days later, which meant Mr. [redacted]'s opioid withdrawal went essentially untreated during a critical period where the risk of serious harm from opioid withdrawal was heightened. As a result, Mr. [redacted]'s substance use treatment did not meet the standard of care.

[redacted]

74. At intake, Mr. [redacted]'s history of alcohol use was identified but his opioid use was not identified. [redacted] Med. Rcd. at 9-10. A comprehensive detox screen was performed for alcohol use only and he was placed on alcohol withdrawal protocols. *See id.* at 89-106. Ten weeks later, Mr. [redacted] requested MAT and informed staff that he had a history of "years of heroin abuse." *Id.* at 235. Four weeks later, on [redacted], 2024, Mr. [redacted] had not been assessed for OUD and he submitted a second request to join the MAT program. Ten days after his second request, a Licensed Marriage and Family Therapist (LMFT) conducted a comprehensive substance use history of Mr. [redacted] for the first time since he was incarcerated, diagnosing him with severe OUD, prompting initiation of buprenorphine/naloxone by a medical provider the following day. *See id.* at 237. Mr. [redacted] was started on the Jail's standard buprenorphine/naloxone 8/2 mg dose. He did not receive an individualized assessment as to whether that dose was adequate for nearly two months, when on [redacted], 2024, he received a MAT evaluation and reported that he was still experiencing opioid cravings at a level of 8/10, at which point, his dose was increased to 12/3 mg. *Id.* at 79.

75. The Jail's failure to use a validated screening tool does not meet the standard of care, which could have contributed to its failure to identify Mr. [redacted]'s opioid use at intake. The Jail also failed to meet the standard of care

by waiting more than five weeks to assess Mr. [redacted] for OUD after he informed the Jail that he had a long history of heroin use. Once Mr. [redacted] was diagnosed with OUD, he was promptly started on buprenorphine/naloxone the next day, but the Jail failed to provide individualized care by waiting nearly two months to assess whether the standard buprenorphine/naloxone 8/2 mg dose was sufficient for Mr. [redacted]. These delays created a substantial risk that Mr. [redacted] would return to use with opioids because he was not receiving an adequate dose of buprenorphine/naloxone, so I disagree with the conclusion in Dr. Murray's report that Mr. [redacted]'s treatment met the standard of care. Murray Rpt. at 217-18. [redacted]

76. During intake on [redacted] 2021, no substance use was identified. [redacted] Med. Rcd. at 10-11. After nearly two years of incarceration in the Jail, Mr. [redacted] requested buprenorphine/naloxone on [redacted], 2023, reporting that he was "in the last stage of getting my [suboxone]" during a prior incarceration in state prison. *Id.* at 25. Six weeks later, Mr. [redacted] was assessed for and diagnosed with OUD on [redacted], 2023. *Id.* at 26. He was prescribed the standard dose of buprenorphine/naloxone 8/2 mg per day and instructed "to submit a s[ick]c[all request] if he reports no improvement in cravings with medication." *Id.* at 93-94. Mr. [redacted] went on to request multiple dose increases due to persistent opioid cravings, resulting in an increase to 12/3 mg on [redacted], 2023, an increase to 16/4 mg on [redacted], 2023, and an increase to 20/5 mg on [redacted], 2024. *See id.* at 100, 114-15.

77. The progress note written in connection with the [redacted], 2024, increase to 20/5 mg is notable because it is the first complete substance use history in Mr. [redacted]' medical record and was written by a physician. *Id.* at 114-15. Thorough, adequate substance use histories such as this are extremely rare in the medical records I have reviewed. Histories such as this should be taken at the beginning of MOUD treatment to provide adequate, individualized treatment with

appropriate dosing based on the patient's medical history. Unfortunately, this history was not taken until after Mr. [redacted] had been receiving an insufficient dose of buprenorphine/naloxone for three months.

78. The delay of six weeks between Mr. [redacted] reporting his history of opioid use, including prior MOUD treatment in prison, did not meet the standard of care. While Mr. [redacted] was started on buprenorphine/naloxone promptly after being diagnosed with OUD, it took three months for the Jail to take a comprehensive substance use history and provide Mr. [redacted] with a sufficient dose of buprenorphine/naloxone. Throughout those three months, Mr. [redacted] reported consistent opioid cravings, meaning the buprenorphine/naloxone treatment did not meet the standard of care during that time and exposed Mr. [redacted] to a risk of return to use due to inadequate dosing.

[redacted]

79. Mr. [redacted]'s medical record illustrates the harms that arise from the Jail's failure to provide individualized care for OUD and its punitive response to suspected diversion. The Jail promptly identified that Mr. [redacted] had an active community-based prescription for buprenorphine/naloxone, specifically buprenorphine/naloxone 8/2 mg twice daily (BID), and began providing it to Mr. [redacted] the day after he was booked. [redacted] Med. Rcd. at 26.

80. The Jail started Mr. [redacted] on buprenorphine/naloxone 16/4 mg, though dosed once daily rather than split twice daily, the dose that he was prescribed in the community. *Id.* at 28. After three days at this dose, Mr. [redacted] submitted a sick call request complaining that the dose was too strong, and he requested to "taper off slowly" on [redacted], 2023. *Id.* at 18. Unfortunately, the Jail's typical practice of providing buprenorphine/naloxone at either 16/4 mg or 8/2 mg, with no dosing in between, prevented Mr. [redacted] from being decreased slowly, and his dose was reduced to 8/2 mg. *Id.* at 28. More nuanced dosing, reducing his dose to 14/3.5 mg or 12/3 mg or 10/2.5 mg, were all feasible options that were not utilized.

Nineteen days later, on [redacted] 2023, Mr. [redacted] submitted another sick call request complaining that the dramatic reduction in his buprenorphine/naloxone led to symptoms of opioid withdrawal, and he requested a small increase "to 10/2.5 or 12/3 mg." *Id.* at 18. This request was denied, with progress notes on [redacted], 2023 and [redacted], 2023, noting that he would be maintained on the "standard dose of 8/2 mg daily." *Id.* at 30. Mr. [redacted] continued to file sick call requests for the next four months because his 8/2 mg dose was insufficient, ultimately requesting that he be returned to his initial 16/4 mg dose, but instead, the Jail maintained Mr. [redacted] at 8/2 mg. *Id.* at 19.

81. The dosing issue came to a head in [redacted] 2023. On [redacted] 2023, medical staff finally decided to "increase[] his dose from 8[/2] mg to 16[/4] mg." *Id.* at 37. But two days later, on [redacted], 2023, Mr. [redacted] was accused by custodial staff of hoarding buprenorphine/naloxone. *Id.* Two days after that, on [redacted] 2023, a court ordered the Jail to "address his prescription and medication." *Id.* At this point, the medical record makes clear that decisions about Mr. [redacted]'s OUD treatment were no longer solely in the hands of medical staff. On [redacted], 2024, in response to the court order, a nurse practitioner assessed Mr. [redacted]'s medical care. *Id.* at 37-38. In response to the hoarding allegation, the NP noted, "if I don't have written documentation to back up hoarding, I will increase his dose back to 16[/4] mg. If there is written proof, then I will talk to IP to explain why his dose was cut in half." *Id.* at 38. This note is concerning because it indicates the NP's medical judgment was that a 16/4 mg dose was appropriate, but that medical judgment would be overridden, and Mr. [redacted] would instead be given half the adequate dose if custody staff provided a written report alleging hoarding. Ultimately, custody staff produced a written report alleging that Mr. [redacted] was caught with methamphetamine and fentanyl, but notably not buprenorphine/naloxone, so the NP ordered his dose increased back to 16/4 mg. She noted, however, that "[o]nce we are presented with proof of hoarding we will

cut the dose in half." *Id.* at 39. One week later, however, a physician reversed that decision and cut Mr. [redacted]'s dose in half on [redacted], 2023, based on allegations of diversion. *Id.*

82. This sequence of events is deeply concerning. I explained in my initial report that "continued opioid use while on MOUD . . . likely indicates that the person is not being treated with an adequate dose of medication, underscoring their need to stay on MOUD." Ramsey Rpt. at 92, ¶ 213. The reason that sufficient dosing of MOUD is so critical is that, when people with OUD do not receive sufficient medication, they are at risk of returning to use and potentially overdosing. Custody staff's allegation that Mr. [redacted] was caught with fentanyl is evidence of this risk coming to fruition. At this point, it should have been clear to Jail medical staff that they had failed to provide Mr. [redacted] with an adequate dose of buprenorphine/naloxone, and they should have sought to protect Mr. [redacted] by ensuring he received a sufficient dose to prevent his return to use. But the Jail's policies, procedures, and practices dictated the opposite outcome, leading to a physician cutting Mr. [redacted]'s dose in half and exposing him to the substantial risk of serious harm from returning to fentanyl use.

83. After his dose was decreased, Mr. [redacted] continued to request that his dose be increased for months. This request was denied on [redacted] 2023, on the basis of his "history of cheeking/hoarding his medication." *Id.* at 45. Eventually, on [redacted], 2023, a physician finally "[u]ptitrated patient [S]uboxone to achieve a more therapeutic dose to reduce cravings and prevent fentanyl OD." *Id.* This record shows that Jail medical staff knowingly exposed Mr. [redacted] to a risk of "fentanyl OD" based on alleged diversion for more than three months. Even once his dose was increased, Mr. [redacted] remained at risk of having his medication reduced due to an allegation of diversion, as demonstrated by a [redacted], 2024, note in which a physician describes "educating him" about "the ZERO tolerance policy for diversion." *Id.* at 88. I strongly disagree with the conclusion in

Dr. Penn's report that Mr. [redacted] had access to care. Penn Rpt. at 184-85.
[redacted]

84. Mr. [redacted]'s medical record shows that the Jail failed to provide him with an adequate dose of buprenorphine/naloxone for years, and it also reflects how the Jail's punitive approach to allegations of diversion risks interfering with adequate provision of buprenorphine/naloxone. Mr. [redacted] was transferred from CDCR custody to the Jail on [redacted], 2021. [redacted] Med. Rcd. at 18. Mr. [redacted] was prescribed MOUD while in state prison custody, specifically buprenorphine/naloxone at a dose of 16/4 mg per day. *Id.* He was incarcerated in the Jail for the next three years (at least until [redacted] 2024, the date the medical records produced to Plaintiffs ends). During that time, the Jail consistently failed to provide an adequate dose of buprenorphine/naloxone to Mr. [redacted].

85. Mr. [redacted]'s medical record reflects numerous problems with the care he received for his OUD. *See generally id.* at 18-34. Some of the inadequacies include disruptions in the provision of MOUD when the Jail ran out of buprenorphine/naloxone on [redacted] 2021, *id.* at 20; switching Mr. [redacted] to ER buprenorphine [Sublocade] on [redacted], 2021, "due to logistical considerations," though that medication was not strong enough to treat his OUD and resulted in swelling of his lower extremities, *id.* at 22-23; providing buprenorphine/naloxone again but denying repeated requests in [redacted] 2022 to increase his dose, prompting Mr. [redacted] to go on a hunger strike, *id.* at 24-25; denying repeated grievances from Mr. [redacted] to see an outside MAT medical provider due to inadequate care in the [redacted] 2022, *id.* at 27; refusing to increase his dose above 16/4 mg in [redacted] 2022 despite "cravings and inability [to] sleep" and instead suggesting he be evaluated for a sleep aid, *id.*; and providing insufficient dosing throughout 2023 and into 2024, *id.* at 29 (request to increase his dose on [redacted] 2023 and [redacted], 2023), *id.* at 32 (request to increase his dose on [redacted], 2023 and [redacted], 2023), *id.* at 33 (request to increase his dose on

[redacted], 2024).

86. The Jail's persistent refusal to provide Mr. [redacted] with an adequate dose of buprenorphine/naloxone appears to have been influenced by allegations of diversion from the first few months of his incarceration. On [redacted] 2021, less than 10 days after entering the Jail, custodial staff alleged that Mr. [redacted] had attempted to give buprenorphine/naloxone to another incarcerated person. *Id.* at 18. On [redacted], 2021, a nurse reported that Mr. [redacted] attempted to divert one of his buprenorphine/naloxone strips by dropping it on the floor and covering it with his foot. *Id.* at 665. He later begged the nurse not to discontinue his buprenorphine/naloxone as a result. *Id.* There is also a vague note from [redacted] 2021, indicating "multiple medications found on inmate cell by" two deputies, including "Prilosec" and "Tylenol," but it is unclear if Mr. [redacted] was not supposed to have those medications. After those minor incidents, there are no indications in Mr. [redacted]'s medical record of attempted diversion, but the allegations followed him for years. Following a request to increase his buprenorphine/naloxone, a physician noted that Mr. [redacted] "has a h[istory] of cheeking so no dose change made at this time." *Id.* at 662. Additionally, in a psychiatric progress note from [redacted] 2023, Mr. [redacted] was subjected to an extensive "evaluation for any underlying condition that might result in the diversion of Suboxone," apparently to establish a basis "for tapering and possible discontinuation of Suboxone should Pt divert this medication since there is no underlying psychiatric issue that would cause this behavior." *Id.* at 609-611.

87. These records demonstrate that the Jail has a practice of deploying punitive measures in response to alleged diversion that risk interfering with the provision of an adequate dose of MOUD. This prioritization of punishment over care is reflected in the summary of Mr. [redacted]'s medical record in Dr. Penn's report. In that summary, the reviewer erroneously states that the record shows "frequent issues with diversion." Penn Rpt. at 162-63. There is no evidence of "frequent

issues with diversion," instead there were two, maybe three, minor allegations of diversion in the first few months of Mr. [redacted]'s incarceration, followed by no evidence of diversion for the remainder of the three years of his medical record. But the summary goes on to state that Mr. [redacted] made "near constant requests for increasing all medications with habituating potential," including buprenorphine/naloxone. *Id.* The reviewer's incorrect assertion that Mr. [redacted] frequently diverted medications clearly informed his opinion as to whether Mr. [redacted]'s requests to increase his medication were valid. A thorough review of Mr. [redacted]'s medical record instead demonstrates that Mr. [redacted] requested adjustments to his treatment for OUD because the Jail failed to provide him with an adequate dose of buprenorphine/naloxone. As a result, I disagree with the conclusion in Dr. Penn's report that Mr. [redacted] received access to care.

[redacted]

88. Mr. [redacted] was transferred from CDCR custody to the Jail on [redacted], 2023. He had a prescription for buprenorphine/naloxone 12/3 mg daily while in CDCR custody, which was noted at intake and initially continued. [redacted] Med. Rcd. at 9-10. But less than two weeks into his incarceration, a nurse and deputy accused Mr. [redacted] of cheeking buprenorphine/naloxone on [redacted] 2023. *Id.* at 27. The Jail's response was harsh, immediately reducing his dose by two-thirds to just 4/1 mg per day starting [redacted], 2023. *Id.* This punishment violated the standard of care, exposing Mr. [redacted] to a risk of return to use due to an inadequate dose of buprenorphine/naloxone in response to one incident shortly after he entered the Jail. *See* Ramsey Rpt. at 86-92. This risk lasted for months, as the medical record indicates that Mr. [redacted] was still being punished with a "dosage reduced due to cheeking medication" into [redacted] 2024. [redacted] Med. Rcd. at 1194.

89. I strongly disagree with the summary in Dr. Murray's report, which "commend[s] the jail on their attention to opioid use disorder" in Mr. [redacted]'s medical record, as well as the conclusion that Mr. [redacted]'s treatment met the standard

of care. Murray Rpt. at 207-08.

[redacted]

90. Mr. [redacted]'s medical record reflects the Jail's practice of failing to refer incarcerated persons for assessment and treatment of substance use disorder when their substance use is not identified during the standard intake screening but is later identified by Jail staff. It also reflects the Jail's lack of policies and procedures to treat non-opioid substance use disorders. Mr. [redacted]'s substance use was not identified during his intake screening on [redacted], 2023. [redacted] Med. Rcd. at 9-10. His history of methamphetamine use was identified roughly eleven weeks later on [redacted], 2023, *id.* at 95, during a behavioral health assessment and twelve days after that identifying daily methamphetamine use, *id.* at 104. Several months later, on [redacted] 2024, a psychiatric evaluation noted a more extensive substance use history, including methamphetamine, fentanyl, heroin, PCP, cocaine, and alcohol. *Id.* at 139. There is no comprehensive substance use history in the medical record, so it is not possible to determine how recently Mr. [redacted] had used these substances or whether he used any of them in the Jail.

91. Mr. [redacted]'s history of daily methamphetamine use indicated that he likely had stimulant use disorder. Under the standard of care, "[a]ny person who is identified as likely having [a substance use disorder] should be seen by a medical provider immediately to establish a diagnosis" "using DSM-5-TR criteria." Ramsey Rpt. at ¶¶ 157-58. But there is no indication in the medical record that Mr. [redacted] was referred to a medical provider to be assessed for stimulant use disorder. (There is also no indication that he was referred to a medical provider to be assessed for a substance use disorder associated with his history of opioid, PCP, cocaine, and alcohol use once that history was identified.) Mr. [redacted] did not receive treatment for substance use disorder as a result. This exposed Mr. [redacted] to a risk of "return to use – either while incarcerated or after being discharged." *Id.* at ¶ 223.

/ / /

[redacted]

92. Mr. [redacted]'s history of substance use was not identified during his intake screening on [redacted] 2023, *id.* at 9-10, but his history of alcohol and methamphetamine use was noted for the first time roughly two months later on [redacted] 2023, based on his medical records from the Department of State Hospitals ("DSH"), *id.* at 164. The DSH Psychiatric Discharge Summary that the Jail received indicated that Mr. [redacted] likely had stimulant use disorder. *See id.* at 3691-92. In that summary, a DSH physician who assessed Mr. [redacted] noted that he "reported he began using methamphetamine between ages 20-21 and used approximately ten times. However, he also reported using two to three times per day. Mr. [redacted] stated he 'went weird' while using methamphetamine and described himself as becoming 'addicted' to it. He also noted he would do anything to get some. Based on Mr. [redacted]'s self-report, it is my opinion he likely has substance use disorder(s) that have caused clinically significant distress and impairment in his functioning." *Id.* at 3691.

93. It is concerning that this DSH summary was apparently not considered by Jail medical staff until more than two months after Mr. [redacted] was booked. It is even more concerning that once this summary was reviewed by Jail medical staff, no action was taken to assess Mr. [redacted] for substance use disorder and provide treatment. This violation of the standard of care is consistent with the Jail's practice of failing to assess and treat persons for substance use disorder when substance use is identified for the first time after the intake screening, as well as the Jail's lack of policies and procedures for treating non-opioid substance use disorders.

[redacted]

94. Ms. [redacted]'s substance use was not identified during her intake screening on [redacted], 2023, [redacted] Med. Rcd. at 84, but on the same day, she tested positive for methamphetamine and amphetamine on her urine drug screen. [redacted] Med. Rcd. at 84, 625. Based on that result, the standard of care was to

monitor Ms. [redacted] for "overamping on stimulants or withdrawing from stimulants," Ramsey Rpt. at ¶¶ 57-58; to assess whether Ms. [redacted] had stimulant use disorder, *id.* at ¶¶ 157-158; and, if she was diagnosed with stimulant use disorder, to provide treatment, *id.* at ¶ 222. None of that happened because the Jail does not have policies and procedures in place to monitor for overamping due to stimulant intoxication, stimulant withdrawal, or to treat stimulant use disorder. [redacted]

95. Mr. [redacted] used multiple substances – including alcohol, opioids, and methamphetamine – and, as a result, his medical record illustrates many of the gaps in the Jail's substance use treatment. Use of all three of those substances was identified during Mr. [redacted]'s intake screening on [redacted], 2023. [redacted] Med. Rcd. at 10. The standard of care was to monitor Mr. [redacted] for intoxication and withdrawal from each of those substances, but the Jail only has policies in place for two of them, alcohol and opioids, which meant his potential overamping from methamphetamine intoxication and methamphetamine withdrawal went unmonitored. Mr. [redacted] "reported [his] last use of methamphetamine was 'right before I got arrested,'" which meant he was at risk of overamping and stimulant withdrawal, but the Jail did nothing to mitigate that risk. *Id.* at 30. Mr. [redacted] was ultimately diagnosed with methamphetamine use disorder during a psychiatric evaluation on [redacted] 2023, *id.* at 52, but there is no evidence that the Jail offered treatment for that diagnosis.

96. As for Mr. [redacted]'s alcohol and opioid use, CIWA-Ar and COWS assessments were initiated on the day he was booked, but they were completed less frequently than the standard of care required, including a more than 38-hour gap between the first and second completed assessments. *See id.* at 147-189. The COWS assessments were discontinued after three and a half days ([redacted],2023 at [redacted] p.m. to [redacted], 2023 at [redacted] a.m.), while the CIWA-Ar assessments were discontinued after five days ([redacted] 2023 at [redacted] p.m. to [redacted], 2024

at [redacted] a.m.). It appears that Mr. [redacted] never received buprenorphine/naloxone while on the opioid withdrawal protocol, *see id.* at 17, and that he was not offered MOUD at any point during his incarceration. He also was not offered medication for alcohol use disorder (MAUD) at any point after CIWA-Ar assessments were discontinued. *Id.* at 18.

[redacted]

97. Mr. [redacted]'s medical record shows several failings in the Jail's withdrawal management and substance use treatment practices and procedures. Mr. [redacted] entered custody under the influence of multiple substances, but he only was assessed for symptoms of withdrawal for some of those substances, and those assessments were not conducted adequately. While going through withdrawal, Mr. [redacted]'s buprenorphine/naloxone was inexplicably delayed for days. And once he was no longer on the withdrawal protocol, Mr. [redacted] did not receive any further treatment for substance use disorder.

98. Mr. [redacted] was first brought to the Jail at [redacted] p.m. on [redacted] 2023, [redacted] Med. Rcd. at 55, but he was initially rejected from the Jail following an intake screening and sent to a hospital due to concerns that he had lost consciousness following head trauma, *id.* at 2. The hospital cleared him, and he returned to the Jail at [redacted] a.m. on [redacted] 2023. *Id.* at 28. During his second intake screening, he was purportedly non-cooperative and was placed in a sobering cell at [redacted] a.m.. *Id.* at 23. The record of that sobering cell placement indicates Mr. [redacted] "admits to being under the influence of . . . Street drugs," but did not specify which substances. *Id.* Mr. [redacted] stayed in the sobering cell for about 13 hours until [redacted] p.m.. *Id.* at 2. Nurses appear to have checked on Mr. [redacted] roughly every 4 hours while he was in the sobering cell, but they did little more than note he was asleep and still breathing. *See id.* at 8-22. Staff did not make any attempt to assess or manage his withdrawal until shortly before Mr. [redacted] was released from the sobering cell, at which point he had been in custody for at least 20 hours and was experiencing symptoms of

withdrawal.

99. Shortly before his release from the sobering cell, Mr. [redacted] reported "recent and/or significant alcohol and opioid use," *id.* at 633-34, and he later stated he was "high on methamphetamine, fentanyl, cannabis, alcohol, and 'a little bit of crack'" when he entered the Jail, *id.* at 639. A urine drug screen the following day returned positive results for methamphetamine, amphetamine, benzodiazepines, cocaine, THC (cannabis), and fentanyl. *Id.* at 670. Consistent with the Jail's lack of policies and procedures for treating stimulant intoxication and withdrawal, Mr. [redacted] was never monitored for overamping or stimulant withdrawal. Of concern, he also was never monitored for benzodiazepine withdrawal, even though the Jail has a policy of using CIWA-B protocols to assess benzodiazepine withdrawal. Because benzodiazepine use was identified only in Mr. [redacted]'s urine drug screen, it appears that urine drug screen does not trigger assessments for substance withdrawal.

100. Mr. [redacted] was monitored for opioid and alcohol withdrawal via COWS and CIWA-Ar assessments for about two weeks, although these assessments were conducted in line with the Jail's practice of attempting only one assessment per day even if the assessment was not completed successfully. *See id.* at 77-167. The first assessments were not attempted until 5:14 p.m. on [redacted] 2023, shortly before Mr. [redacted] was released from the sobering cell and 20 hours after he was first received at the Jail. The first CIWA-Ar assessment resulted in a score of 10, *id.* at 167, and the first COWS assessment resulted in a score of 12, *id.* at 162, indicating Mr. [redacted] was experiencing acute alcohol and opioid withdrawal. Those assessments triggered alerts to STATCare, and, on the same day, a STATCare PA ordered diazepam to treat alcohol withdrawal and initiation of a buprenorphine/naloxone taper. *Id.* at 632-33. Mr. [redacted] was provided diazepam that night, *id.* at 628, but he was not provided buprenorphine/naloxone until six days later, receiving his first dose at 10:59 a.m. on [redacted] 2023, *id.* at 774-79. That delay was potentially dangerous, as it meant Mr. [redacted] went through opioid

withdrawal without medication for nearly a week between his last use on [redacted] 2023, and his first dose of buprenorphine/naloxone on [redacted], 2023. Throughout that time, he was at risk of complications from opioid withdrawal, including death. He ultimately received a total of four doses of buprenorphine/naloxone on [redacted], 2023. *Id.*

101. After Mr. [redacted] completed the withdrawal protocol on [redacted], 2023, there is no evidence that he was ever assessed for opioid use disorder or provided MOUD continuation. Under the standard of care, "[a]ll persons with opioid use and/or OUD should be monitored medically for acute opioid withdrawal syndrome and offered MOUD ***as an ongoing treatment***." Ramsey Rpt. at ¶ 173 (emphasis added). Mr. [redacted] was given buprenorphine/naloxone for just four days, and no medical provider tried to transition Mr. [redacted] onto ongoing, longer-term MOUD after that. This exposed Mr. [redacted] to the risk of return to use and potential overdose while he was in custody.

[redacted]

102. Mr. [redacted]'s substance use was not identified during his intake screening on [redacted] 2022, [redacted] Med. Rcd. at 16-17, but a behavioral health assessment the following month on [redacted], 2022, identified a history of daily opioid and daily methamphetamine use that had been ongoing until his incarceration, *id.* at 33. Once that history was identified, the standard of care required that Mr. [redacted] be assessed promptly for opioid use disorder and stimulant use disorder, with medication or treatment started immediately if he was diagnosed with either. But the Jail's practices of failing to assess incarcerated persons for OUD if their substance use is identified after the intake screening and failing to provide treatment for stimulant use disorder at all meant the standard of care was not met. Mr. [redacted] was never assessed or provided treatment for stimulant use disorder. It took well over a year for him to be provided with MOUD for his OUD.

103. On [redacted] 2023, more than 15 months after Jail medical staff became aware of Mr. [redacted]'s history of daily opioid use, he submitted a sick call request to be in the MAT program. *Id.* at 349. Mr. [redacted] was assessed for and diagnosed with opioid use disorder two weeks later, *id.* at 781, and he began receiving buprenorphine/naloxone six days after that on [redacted], 2023. *Id.* at 350. Unfortunately, Mr. [redacted] began experiencing constipation within one month, *id.* at 351, and his MOUD was discontinued after taking it for just two months, *id.* at 359. Mr. [redacted]'s side effects could have been managed if the Jail had provided adequate pre-emptive education on those potential side effects when Mr. [redacted] started buprenorphine/naloxone and if they had proactively provided medication to treat his constipation with a scheduled bowel regimen.

104. Mr. [redacted] also told medical staff that "he no longer wants to take Suboxone as he wants to be a Trustee" shortly before his buprenorphine/naloxone was discontinued. *Id.* at 158. This is concerning, as persons on buprenorphine/naloxone can work, and Mr. [redacted]'s apparent belief that the Jail did not allow persons receiving buprenorphine/naloxone to be trustee workers could reflect a practice of discriminating against persons with substance use disorder and persons on medication for substance use disorder. If the Jail does not bar persons on MOUD from being trustee workers, then this represents yet another failure to adequately educate Mr. [redacted] on his MOUD treatment when it was initiated. [redacted]

105. Mr. [redacted]'s substance use history was not identified during his intake screening on [redacted] 2022. [redacted] Med. Rcd. at 9-10. Six weeks later, on [redacted] 2022, a behavioral health assessment identified a history of daily alcohol and stimulant use. *Id.* at 35. There is no indication in his medical record that any effort was made to assess Mr. [redacted] for alcohol or stimulant use disorder, nor is there any indication he received treatment for his alcohol or stimulant use.

Eric Wolf

106. The death of Eric Wolf, summarized briefly in Dr. Murray's report, is a tragic example of the risk of overdose created by the Jail's failure to promptly diagnose and treat OUD when it is identified outside of the regular screening process. Mr. Wolf was booked on July 26, 2023, but his substance use was not identified at intake that day. Wolf Med. Rcd. at 18-19. His history of opioid, stimulant, and alcohol use was identified during an ISP assessment on July 28, 2023, based on the Jail staff's review of his medical records. *Id.* at 70. By that point, Mr. Wolf was still at risk of withdrawal, so he should have been referred for COWS and CIWA-Ar monitoring, and then assessed for any OUD and prescribed MOUD. None of that happened.

107. Mr. Wolf's substance use was identified many additional times during his incarceration. *See id.* at 74, 92 (July 29, 2023); *id.* at 202 (October 19, 2023); *id.* 257 (October 23, 2023, self-reporting that he "wore the drugs," using opioids multiple times per week as well as alcohol and stimulant use daily). Nevertheless, the Jail never assessed him appropriately. On July 29, 2023, staff again identified Mr. Wolf's history of stimulant, alcohol, and opioid use during both a psychiatric evaluation, *id.* at 74, and in another ISP assessment, *id.* at 92. A behavioral health assessment on July 31, 2023, identified that same substance use. *Id.* at 95. But there were no attempts to assess Mr. Wolf for opioid withdrawal or diagnose him with OUD so he could be provided with MOUD. The medical record shows Jail staff continually noting Mr. Wolf's history of substance use for months, including on October 19, 2023, *id.* at 202, and on October 23, 2023, by which point Mr. Wolf described his substance use during a psychosocial assessment, stating he "wore the drugs," using opioids multiple times per week as well as alcohol and stimulant use daily, *id.* at 257. Mr. Wolf's description of his own significant substance use history for the first time should have triggered a prompt assessment of whether he met the DSM-5-TR criteria for OUD so he could be provided with MOUD and avoid a

return to use and risk of overdose.

108. On January 5, 2024, staff found Mr. Wolf face down and unresponsive on the floor of his cell. *Id.* at 1272. Staff deployed naloxone ten times with no effect, and Mr. Wolf was pronounced dead shortly thereafter. *Id.* at 1272-73. While an official cause of death is still pending, staff found baggies of fentanyl in Mr. Wolf's cell and an autopsy the following day returned a presumptive positive test for fentanyl. *See* Wolf 3-Day ICD Review at 21. This evidence strongly indicates that Mr. Wolf died of a fentanyl overdose.

109. Had the Jail acted on his reports of frequent opioid use, assessed him for OUD, and provided him with MOUD, it is possible that Mr. Wolf would not have overdosed on fentanyl. As I discussed above, the purpose of MOUD is to prevent the opioid cravings. Had Mr. Wolf been receiving an adequate dose of MOUD, he may not have had opioid cravings and sought out opioids in the Jail. Without MOUD, Mr. Wolf returned to use and fatally overdosed.