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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 PABLO STEWART**

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

Trial Date: None Set

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## I. INTRODUCTION

I, Pablo Stewart, declare:

1. I was asked to review and analyze the opinions and conclusions expressed in the August 21, 2024, Expert Reports of Joseph Penn and Lenard Vare, and to opine whether those reports cause a change in my opinions or conclusions as set forth in my August 19, 2024 expert report in this matter (hereinafter "Stewart Report"), and to provide my opinions as to those reports.

2. I have reviewed and analyzed the opinions in the expert reports noted above. Neither the opinions nor conclusions outlined in those reports cause me to change any of the opinions or conclusions stated in my expert report dated August 19, 2024.

3. The opinions expressed in this rebuttal report are based on information that has been made available to me. Should new information become available to me in the future, I reserve the right to analyze that information and revise my opinions and/or conclusions.

## II. RESPONSE TO THE REPORT OF LENARD VARE

4. I reviewed Defendants' expert Lenard Vare's report, dated August 21, 2024. As set forth below, I strongly disagree with many of the opinions Mr. Vare offers in his report (hereinafter "Vare Report").

### A. Mr. Vare's Opinion Suggesting that the Jail's Suicide Prevention Policies and Procedures Are Appropriate Is Incomplete and Ill-Informed.

5. Mr. Vare writes that the "suicide prevention policies as well as policies related to managing suicidal individuals at San Diego County jails are appropriate in identifying and addressing the concerns related to incarcerated persons." Vare Report at 19-40 (Opinion 1). I strongly disagree with this opinion, and note a few important ways that Mr. Vare's analysis is incomplete and ill-informed.

6. Mr. Vare's opinion does not mention, and appears not to be informed by, critically important sources of data—including the findings and

recommendations of suicide prevention expert Lindsay Hayes and the findings and recommendations of the clinical and investigative team that issued Disability Rights California's report, *Suicides in San Diego County Jail: A System Failing People with Mental Illness*, among other detailed reports on suicide prevention-related deficiencies as I set forth in my report. Stewart Report ¶¶ 284-350.

7. Nor is Mr. Vare's assessment based on analysis of any of the approximately 40-plus suicides that have occurred among incarcerated people at San Diego County Jail in recent years. In determining the adequacy of a jail system's suicide prevention policies and practices, it is essential to look at individual critical incidents – including completed suicides and serious suicide attempts – and to explore whether and to what extent systemic deficiencies are in evidence. I engaged in such an assessment in my August 2024 report; Mr. Vare has not done so.

8. I was surprised and troubled to see the statistical data that Mr. Vare relies upon to support his opinion that the San Diego County Jail's suicide prevention policies and practices are "appropriate." Specifically, he includes this chart (Vare Report at 27):

| Year | Total Self-Harm Incidents including Attempted Suicides | Attempted Suicides Only |
|---|---|---|
| 2021 | 299 | 56 |
| 2022 | 272 | 41 |
| 2023 | 286 | 22 |

9. The County has stated to DRC that it began utilizing new definitions for "Suicide Attempt" and "Non-Suicidal Self Injury" in 2017. Under these definitions, the County determined that just 10 of the 73 incidents reported as "Suicide Attempts" were in fact suicide attempts under the new definition. DRC Report at 5.

10. Mr. Vare writes that, during the 2021-2023 time period, there were five

(5) completed suicides in San Diego County Jails. He then contrasts that number with the "857 individuals" reflected in the above chart's "Total Self-Harm Incidents including Attempted Suicides" column who "were prevented from further harming themselves or completing their suicidal intent over the three-year period." Vare Report at 27. This statement is nonsensical and a misrepresentation of this data.

11. To begin with, Mr. Vare's statement is factually incorrect. There are individuals almost certainly reflected on this chart who in fact *did* further harm themselves and even committed suicide during this three-year period. Take, for example, Mr. Marroquin, whose May 2021 suicide I describe in detail in my report. Stewart Report ¶¶ 275-281. Mr. Marroquin was placed in safety cells and enhanced observation cells for serious self-harm incidents resulting from auditory hallucinations and other acute psychiatric symptoms in the early months of 2021. Mr. Marroquin was then placed in a clinically inappropriate and dangerous solitary confinement cell, where he died by suicide. His self-harm/suicide attempt incidents in 2021 are (or should be) reflected on Mr. Vare's chart. Mr. Vare's claiming that those incidents are evidence of an adequate jail suicide prevention system is deeply wrong-headed. Mr. Marroquin's death was a terrible failure with respect to both mental health treatment and suicide prevention. His earlier suicide attempts and self-harm incidents do not demonstrate success; they underscore the system's deficiencies.

12. Mr. McDowell's egregious case is another example of a suicide attempt in 2023 and was followed by his placement in solitary confinement without necessary psychiatric treatment for several weeks leading up to his suicide, is another example. Stewart Report ¶¶ 258-265. Mr. Vare's statement would have one consider Mr. McDowell's suicide attempt to be evidence of systemic success (notwithstanding that the Jail then put Mr. McDowell in even greater danger and denied him care, leading to his completed suicide). It is in fact the opposite – evidence of a system that places people with serious mental illness at grave and

unacceptable risk.

13. The goal of an adequate suicide prevention system is not merely to prevent people who engage in self-harm or attempt suicide from dying. The goal must also be to proactively identify and treat serious mental illness and suicide risk, to reduce suicidality, and to *prevent* self-harm and suicide attempt incidents. In this three-year span, in addition to the completed in-jail suicides, the chart shows that at least 119 people attempted suicide, and at least 857 people engaged in self-harm, including the suicide attempts. **This finding of such a large number of incarcerated people engaging in self-harming behavior in this Jail is very significant, and serves only to increase my concern.** These data highlight the desperate need for improved psychiatric care and mental health treatment as well as more clinically appropriate settings for people who are now clearly at great risk in the San Diego County Jail.

14. The numbers of attempted suicides in 2021, 2022, 2023, as reflected in Mr. Vare's chart, are substantial, and appear to be significantly higher as compared to a few years earlier – in 2017, another year for which the County has provided suicide attempt data. In Disability Rights California's 2018 report on suicides in San Diego County Jail, the County reported that there were ten (10) incidents meeting the Jail's definition of "Suicide Attempt" between January 2017 and mid-September 2017 (8½ months), or about one per month. DRC Report at 5. Mr. Vare's data show that by 2021, there were 56 attempted suicides over a 12-month period (almost 5 suicide attempts per month), a huge increase that continued at least through 2022 (41 attempted suicides over a 12-month period, or 3½ suicide attempts per month).

15. Mr. Vare's discussion of the plaintiffs in this case offers no evidence that the Jail's suicide prevention policies and practices are appropriate. In fact, Mr. Vare's own descriptions of the plaintiffs' experiences raise serious concern. For example, the case of Plaintiff Olivares is extremely alarming with respect to suicide

prevention protocols, as Mr. Vare recounts:

> Olivares decided to stop eating and go on a hunger strike in January 2022. He was seen by a mental health professional and the mental health staff determined that Olivares should be placed in the Inmate Safety Program. He was interviewed in a medical clinic room, and he informed mental health staff that he was not going to change his mind about his decision. He even reported that he had told his family and friends and made peace with them. He was then placed in an EOH cell. . . . Olivares was again placed into EOH in February 2022 after he informed staff that he was on his second hunger strike.

Vare Report at 35-36.

16. The County's response to this patient's decision to go on a hunger strike makes no sense. In Enhanced Observation Housing (EOH), all patients are denied clothing, placed in a safety smock, and denied various personal belongings and activities (*e.g.*, family visits). None of these deprivations address Mr. Olivares' clinical needs related to an intended hunger strike. (Removal of clothing and placement in a safety smock is clinically indicated when a person demonstrates a risk of hanging themselves of strangling themselves with their clothing. A safety smock is not indicated for a potential hunger strike.) In my experience, placing someone with serious mental health needs in a highly restrictive setting with such deprivations in this kind of situation is clinically countertherapeutic and can feel punitive. It does not serve to treat or meaningfully address a patient's suicidality or mental health needs.

17. Nothing in Mr. Vare's discussion of suicide prevention policies and practices directly addresses, or changes, the detailed findings of systemic deficiencies in my August 2024 report.

### B. Mr. Vare's Opinion Dismissing Serious Concerns About Improper Custody Staff Interference with Mental Health Care Decisions Is Incomplete and Based on Irrelevant Analogies.

18. Mr. Vare writes that Plaintiffs' allegations that "custody staff improperly controls clinical mental health care decisions" are "completely without merit." Vare Report at 40-43 (Opinion 2). Mr. Vare's opinion is remarkably incomplete and relies on irrelevant analogies regarding other government systems.

19. Mr. Vare first dismisses the real and consequential structural deficiency in the Jail's organizational structure, whereby San Diego County Jail health care staff and leadership report directly to a Jail Captain and the Sheriff's Command team. I describe in my report how San Diego County Jail's organizational structure is inconsistent with modern correctional psychiatric practices and is extremely problematic, especially when contrasted with the organizational structures that exist in other medium and large county jail systems in California where jail medical and mental health care staff are overseen by the county's respective health services agencies – including in the Counties of Los Angeles, Orange, Riverside, Sacramento, San Francisco, and Santa Clara. *See* Stewart Report ¶¶ 370-388. Mr. Vare's dismissal of this concern is confusing and off-topic, as he states:

> In city governments, the elected mayor supervises the chief of police even though the mayor is not a peace officer. In state governments, the governor is the commander of the state national guard even though the governor is not a member of the armed forces. The governor's cabinet in California includes directors of Health and Human Services, and the mental health facilities operated by the Department of State Hospitals. Governor Gavin Newsom is neither a physician nor a psychiatrist, yet he is elected by the people of the state to provide leadership to numerous public agencies including those that provide medical and mental health services.

Vare Report at 40-41.

20. These supposed analogies offer no insight on this important issue. Mr. Vare then offers his background as a former state prison warden, noting that the medical and mental health directors in the state prison system would "send me requests for vacation," among other things. This analogy is also not relevant to a local jail system like San Diego County's, *where there are numerous examples of custody staff and leadership making policy and practice decisions that should be in the purview of mental health professionals and clinical leadership* – including as to improper custodial blanket ban policies preventing access to the Outpatient Step Down Program (OPSD) for patients when clinically indicated (Stewart Report Finding 3.D.) and improper custody-driven placements in solitary confinement

without consideration of mental health input (Stewart Report Finding 4.B).

21. Mr. Vare then states that "there is no evidence that medical or mental health personnel are not making medical and mental health decisions independently." Vare Report at 42. But the County's own witnesses demonstrate that it *is* the case that custody staff, by policy and practice, are making what should be clinical determinations without clinicians' involvement.

22. For example, take San Diego County Jail's policies and procedures regarding placement of patients in a restraint chair inside a safety cell. The placement and removal of a patient with mental illness in a restraint chair *should* be based on clinical, not custody, determinations. But it was made very clear to me that such decisions in this Jail system are exclusively "custody decisions." *See* Stewart Report ¶¶ 405-408. The Jail's own mental health coordinator (Ms. Quiroz) testified that she thinks it is important that mental health professionals be involved in these uses of a restraint chair, and *that they are not:*

> Ms. Quiroz: I mean, we've witnessed people in a restraint chair. We're not necessarily the ones determining when they're getting out of that chair. You know, we're not -- they're not calling us for that reason, to say, should this person be removed.
>
> …
>
> [I]t's not common that we see somebody -- that we are going to assess somebody in a [restraint] chair. It is not common.
>
> Q: … [D]o you think it's important for clinicians to be involved when a restraint like a restraint chair is used on somebody who may be manifesting mental illness?
>
> A: Although I think it's important for a clinician, I think a psychiatrist should be -- I mean, if somebody's in a restraint chair I think we should probably get an M.D. level involved.
>
> …
>
> Q: You're not aware of any policy right now for an M.D. level staff member to get involved in a certain way when someone is placed in a restraint chair by custody?
>
> A: No.

Quiroz PMK Dep. at 72-74.

23. As a second example, take the San Diego County Jail's failure to follow U.S. DOJ guidance making clear that a person with serious mental illness "should not be placed in restrictive housing [like the San Diego County Jail's Administrative Separation units], unless:

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

Stewart Report ¶¶ 184-186 (quoting and discussing U.S. DOJ guidance); *see also* NCCHC Standards for Mental Health Services in Correctional Facilities' Standard MH-E-07 (Segregated Inmates) (For a patient being placed in segregation, it is necessary that "mental health staff reviews the inmate's mental health record to determine ***whether existing mental health needs contraindicate the placement*** [in segregation] or require accommodation" (emphasis added)).

24. Based on my on-site observations, patient interviews, and review of individual records, it is beyond question that the dangerous practice of placing – and retaining – people in solitary confinement-type Administrative Separation units without consideration of whether their current mental health condition and needs contraindicate the placement, is pervasive in the San Diego County Jail system. Stewart Report ¶¶ 207-226. Jail leadership and staff testimony confirm that this is true. *See* Quiroz PMK Depo. at 250-51 (noting there is no mental health clinical assessment done for a person being placed in Administrative Separation, with clinical issues something that can be discussed late at staff meetings that occur every two weeks); Ross Dep. at 43 ("Q: … Have there been examples in your experience

where you made a recommendation that somebody be removed from AdSep based on their mental health where classification says, no, they need to remain in AdSep and they so remain? A: Yes. Q: Do you have any examples that come to mind? A: Yeah.").

25. A third example, also unaddressed by Mr. Vare in his report, is the blanket *custodial* restrictions on clothing, bedding, property, and privileges for patients on suicide precautions. By policy and in practice, there is no clinical judgment or input that goes into making these decisions in the San Diego County Jail – a considerable deviation from modern correctional standards. Stewart Report ¶¶ 312-316; *see also* Quiroz PMK Dep. at 156 ("That all happens outside of the clinical world. … [T]hat's in the very custody world.").

26. On this topic, Mr. Vare in fact misrepresents the testimony of Jail mental health director Melissa Quiroz. Mr. Vare writes that Ms. Quiroz testified that "[c]linicians also determine that the individuals must be placed in safety smocks" (p. 42). This is *not* accurate. *See* Quiroz PMK Depo. at 145 ("Q: You're confident that the practice is that ***there's no clinical judgment exercised as to whether a person is placed in a safety smock*** once they go into a safety cell or an EOH? **A: Yeah**.") (emphasis added).

27. A draft policy that would help to remedy this serious deficiency was considered by Jail leadership more than two years ago, but the County has declined to implement it. Stewart Report ¶ 314 (quoting draft policy and citing Ms. Quiroz's testimony that the policy "is not in place at this time").

28. In my patient chart reviews and individual interviews, I found repeated instances where custody staff, by policy and in practice, improperly interfere with important clinical determinations regarding treatment, placement, and conditions for incarcerated people with serious mental illness in the San Diego County Jail. *See, e.g.*, the alarming case of Patient [redacted] an illustrative but by no means outlier case. Stewart Report ¶¶ 229-238. Such instances put patients at substantial

risk of serious harm, including needless suffering and even death.

29. I strongly disagree with Mr. Vare's opinion that there is no improper custody staff interference with mental health clinical decisions in the San Diego County Jail system. His opinion is not rooted in fact, and it is at odds with Jail leadership's own testimony and policies. Nothing in Mr. Vare's report changes my detailed findings and opinions on the Jail's systemic deficiencies in this area.

### C. Mr. Vare's Opinion that There are No Deficiencies with Respect to Safety Checks Ignores the Repeated Findings of Deficiencies by Multiple Independent Factfinders.

30. Mr. Vare writes that "safety checks are done appropriately" in the San Diego County Jail system, and that "there is an adequate process for the safety checks to be audited and lapses in checks are addressed appropriately." Vare Report at 89-94 (Opinion 8). I strongly disagree. Mr. Vare appears to ignore entirely the repeated findings that inadequate safety checks are a major deficiency in this Jail's system, by nationally recognized Suicide Prevention expert Lindsay Hayes, the California State Auditor, Disability Rights California, and the San Diego County Citizens' Law Enforcement Review Board (CLERB). *See* Stewart Decl. ¶¶ 320-335.

31. It was puzzling to see that Mr. Vare found that the County's auditing system for safety checks was "thorough and transparent" (Vare Report at 90) based on review of "an Excel spreadsheet provided to me which showed several supervisory audits that were conducted *during 2021*" (emphasis added). It was in 2022 that the California State Auditor found terrible deficiencies both in the observed safety check practices themselves ("Based on our review of video surveillance footage, we observed multiple instances of sworn staff who spent no more than one second glancing into an individual's cell, sometimes without breaking stride as they walked through the housing module . . . .") and in the adequacy of auditing those checks ("The assistant sheriff of detentions indicated that the department has an *informal process* for assessing the quality of safety checks,

which can include watching video footage. However, the Sheriff's Department has not documented this assessment process in its policy, and *establishing an informal practice does not ensure that each facility's management team will consistently verify the quality of safety checks*.") (emphases added). 2022 California State Auditor Report at 25-26.

32. Mr. Vare says nothing of the many in-custody deaths that have occurred where subsequent findings revealed inadequate safety checks that very likely contributed to the deaths (including Mr. Horsey (2017), Mr. Wilson (2020), and Mr. Settles (2022)). *See* Stewart Report ¶¶ 329-332. In my experience working in and monitoring jail and prison systems, a *single* in-custody death involving deficient safety check procedures would lead to concerted corrective action to ensure that such deficiencies do not recur. The San Diego County Jail system has had *multiple* in-custody deaths with deficient safety check findings, along with numerous outside experts and investigating bodies issuing strong recommendations to address the issue. Yet the deficiencies persist. Mr. Vare's stamp of approval in this area, without any reference to these facts, is disturbing and wrong.

33. Mr. Vare also provides no opinion regarding another key deficit in the San Diego County Jail's safety check policies and procedures – that is, the need to align with the modern practice of 30-minute (rather than hourly) checks in Administrate Separation-type housing units. *See* Stewart Decl. ¶ 322 (citing the American Correctional Association's standard on this point), ¶ 327 (Suicide Prevention expert consultant Lindsay Hayes "strongly recommended" that San Diego County Jail implement 30-minute checks), ¶ 333 (citing other California jail systems that have implement 30-minute checks in solitary confinement-type housing), ¶ 279 (Marroquin suicide by water intoxication, body found after 54 minutes between Administrative Separation safety checks), ¶ 332 (Settles suicide, body found after 75 minutes between Administrative Separation safety checks).

34. My opinion remains that the Jail staff and system currently conduct

inadequate safety checks, and that the County continues (in policy and procedure) to fail to conduct the appropriate 30-minute safety checks in Administrative Separation, all of which place people at substantial risk of serious harm, including death.

35. Nothing in Mr. Vare's discussion of safety check policies and practices directly addresses, or changes, my detailed findings of deficiencies on this topic.

**D. Mr. Vare's Opinion Regarding the Outpatient Step-Down (OPSD) Program's Exclusion of Protective Custody Patients Misses the Point and Ignores County Leadership's Recognition of this Deficit.**

36. Mr. Vare writes that "Plaintiffs' allegation that the Sheriff's Office excludes people designated as protective custody from housing in the Out-Patient Step Down ('OPSD') unit lacks merit because it does not consider the complexity of classification related issues in managing the safety and security of individuals in protective custody." Vare Report at 105-110 (Opinion 10). Mr. Vare has missed the point here entirely, and even ignores the County's own person-most-knowledgeable (its Jail mental health coordinator) on this subject.

37. It is a basic principle with respect to mental health standards of care, including in the jail setting, that a person should be provided mental health care placement and treatment consistent with their individual *clinical* needs. In a functioning jail mental health care system, a patient with serious mental illness is not provided safety *or* adequate mental health care. They are provided safety *and* adequate mental health care.

38. San Diego County Jail fails in this regard. Through its blanket ban policy, the Jail excludes people designated as Protective Custody from OPSD placement, the *only* mental health program available across the Jail population outside of the inpatient Psychiatric Services Unit, which is reserved for people who are acutely psychotic and meet Section 5150 involuntary hospitalization criteria.

39. It is a common practice for a jail system to override classification designations like "General Population" or "Protective Custody" when a person

requires a mental health treatment bed. (San Diego County itself appears to do this once a person is so acutely ill that they require inpatient PSU level of care.) In other jail systems, custody staff continue to conduct appropriate housing assessments to ensure against an unsafe placement, and they do so based on individualized security assessments, not simply based on a patient's existing classification designation. San Diego County Jail does *not* follow this practice, which has the effect of preventing Protective Custody-designated patients from accessing OPSD care. This policy-driven denial of care is dangerous and concerning.

40. But even in a jail system where a re-classification to "mental health" does not occur for patients with serious mental illness, enhanced mental health outpatient placements can and must be provided to all patients who need them, both among the General Population and the Protective Custody population. This is accomplished rather simply. In San Diego County Jail, there would be enhanced mental health units designated as OPSD-General Population, and separate enhanced mental health units designated as OPSD-Protective Custody. *There is, in short, no excuse for a system that denies enhanced mental health program placement to all Protective Custody patients.*

41. Mr. Vare is also wrong to emphasize only the risk of placing a Protective Custody patient in a mental health unit with General Population patients. It is also unacceptably dangerous to *exclude* Protective Custody patients with serious mental illness from the appropriate mental health placement, both because they are denied clinically necessary treatment and also because they may be vulnerable to harm and victimization being housed with people who do not have mental illness. The risks can be deadly, as I recount in my report regarding the brutal death of **Derek Baker**, a man with serious mental illness who was found clinically appropriate for OPSD housing in San Diego County Jail but excluded because he was "Protective Custody." He was then violently murdered by another Protective Custody individual who did not have serious mental illness. Stewart

Report ¶¶ 169-170.

42. It is quite disturbing that Mr. Vare has no concern about this systemic deficiency, even as the Jail system's own mental health coordinator has stated that the creation of an OPSD-Protective Custody unit would be "useful" and "good." Quiroz PMK Dep. at 64-65 (Quiroz: … "there is not an identified outpatient step-down PC mod per se. There is not that." Q: "Do you think that that sort of module would be useful to have?" A: "It would be useful." Q: "And the objective of it would be to ensure that people who both need outpatient step-down and are designated as protective custody can get that level of service?" A: "That would be good."). This remains a systemic deficiency that is harming people with serious mental illness, and it must be addressed.

## III. RESPONSE TO THE REPORT OF JOSEPH PENN

43. I have reviewed the Defendants' expert Joseph Penn's report, undated and unsigned, but produced on August 21, 2024 (hereinafter "Penn Report").

44. In Dr. Penn's report, he states that a "random selection methodology" was used to conduct a review of psychiatric and mental health records. Penn Report at 9. He does not explain what this methodology was, and so I am not clear as to how these patient records were selected. He writes that he enlisted three practicing correctional forensic psychiatrist consultants (Natasha Cervantes, M.D., Joseph Baskin, M.D., and Ariana Nesbit Huselid, M.D.) to review these records. *Id.* Dr. Penn states that he reviewed their case summaries and incorporated their evaluations into his analysis and opinions. *See* Penn Report Appendix D (at 156-205).

45. These three designated reviewers provided summaries for more than 80 past or current San Diego County Jail patients. Almost *none* of them were patients whose records were provided to me for my previous report. I am informed that the records previously provided to me were chosen by San Diego County as being representative of particular categories that I developed consistent with my

methodology in this case. *See* Stewart Report ¶ 16.

46. To complete my rebuttal report, it was important that I have the opportunity to conduct my own assessment of the case records that were reviewed by Dr. Penn's three designated reviewers. The County did not produce, and I therefore did not receive, these records until approximately September 21, 2024, one month after the initial expert reports were produced in this case.

47. These records are voluminous, and required extensive time and effort to review. As with my previous report, I utilized the assistance of a psychiatrist colleague who has experience in jail mental health care, to review patient records. The reviews conducted by this colleague were done under my supervision, as is my frequent practice when conducting large detention mental health care system assessments. My analysis is ultimately done independently and all findings contained in this report are my own.

48. I cannot discern how Dr. Penn incorporated the findings of his three designated reviewers (Appendix D) into his report. He does not reference a single patient record review in his own report narrative.

49. More importantly, as discussed throughout this report, I observed that many findings by Dr. Penn's three designated reviewers are in direct contradiction with Dr. Penn's opinions and conclusions.

50. As set forth below, I disagree with the opinions that Dr. Penn has offered in his report. Nothing in his report changes any of my findings or conclusions. In many respects, his report only raises my concerns about the systemic failures and inadequacies of the San Diego County Jail's mental health care system.

### A. Dr. Penn's Review Completely Ignores Jail Suicides and Mental Health-Related Deaths that Have Occurred in San Diego County Jail, which Is a Fundamental Flaw in His Methodology.

51. In my decades of experience evaluating correctional mental health care systems, a core component of my work is to look closely at sentinel events (*i.e.*,

incidents that result in death or severe harm to a patient) – most specifically, suicides and other mental health-related deaths. Such a review is foundational and essential to doing a proper assessment as to the adequacy of a correctional mental health care system.

52. I was thus shocked to see that, as confirmed in Dr. Penn's Report Appendix C ("Materials Reviewed"), Dr. Penn did not review records from any suicides or other mental health-related deaths. Nor did his designated reviewers provide any mention or analysis of any of such deaths. This is a glaring omission in Dr. Penn's methodology as a mental health professional claiming to assess the functioning of a mental health system. This is especially relevant in this case, where San Diego County Jail has had scores of suicides and other mental health-related deaths in recent years. It is critical to examine those cases, to identify any individual deficiencies or recurring problems that indicate a need for systemic remedial action. Remarkably, Dr. Penn's assessment does not include a specific analysis of any completed suicide and other mental health-related death. The failure to do so falls below what I understand to be accepted practice for the evaluation of a jail's mental health care and suicide prevention system.

53. Dr. Penn includes only a chart listing ten in-custody suicides at the Jail, dating from March 2019 to July 2023. Penn Report at 49-50. I reviewed the records and reports of several of those deaths, providing detailed analyses in my previous report. Dr. Penn did not provide analysis on a single one.

54. I similarly found it puzzling and troubling that Dr. Penn gave a passing grade to the County and its health care contractor NaphCare on their suicide death review processes. Penn Report at 50 ("In the rare event of a suicide, SDSO conducts psychological autopsies, administrative suicide reviews, and morbidity and mortality reviews to assess contributing factors and enhance prevention practices. I confirmed that both the county and the contracted health NaphCare conduct independent suicide and medical, natural deaths, or substance use related death

reviews, morbidity and mortality reviews, and these are conducted in a timely manner."). Dr. Penn's "Materials Reviewed" list (Appendix C) does not appear to contain a single psychological autopsy, administrative suicide review, or morbidity and mortality review. He does not discuss the details of any suicide death review in his report. I cannot tell how Dr. Penn reached his conclusion as to appropriate timeliness, much less quality, of these death reviews.

55. In contrast, my analysis included extensive records from many San Diego County Jail suicides and mental health-related deaths. I provide specific examples of deficiencies in the post-death review processes. *See, e.g.*, Stewart Report ¶ 265 (McDowell suicide); *id.* ¶¶ 341-342 (NaphCare PMK witness testimony that psychological autopsies are not always completed, with portions often left completely blank); *id.* ¶ 348 (San Diego County Jail mental health care leadership concedes that they do *not* consider CLERB in-custody death reviews or findings at all).

56. Reviewing sentinel events – such as deaths in custody – is not only standard practice but also a vital step in evaluating a system's effectiveness in ensuring the safety and welfare of both incarcerated people and staff. This is why my assessment includes a detailed review of these events – to gain insight into the system's strengths and weaknesses. In contrast, Dr. Penn listed a few such incidents in a chart but does not address any of them further. His omission raises serious concerns about the depth of his analysis and the accuracy of his conclusions.

### B. Dr. Penn's Methodology, Findings, and Opinions Are Confusing and Unreliable Due to His Use of "Copy-and-Paste" Passages from His Reports from Other Cases and Correctional Mental Health Systems.

57. As should be clear by the discussion below, my findings and opinions are starkly different from those of Dr. Penn. I emphasize that my findings and opinions are based on a specific analysis of *this* San Diego County Jail system. Upon close review, however, it is apparent that Dr. Penn's findings and opinions

may not be. I am familiar with Dr. Penn's expert work from other litigations, including in the statewide Arizona prisons class litigation (*Jensen v. Shinn*), where I have served as plaintiffs' class expert and Dr. Penn served as defendants' expert. My experience in that case provides me some insight regarding Dr. Penn's San Diego County Jail report, which copy-and-pastes significant findings and opinions from his Arizona report in ways that are inapplicable at best and, more often, factually inaccurate.

58. For example, I was confused to read this finding on involuntary antipsychotic medications and clinical restraints from Dr. Penn's report:

> During numerous interviews with nursing and mental health care staff across the state, and also as spelled out in NaphCare SDSO policy, I learned that if and when there is a clinical question involving the clinical necessity, consideration of the clinical necessity and/or appropriateness of forced antipsychotic medications, or the need to begin to pursue this process with due process protections for IP patients who may be subjected to involuntary administration of psychotropic mediations (when clinically indicated as a means of treating psychiatric illness or urgently reducing harm, dangerousness, or severe violence towards self or others), that the NaphCare treating psychiatrists who have offices near the Psychiatric Stabilization Unit (PSU) are readily available to discuss by phone, or alternatively, an on call psychiatrist or psychiatric provider is available 24 hours per day, 365 days per year, even afterhours and on weekends. **I understand this same process to be in place for orders of emergency clinical seclusion or restraint.**

Penn Report at 41 (emphasis added).

59. I was confused by Dr. Penn's factual finding that clinical restraints use at the Jail entail significant involvement of clinical and psychiatric staff. As I learned during my tours and as was confirmed by Ms. Quiroz, this is not the case at San Diego County Jail. Quiroz PMK Dep. at 72-74 ("Ms. Quiroz: I mean, we've witnessed people in a restraint chair. We're not necessarily the ones determining when they're getting out of that chair. You know, we're not -- they're not calling us for that reason, to say, should this person be removed. [I]t's not common that we see somebody -- that we are going to assess somebody in a [restraint] chair. It is not common. Q: … [D]o you think it's important for clinicians to be involved when a restraint like a restraint chair is used on somebody who may be manifesting mental

illness? A: Although I think it's important for a clinician, I think a psychiatrist should be -- I mean, if somebody's in a restraint chair I think we should probably get an M.D. level involved. … Q: You're not aware of any policy right now for an M.D. level staff member to get involved in a certain way when someone is placed in a restraint chair by custody? A: No.").

60. I notice that Dr. Penn's first sentence states that he based his opinions on "numerous interviews with nursing and mental health care staff **across the state**." Penn Report at 41. This "across the state" reference makes no sense in the context of an expert assessment of San Diego *County* Jail. I then looked back at Dr. Penn's testimony in the Arizona statewide prisons case, and found that Dr. Penn had made this exact factual finding, with the same wording (changing only the name of the detention system and mental health system provider):

> 220. During numerous interviews with nursing and mental health care staff **across the state**, and also as spelled out in Centurion and Arizona DOC policy, I learned that if and when there is a clinical question involving the clinical necessity, consideration of the clinical necessity and/or appropriateness of PMRB, or the need to begin to pursue this process with due process protections for inmate patients who may be subjected to involuntary administration of psychotropic mediations (when clinically indicated as a means of treating psychiatric illness or urgently reducing harm, dangerousness, or severe violence towards self or others), that Dr. Carr (or his designee) are readily available to discuss by phone, or alternatively, an on call psychiatrist is available 24 hours per day, 365 days per year, even afterhours and on weekends. **I understand this same process to be in place for orders of seclusion or restraint.**

Joseph Penn Expert Report, *Jensen v. Shinn*, No. 2:12-cv-00601-ROS (D. Ariz.), Dkt. 4172 at 76 (¶ 220) (emphasis added). (Note that both passages also misspell "medications" as "mediations.") Dr. Penn's asserted finding in the context of the San Diego County Jail system is inconsistent with the facts and evidence.

61. This is not the only example of what appears to be Dr. Penn's "copy-and-paste" from another report regarding a separate and very different correctional mental health care system. In Dr. Penn's report in this case, he states:

The following are examples of specific mental health policies,

procedures, and practices that I have observed and confirmed during my tours, interviews with staff, and review of existing policies, and additional verification with mental health leadership:

- mental healthcare
- mental healthcare staffing
- medical record organization
- medication system
- monitoring of prisoners taking psychotropic medication
- monitoring of psychotropic medication therapeutic levels and side effects
- access to medical and mental healthcare
- mental health programming
- inpatient care
- treatment plan
- **heat precaution**
- suicide prevention
- confinement of prisoners with mental illness
- **use of chemical agents with prisoners with mental illness**
- use of telepsychiatry
- monitoring and oversight
- overall access to mental health services

Penn Report at 51 (emphasis added).

62. This list is *identical* to the list of areas he claimed to have reviewed in the Arizona state prisons litigation. Joseph Penn Expert Report, *Jensen v. Shinn*, No. 2:12-cv-00601-ROS (D. Ariz.), Dkt. 4172 at 34-35 (¶ 103). But this list makes little sense in the context of San Diego County Jail's system, where to my knowledge, there are no policies or procedures regarding topics like "heat precaution" or "use of chemical agents with prisoners with mental illness." Dr. Penn's "copy-and-paste" practice of presenting an expert's methodology and conclusions, across substantially different cases and correctional mental health systems, makes it difficult for one to know what in this report actually relates to San Diego County Jail and what has been mechanically copied from other cases.

63. Nevertheless, I am able to critically assess Dr. Penn's opinions and conclusions, and present my strong disagreement with them, as set forth below.

### C. Dr. Penn's Opinion that the Jails' Practices and Policies Ensure that Patients in Need of Mental Health Care Are Appropriately Identified and Tracked Is Not Supported By Facts.

64. Dr. Penn opines that any claim that the "Sheriff's department fails to

identify and track IPs in need of mental health care . . . is refuted by the established practices and policies at SDSO facilities, which I observed and corroborated through interviews with custody, nursing, medical, and mental health staff during my onsite tours." Penn Report at 13-14. He goes on to state that various staff members explained to him how things are supposed to work, including through intake screening, "gatekeeping," mental health "flags," and "trip sheets." None of his discussion changes my strong opinion that San Diego County Jail's system fails to adequately identify and track incarcerated people with serious mental health needs.

65. Remarkably, Dr. Penn states that he formed his opinion based only on his observations and staff interviews "during [his] onsite tours." Penn Report at 14. He makes no reference to considering any individual patient assessments or records review. The only individual patient mentioned in this entire section of the report is a man who he observed experiencing an apparent opioid overdose. *Id.* at 18.

66. In my report, I describe horrific examples of identification and tracking failures, some of which led to a patient's avoidable death. For example, take **Roselee Bartolacci**, whose intellectual disabilities were not identified, contributing to her May 2023 in-custody death after she was placed in solitary confinement and lost more than 40 pounds in just six (6) weeks, without appropriate intervention or treatment. Stewart Report ¶¶ 133-138. Or another example, the suicide of **Pedro Ornelas** in June 2023. Mr. Ornelas's initial screening inexplicably identified no mental health history, despite records from a previous incarceration at the Jail showing prior mental health diagnoses, a considerable medication history, and past treatment in the community. His requests to "get back on my medications" went unanswered, and he died by hanging ten days after he arrived at the Jail. These identification failures are staggering and demand systemic remedial action. Stewart Report ¶¶ 82-85.

67. Failures in *tracking* people with serious mental health treatment needs are also pervasive in the San Diego County Jail system. In my report, I describe one

patient who was prescribed psychotropic medications and then not seen by a psychiatric provider *for nine (9) months*. When he was finally seen in [redacted] 2023, he was experiencing auditory hallucinations. This is a significant, consequential, and harmful failure in tracking and follow-up for a patient with serious mental illness. *See* Stewart Report ¶ 92. I found that, by policy and practice, the San Diego County Jail system consistently fails to meet the standard of care for tracking and follow-up with people requiring psychiatric treatment – including extreme violations of the maximum allowable time between *routine* psychiatric visits (30 days), and the maximum allowable time for psychiatric follow-up after initiation of medication or dose adjustment (one week). *See* Stewart Report ¶¶ 86-87, 91-92, 95, 260 (individual examples of such failures).

68. I also examined records from the individual patients whose Dr. Penn's designated reviewers looked at, as he appends to his report (Appendix D). There are multiple examples in those patient records of very similar identification and tracking failures:

69. [redacted] (Penn Report at 189-190): The psychiatric reviewer stated that her "primary concern is regarding several medication expirations." She described how the Jail system lost track of the patient's prescribed medication needs, leading to the patient "being without his psych meds for 15 days" due to the systems tracking deficiency.

70. [redacted] (Penn Report at 159): This patient had an extensive history of psychiatric treatment needs, and presented as psychotic with hallucinations and delusional thought content while in jail. Psychiatric staff first engaged in grossly inadequate follow-up with the patient when he had poor medication adherence. When he was prescribed an antipsychotic medication, he showed consistent compliance with the medication for five days, until records show he stopped receiving it simply because "Medication was not available." The documentation provided by the various mental health staff did not meet the standard

of care. The clinical notes failed to identify a diagnosis, demonstrated a failure to coordinate between the clinicians and psychiatric prescribers, and evidenced no effort to track and improve medication adherence. All of these issues are systemic in nature and place this patient and others at substantial risk of serious harm.

71. [redacted] (Penn Report at 165-166): This patient had a history of a severe traumatic brain injury (TBI) when he was a young teenager, with subsequent diagnosis of a seizure disorder. The designated reviewer (Dr. Baskin) correctly summarizes that the "1st mention of this [TBI history and seizure disorder] by psych provider is his 5th (NP Anthony) who does an excellent and thorough review, makes good recs, and never sees patient again. The NP who followed made no mention of those recs and proceeded on own plan of care (not inappropriate, but lacking continuity)." This is a remarkable failure. Mr. [redacted]'s very serious medical and mental health history was not identified until he was seen by a *fifth* psychiatric provider at the Jail. This provider was the first to adjust the patient's medications to address the risk of seizures. Records review shows that this did not occur until the patient had been at the Jail *for eight (8) months*. And, as Dr. Baskin notes, the *sixth* psychiatric provider then *ignored* this critical diagnostic information and "proceeded on own plan of care" which was "lacking continuity." These are gross failures of both identification *and* tracking that put this patient at enormous risk of irreparable harm from medication-induced seizures.

72. [redacted] (Penn Report at 170): This patient was treated with two different antipsychotics over a period of nearly two years at the Jail, and as Dr. Penn's designated reviewer Dr. Cervantes notes, he was "never seen by a psychiatrist." Dr. Cervantes notes that there was "unclear verification or record request to verify [his diagnosis]." And she is appropriately critical of the fact that the nurse practitioners who saw him failed to identify or properly address the serious risks of the medication regimen. I agree with her finding that this patient "likely experienced metabolic syndrome as a side effect" and that "[a]n evaluation by a

psychiatrist and/or more collateral information may have clarified actual treatment needs." These failures of identification and proper tracking led to care that fell well below any acceptable standard of care, in ways that placed the patient at extraordinary risks, including of a diabetic crisis and a myocardial infarction. The deficient care of this patient over nearly two years screams out for immediate systemic intervention.

73. Dr. Penn's report does not contain a specific analysis of the Jail's mental health screening system or protocols. My report provides detailed findings that the screening policies and procedures are deficient in identifying patients' mental health care needs. Stewart Report ¶¶ 26-47.

74. I am, of course, not the first person to identify alarming deficiencies in this area. The 2022 California State Auditor Report identified eight (8) recent in-custody deaths where the individual "had serious medical or mental health needs that health staff did not identify or communicate to detention staff at intake." 2022 California State Auditor Report at 20, DUNSMORE0117735.

75. The County itself has acknowledged that its system falls short in this area, and it is strange that Dr. Penn simply ignores that fact. The 2022 California State Auditor Report recommended, in order to address systemic problems with the Jail's mental health need identification system, that the County "create a policy requiring health staff to review and consider each individual's medical and mental health history from the county health system during the intake screening process." DUNSMORE0117769. The County publicly confirmed in 2023 that this deficit exists, and acknowledged that other county jail systems have taken the necessary steps to implement such a practice, stating: "*Unlike many other counties, San Diego does not have a coordinated county health system or shared electronic health care records system. As a result, we cannot meet this recommendation as written*." Progress Report at 5, SD_184479 (emphasis added); *see also* Quiroz PMK Dep. at 98-99 (noting that the County has no "policy or written expectation that intake

nurses review the [County behavioral health] system as part of the intake process, instead "relying on self-reporting by the new arrival"). The failure to address this deficiency puts patients at risk of harm every day.

76. Based on my personal observations, discussions with staff, review of testimony, policies, and reports, and my review of individual patient records, it remains my strong opinion that the Jail's system fails to adequately identify and track incarcerated people with serious mental health care needs, in ways that are systemic and that put incarcerated people at substantial risk of serious harm.

### D. Dr. Penn's Opinion that the San Diego County Jail System Maintains Adequate Mental Health Staff to Meet the Incarcerated Population's Needs Ignores Well-Established and Readily Acknowledged Facts that the System Does *Not* Have Sufficient Staffing Resources.

77. Dr. Penn opines that "mental health and psychiatric provider staffing levels at [San Diego Sheriff's Office] are sufficient and comport with the correctional standard of care." Penn Report at 26 (with narrative at 19-26). I strongly disagree with this opinion, which is contradicted by well-established and readily acknowledged facts that the system does *not* have sufficient mental health staffing resources.

78. Even when Dr. Penn acknowledges staffing shortages, including 14 mental health clinician vacancies, he states blithely (and without analysis of the Jail population's mental health service needs): "Despite these staffing vacancies, there were no discernible delays in care nor any identifiable impediments in SDSO IP patients' access to and continuity of mental health care." Penn Report at 21. Given the Jail's recent overall count of 26 mental health clinicians, *see* Quiroz PMK Dep. at 30, the 14 unfilled positions amount to a vacancy rate of approximately 35%. This is notable, consequential, and points to insufficient staffing to deliver necessary mental health care.

79. Instead of looking at what treatment programming is needed for the population and what staffing is required to meet that need, Dr. Penn relies on

abstract and ephemeral language that is of little use in assessing whether the Jail system has sufficient staffing resources to provide adequate mental health care for its population. He writes:

> Staffing levels in correctional settings should be evaluated based on the clinical determination of whether adequate mental health services are provided by the available staff. This means that the adequacy of staffing is determined by whether the care meets established standards rather than by adhering to a specific numerical ratio. According to the NCCHC Standards for Health Services in Jails, 2018 Jail Standard, J-C-07, page 60, "Staffing," is defined, the responsible health authority (RHA) ensures sufficient numbers and types of health staff to care for the incarcerated person population.
>
> There are no universally accepted or empirically validated staffing plans, ratios, or recommendations for mental health and psychiatric staff within correctional settings. Staffing decisions should be made based on the clinical needs of the population served, considering the unique requirements of each facility, county, or state.

Penn Report at 20.

80. In my report, I relied on San Diego County Jail *system-specific* findings that point directly to staffing deficits that negatively impact the delivery of clinically necessary mental health treatment for the San Diego County Jail's patient population. Stewart Report ¶¶ 351-388, 432-435.

81. I agree with Dr. Penn that the Jail must come up with an adequate staffing plan to meet the specific clinical needs of its mental health population and unique requirements of its system. However, as discussed in my report, the San Diego County Jail has failed to conduct and implement an appropriate mental health program needs assessment. Given the Jail's mental health population, current conditions, and currently available treatment services, it is my strong opinion that understaffing is a major contributor to dangerous failures to provide clinically necessary mental health care to meet existing treatment needs.

82. There are still additional findings of mental health staffing deficiencies, *confirmed by San Diego County itself*. For example:

- In 2023, the San Diego County Grand Jury found that "[t]here is an insufficient number of mental health clinicians to provide appropriate basic on-site mental health services, as defined by NCCHC

accreditation standards." The Sheriff's Department "disagree[d] partially" with this finding, stating that "[i]t is a true statement that the San Diego Sheriff's Department does not currently meet accreditation standards as it applies to mental health" while stating that "this is not attributable to the fact that there is an insufficient number of staff providing services." The Department did state that it "is seeking to hire more mental health professionals in order to streamline workloads and provide proactive mental health programs for our population." Quiroz Dep. Ex. 9, *2022/2023 Grand Jury Response-Crisis in Treatment Access for Incompetent to Stand Trail Incarcerated Persons in the County Jails* at 8-9, July 10, 2023.

- A December 2023 Sheriff's Department Corrective Action Notice documented a persistent psychiatric sick call backlog, resulting in significant psychiatric care delays. It noted that "periodic blitzes are done 3-4 months, **with no solution to maintain the rising number of sick calls**." Quiroz PMK Dep. Ex. 10, at 17 (emphasis added).

- The Jail mental health coordinator Ms. Quiroz wrote in July 2023 about the sick call request backlog and treatment delays in the Jail's system, and she testified in May 2024 about how these things "illustrate that **we have an overwhelmed system and we all need help**." Quiroz PMK Dep. at 270-71 & Ex. 14 (emphasis added).

- Jail leadership have issued corrective action notices to the contractor NaphCare regarding psychiatric care untimeliness, noting hundreds of pending psychiatry appointments and wait times of several weeks. Ms. Quiroz testified just recently that **delays in access to psychiatry care remain a "key deficiency area," noting that the "volume of pending appointments" is a problem**. Quiroz PMK Dep. at 186.

- Ms. Quiroz testified that the Jail's current discharge planning staff does not meet the needs of the approximately 1,600 (or more) mental health caseload patients in the Jail system, noting **"we do need more" staffing resources** and that the County did not have sufficient data to know how many discharge planners were necessary to meet patient needs, noting only that "[m]ore is certainly better." Quiroz PMK Dep. at 171-72 (emphasis added).

83. Dr. Penn's statement that he could find "no discernible delays in care nor any identifiable impediments in SDSO IP patients' access to and continuity of mental health care" (Penn Report at 21) is simply not supported by the facts, as set forth in my report. *See* Stewart Report ¶¶ 69-95 (discussion of clinically inappropriate delays in psychiatric care, including many examples), ¶ 254 (lengthy delay for initial psychiatric evaluation for **Mr. Settles**, who subsequently died by suicide in 2022); ¶ 259 (unacceptable delay in psychiatric care for **Mr. McDowell**, who subsequently died by suicide in 2023); ¶ 267

(**Mr. Rupard**'s initial mental evaluation canceled two times with note that "due to time constraints, patient was unable to be seen," which was followed by acute psychiatric decompensation that ended with his starving to death without Jail health care staff's intervention).

84. Still more examples of insufficient mental health staffing having serious negative impacts on mental health care delivery can be drawn from the patient cases summarized by the designated reviewers in Dr. Penn's own report:

85. [redacted] (Penn Report at 191-192): Dr. Huselid describes a delay in access to care for Mr. [redacted], who had a history of suicide attempts, had endorsed suicidal ideations, and was being housed in Administrative Separation. She noted that Mr. [redacted] wrote a health care request stating: "I need to speak to a mental health counselor." This request was not even logged for 4 days, then scheduled to be seen 14 days later, and then "pushed back" for another 6 days. She found of this 24-day wait to see a mental health clinician: "I think this is a reasonable (~2-3wk) but not ideal delay, given that we did not know why he needed to see a mental health counselor, and given his history of suicide attempts." Based on my experience as a jail psychiatrist, this delay was far more serious than "not ideal." For this sort of patient with serious mental health needs housed in an exceedingly high-risk Administrative Separation setting, it is dangerous and unacceptable. Based on my review in this case, staffing shortages play a substantial role in these access-to-care delays, which put patients at substantial risk of serious harm.

86. There is a further and troubling staffing-related deficiency that comes up repeatedly in the record reviews conducted by Dr. Penn's designees. That is, the lack of continuity of care with a treatment provider. Dr. Baskin notes that this is an issue in many cases. Penn Report at 158 ("There is a lack of continuity with the psych providers. This patient saw 5 different prescribers. . . . [T]here are inherent problems with this approach such as failure to spot patterns, slow rapport process,

and limit splitting"); *id.* 159 ("I again make mention of the many providers which breaks continuity. IP had no insight, so verbal reports not accurate. The same provider over time can mark this better and develop better interventions."); *id.* at 160 ("again, the handoffs to several different providers causes continuity of care issues"); *id.* at 165-166 (5 different providers caused "inconsistency" and failures to track and address TBI and seizure disorder). Dr. Cervantes identified the same systemic issue and how it negatively impacts care. *Id.* at 174-175 ("it appeared that because there were at least 10 different prescribers assigned to the IP, and it is possible that they were unfamiliar with his history," medication orders were deficient).

87. In my experience, a major contributing factor to this kind of inconsistency in mental health and psychiatric treatment for patients is staffing deficiencies – usually a combination of structural deficiencies and staffing shortages. Both are clearly on display in San Diego County Jail's mental health care system.

88. Dr. Penn makes an additional finding that is factually misleading (if not wholly incorrect) and warrants mention. He found that the Jail system requires that all mental health professionals be licensed (Penn Report at 18, italics mine):

> With regard to licensing of mental health staff, all qualified mental health professionals (QMHP) serving as mental health clinicians must be fully independently licensed professionals according to California's licensing entities, such as the Board of Psychology, the Board of Marriage and Family Therapists, the Board of Professional Counselors, or the Board of Social Workers. They cannot be pre-licensed or in a master's-level training phase.

89. I am uncertain as to Dr. Penn's basis for this finding, but it is inaccurate based on my review. The Jail mental health coordinator, Ms. Quiroz, recently testified that there are at least 10 mental health staff members who are "prelicensed" and working as "mental health clinical case managers." When asked what these pre-licensed staff members' duties entail, Ms. Quiroz testified, "They're similar to a clinician." Quiroz PMK Dep. at 30-

31; *see also id.* at 42 (noting that there is a pre-licensed psychologist working at the intake screening at Las Colinas). Dr. Penn's finding that mental health staff "cannot be pre-licensed" in this Jail system is factually incorrect.

90. It is strange that Dr. Penn finds that mental health clinicians "cannot be pre-licensed or in a master's-level training phase" at the San Diego County Jail and subsequently contradicts himself in a nearby section of his report, where he includes a mental health program description that specifically mentions that a "pre-licensed MH clinician" is in charge of facilitating treatment groups on the Fourth floor at the Central Jail. Penn Report at 37. His assessment methodology and analysis of the facts here are quite problematic.

91. While the use of pre-licensed mental health staff can be clinically impactful in a Jail system, there must be adequate supervision and other processes. Dr. Penn clearly has not done the necessary analysis of how these pre-licensed staff are utilized or supervised. My report, however, raises extremely serious concerns regarding the lack of supervision during delivery of mental health care in this Jail system. *See* Stewart Report ¶¶ 54-61 (inadequate supervision of psychiatric nurse practitioner); *id.* ¶ 375 ("I am extremely concerned about the lack of supervision and coordination in this Jail's mental health care system. For example, the County-employed clinicians (social workers and MFTs) should be – but are not – supervised by higher-level mental health care professionals like psychologists or psychiatrists. . . . This is inconsistent with the standard of care for a mental health care system.").

### E. Dr. Penn's Opinion that San Diego County Jail Custody Staff Do Not Interfere with Mental Health Care Staff's Clinical Decisions Is Not Supported by the Facts.

92. Dr. Penn opines that the Jail's "custody staff does not control mental health care staff's clinical decisions and it assists in the delivery of care by mental health professionals." Penn Report at 26. He acknowledges that "there may have been isolated cases in the past" where such interference occurred, *id.*, but brushes

off those cases without discussion.

93. This section of Dr. Penn's report runs about half of a page, but it does require a response. He relies solely on custody staff interviews ("sworn officers, captains, lieutenants, and JPMU personnel") to "confirm[] that custody staff do not attempt to override or improperly control health care decisions." Penn Report at 27. While he mentions that "various mental health and nursing staff consistently denied any instances where custody staff interfered with, impeded, or improperly controlled clinical decision-making related to incarcerated persons with mental health needs" (*id.* at 26), he does not indicate that he conducted interviews with mental health care staff as he did with custody staff. In fact, as discussed below, mental health care staff and leadership consistently acknowledge such custodial interference.

94. Dr. Penn's statement that he "verified that health care input is actively included and considered in [1] classification, [2] disciplinary reviews, and [3] SPFRT (safety cell placements)" is factually inaccurate and quite incomplete. *See* Penn Report at 27. I address each claim in turn.

95. First, Dr. Penn ignores that nearly every Jail mental health staff member who has provided testimony in this case reports that the practice of custody staff overruling clinical staff regarding **housing and classification decisions** occurs with frequency:

- **Jail Clinician Aseel Ross (Dep. at 43):**

  *Q: ... Have there been examples in your experience where you made a recommendation that somebody be removed from AdSep based on their mental health where classification says, no, they need to remain in AdSep and they so remain?*

  *A. Yes.*

  *Q. Do you have any examples that come to mind?*

  *A. Yeah.*

- **Jail Psychiatrist and Medical Director Christine Evans (Decl. ¶ 20, Dkt. 119-10):**

  *I saw many people being placed into Administrative Segregation when*

*clinicians knew and made known that such a placement would be harmful.*

- **Jail Clinician Jennifer Alonso (Decl. ¶¶ 21, 23, Dkt. 119-11)**

  *[T]he Jail system's mental health co-coordinator (who hired me to work in the OPSD units) made a specific recommendation to the Sheriff's Department to stop putting people with mental illness in the solitary confinement-type Ad-Seg units, given the risks to their psychological and physical well-being there. My understanding is that the Sheriff's Department Command staff refused to implement this recommendation.*

  *I received an email from custody staff about one of my patients who was experiencing significant psychiatric symptoms. The email stated that the line custody staff thought my patient should be transferred to Ad-Seg housing. No reason was provided. The placement appeared arbitrary and more for the custody staff's convenience than the security or well-being of anyone. No one asked me for my clinical input; custody staff simply directed me to modify the patient's record (removing the patient's OPSD status) so that custody could move the man into Ad-Seg. Similar incidents happen multiple times each month."*

- **Jail Mental Health Coordinator (and County's Person-Most-Knowledgeable) Melissa Quiroz (PMK Dep. at 59)**

  *Q: [H]istorically has there been a problem in the San Diego County Jail for deputies to overrule clinicians on housing placements for people with mental illness?*

  *A: I don't have the exact language, but I can think of times when there may have been some tension between, you know, a clinician trying to advocate for what they felt was recommended and a sworn staff member having a difference of opinion.*

  *Q: Have clinicians come to you with those concerns?*

  *A: Yes.*

  *Q: Sounds like that's something that you care about deeply and want to have addressed, is that correct?*

  *A: Yes, absolutely.*

96. Further findings on custodial interference with housing and program placements for people with serious mental illness are discussed in my previous report. Stewart Report ¶¶ 167-181.

97. Second, Dr. Penn is simply wrong that mental health staff provide input regarding **disciplinary reviews**. *See* Stewart Report ¶¶ 427-430. The Jail's own

person-most-knowledge confirmed that there are no policies or procedures at the Jail for mental health care staff to provide input regarding disciplinary processes. Quiroz PMK Dep. at 178-79 ("Q: Does mental health staff play any role in the administration of discipline for people with serious mental illness? A:No, [they] do not."). And another of the County's own experts who looked closely at this issue made a finding directly in contradiction to Dr. Penn's statement on this point:

> ***The SDCSO does not have a process for a clinician to provide his/her professional recommendations*** (e.g., whether the incarcerated person fully understood the nature of his/her actions at the time of the disciplinary charge and alleged actions) ***to the hearing official so they can give consideration to the recommendations prior to ruling on the charge and issuing any sanctions.*** The SDCSO should develop policies and a process for clinicians to provide their professional recommendations regarding the incarcerated persons understanding of their actions and for the hearing official to consider the clinical input of sanctions that should be avoided based on the clinician's assessment.

Defs.' Expert Report of Julian Martinez at 75 (emphasis added).

98. Third, Dr. Penn is wrong that mental health staff provide input regarding critical aspects of **safety cell placements and suicide precaution processes.** In fact, mental health staff fail to provide such clinical input on these matters in ways that are *not* consistent with the standard of care and represent a considerable deviation from modern correctional standards. Stewart Report ¶¶ 312-316. The Jail's mental health coordinator confirmed this fact. Quiroz PMK Dep. at 156 (noting that restrictions clothing, bedding, property, and privileges for patients on suicide precautions "all happens outside of the clinical world. . . . [T]hat's in the very custody world.").

99. Again, the patient cases discussed in Dr. Penn's own report contradict his own finding that custody practices do not interfere with the provision of mental health treatment. For example, in my review of patient [redacted] (discussed in Penn Report at 196-197), I found repeated instances when this patient was denied access to appropriate clinical care. To provide just a few examples: (1) in [redacted] 2023, a nurse notes that they could not perform an EKG "d/t [due to] security

reason"; (2) in [redacted] 2024, the day of a reported medication overdose by Mr. [redacted], a nurse notes that they were "unable to perform healthcare assessment at this time due to patient's housing situation. Per floor deputy, due to safety concerns, patient cannot come out of the cell"; (3) in [redacted] 2024, a telepsychiatry appointment was not performed due to "security risk." In each instance, there is *no* documented explanation as to any individualized safety or security concern that would justify the denial of clinically indicated treatment. In at least one instance, the denial of an appointment due to a vague "security risk" is (inaccurately) marked as a patient "refusal." Based on my review of this patient's experience and my other observations in this system, it is very likely that blanket custodial policies and practices caused these custodial interferences with the provision of necessary care.

100. My opinion that Jail custody staff exert improper and dangerous control over clinical mental health care decisions, as stated in Finding #8 in my report (¶¶ 402-417) and in Section II.B., above, is unchanged.

### F. Dr. Penn's Opinion that San Diego County Jail Has an Adequate Psychiatric Medication System to Meet Patient Needs Is Not Supported by the Facts, Including Those in His Own Report.

101. Dr. Penn opines that the Jail "maintains an effective medication management system across its facilities" and that its "systems for identifying incarcerated persons who were recently prescribed psychotropic medications, as well as for administering and distributing these medications, meet or exceed both correctional health and community standards of care." Penn Report at 29-30. These conclusions are inconsistent with the available evidence, including factual findings and cases reviewed in Dr. Penn's own report.

102. First, I take strong issue with Dr. Penn's statement that there is no evidence of "delays in the prescribing or delivery of psychotropic medications, nor in the provision of mental health treatment for new intake incarcerated persons at SDSO." Penn Report at 29.

103. In my review of patient records, I identified numerous cases where

psychiatric medications were delayed for newly arrived incarcerated patients, where medications were interrupted due to systemic failures (and without exercise of clinical judgment), and where there was inadequate follow-up by psychiatric providers for people on medication. I provide many individual case examples in Finding #2 of my August 21, 2024 report. Stewart Report ¶¶ 53-95.

104. Dr. Penn does state: "I acknowledge that occasional missed doses of psychotropic medication can occur." Penn Report at 29. But his own expert reviewer Dr. Huselid, determined that the issue was far more than "occasional," stating in Dr. Penn's report: "I've seen many [] examples of expiring medications in [patient] charts, **there does seem to be a systems issue."** *Id.* at 189 (emphasis added).

105. The Sheriff's Department's Corrective Action Notices and other reports from just this past year identify serious, pervasive, and persistent deficiencies with respect to the Jail's system for provision of psychiatric medication to the incarcerated population. Ms. Quiroz, the Jail's mental health coordinator, has confirmed that these deficiencies remain, including:

- **There is a persistent psychiatric sick call backlog, resulting in psychiatric care delays.** The Sheriff's Department's Corrective Action Notice documented that "periodic blitzes are done 3-4 months, with no solution to maintain the rising number of sick calls." Quiroz PMK Dep. Ex. 10 at 17 (Sheriff's Department Corrective Action Notice, Dec. 1, 2023); *see also* Quiroz PMK Dep. at 186 (as of May 2024, describing delays in access to psychiatry care as a "key deficiency area" given the high "volume of pending appointments).

- **Psychiatry providers do not participate meaningfully (or at all) in essential Continuous Quality Improvement (CQI) activities.** Quiroz PMK Dep. at 187 ("I don't know that it's been fully resolved, but it … [d]oes probably need to work towards improvement.").

- **There is no documented peer review process for psychiatric prescribers.** Quiroz PMK Dep. at 190-91 ("I can't be for certain that they're not doing peer reviews. It's nothing that they hand back to us. I mean, if they do the peer reviews it's something that they're keeping records of on their own."); *id.* at 100-01 (there is no County employee or entity who is responsible for determining whether NaphCare's peer review process is adequate).

- **There is insufficient clinical oversight of psychiatric prescribers**

- **(especially psychiatric nurse practitioners).** Quiroz PMK Dep. at 192 & 198 (confirming that the Jail's chief medical officer, Dr. Montgomery, has shared concerns about adequacy of clinical oversight for psychiatric nurse practitioners at the Jail and the impact on medication management for the mental health population, and stating "it's still a concern").

- **The Jail regularly fails to provide *timely* psychiatric evaluations for newly incarcerated patients.** Quiroz PMK Dep. at 111 ("Q: [I]s your team concerned about timeliness of initial psychiatry contacts with patients? … A: We want them seen as soon as possible, and there's times we may feel that it's not soon enough.").

106. Second, I strongly disagree with Dr. Penn's statements that there is "no evidence indicating that any isolated incidents of missed psychotropic medication doses at SDSO led to immediate or delayed clinical decompensation or further issues" and that there are "no documented instances of undue delays resulting in self-harm, suicide attempts, completed suicides, or serious harm to incarcerated persons due to these medication delays." Penn Report at 29.

107. I have discussed in detail the horrific and preventable suicides of **Pedro Ornelas** and **Jonathan McDowell** in 2023. Stewart Report ¶¶ 82-85 (Mr. Ornelas, a man with an extensive mental health and medication history who twice submitted requests to see a psychiatrist to "get back on my medications" but was never seen or started on medications in the nearly two weeks leading up to his suicide); *id.* ¶¶ 258-265 (Mr. McDowell, a man with history of psychiatric medication needs, who reported that he feared he was having a "mental breakdown" and auditory hallucinations, yet was not started on his psychiatric medication for three and half months, then received no clinical follow-up despite reporting that "I'm stressed to the gills" and that his medication regimen was "not working out" and that he was seeing lights and stars "like an electrical storm," and was instead placed in solitary confinement and never again seen by a psychiatric prescriber over the next six weeks leading up to his suicide).

108. Even beyond the cases where people have died after being denied clinically necessary psychiatric treatment, it is my assessment that a very large

number of people are being made to suffer needlessly due to widespread delays and failures in with respect to psychiatric medication practices in this Jail system. The case of [redacted] who was made to wait for three desperate weeks to see a psychiatric prescriber even as he submitted at least 10 requests for help and reported increasingly alarming symptoms and, according to one clinician, "started to tear up and stated 'I am just trying to be better,'" is one such example. (Mr. [redacted]'s case illustrates extremely serious problems with psychiatric prescribing practices, and the lack of supervision over psychiatric nurse practitioners, at the Jail.) Stewart Report ¶¶ 86-87.

109. Further remarkable is that individual cases in *in Dr. Penn's own report* reveal systemic psychiatric treatment deficiencies that contradict Dr. Penn's opinions. For example:

110. [redacted] (Penn Report at 186-187): Dr. Penn's designated reviewer, Dr. Huselid, found "several lapses" related to Mr. [redacted]'s psychiatric medication needs, such that he did not have "access to care (e.g., access to care means that, in a timely manner, seen by a qualified MH professional, is rendered a clinical judgment, and receives MH care that is ordered) for [his] . . . mental health needs." I have also now reviewed Mr. [redacted]'s records, and agree that the care was deficient. Mr. [redacted], who had a history of psychosis, submitted multiple requests to get psychiatric help for hallucinations and anxiety. However, he was not seen for an initial evaluation until nearly three weeks after his arrival, when he was prescribed a medication regimen that was very problematic. According to Dr. Penn's designated reviewer, Dr. Huselid, the prescription was "*a high dose of haloperidol to start someone on . . . and without knowing what doses they have previously taken.*" Penn Report at 186. The treatment prescribed carried an unreasonable risk of serious side effects, which in fact manifest in the weeks that followed, including jerking involuntary movements, tongue protrusion, and vomiting. These side effects prompted an emergency hospital visit where dystonia

(a known side effect of the medication) was suspected. When he was sent back to the Jail, it was very important to monitor him closely and discontinue haloperidol, a request that Mr. [redacted] made himself in a sick call request asking that his medication be modified "because [it] causes twist tongue, can't breath [sic]." Yet he was continued on the *same* medication and had no psychiatric appointment for two months, during which period (as noted by Dr. Huselid) he submitted no less than "nine health care requests/grievances about needing to see a psychiatrist." Dr. Huselid concluded: "**I am very concerned that he didn't see a prescriber for more than two months** and was continued on haloperidol—ESPECIALLY without standing Cogentin/Benadryl—after his ER trip for dystonia." Penn Report at 187 (bold added). This case indicates not just poor clinical decisions by psychiatric prescribers (who, as noted above, do not receive adequate supervision) but also a dangerous failure to respond when dangerous side effects and clearly articulated concerns are raised. This case raises alarming systemic – and not just individual – issues with treatment in this Jail system.

111. [redacted] (Penn Report at 205): This man with diagnosed schizophrenia was a state psychiatric hospital returnee whose condition had been stabilized on antipsychotic medication. As described by Dr. Huselid, Dr. Penn's designated reviewer, his prescription expired without any action take for nearly four weeks, which she found to have been concerning "given that [the patient] had just returned from Napa State Hospital for competency restoration, [as] this could have been very consequential (if he deteriorated and had to go back)." This medication failure stems from systemic tracking and follow-up deficiencies, and puts patients at entirely unnecessary and inexcusable risk of harm.

112. [redacted] (Penn Report at 167-169): Dr. Penn's designated reviewer, Dr. Cervantes, identified several deficiencies in the psychiatric care of this patient. She noted that the "starting dose and escalation rate" of the antipsychotic medication (Remeron) was "too rapid and increased risk for side effects, particularly

when there isn't even a well-defined diagnosis." She noted the failure to conduct baseline lab tests and weight checks, which were clearly clinically indicated due to the patient's high Body Mass Index. My review of this patient's records confirm these failures and the serious risks to the patient. When lab tests were done and revealed abnormal results, there is no indication of medication review or modification, indicating serious deficiencies in medication management and psychiatric follow-up. This patient's course of treatment did not meet the standard of care.

113. [redacted] (Penn Report at 174): Dr. Penn's designated reviewer, Dr. Cervantes, strongly criticized the psychiatric nurse practitioners who treated Mr. [redacted]. I agree with Dr. Cervantes's assessment, and note that this again speaks to the systemic failure to appropriately supervise psychiatric nurse practitioners who, based on my review of many patient cases, provide horribly inadequate psychiatric care. Here, Dr. Cervantes found that the medication regimen was "wholly unnecessary in this case and generally poor choices of meds" given the patient's presentation. This case is especially egregious insofar as this patient was unnecessarily subjected to the potentially serious side effects of the antipsychotic medication prescribed without clinical justification.

114. [redacted] (Penn Report at 160-161): Dr. Penn's designated reviewer, Dr. Baskin, noted significant concerns with the prescribing practices in this case. He noted that the patient "goes for one year without medications, then rapidly grows to 5 different meds including 2 sleepers (quetiapine/trazodone)." He noted that the Jail's psychiatric providers allowed for an "inappropriate confound and layer of complexity" and that this is "an instance where a single provider developing rapport might have proved more valuable to IP in giving meds longer trials and avoiding polypharmacy." I also reviewed this case, and I agree with the concerns about the poor treatment provided. I was in fact shocked by what I found. This was a dangerous polypharmacological situation that does not come close to

meeting the standard of care. The Jail's psychiatric providers started multiple medications without an appropriate evaluation of what this patient actually required. I also note that a treating psychiatrist failed to take steps to remove this patient from Administrative Separation housing after it became clear that the conditions there were contributing to her mental breakdown. (This, of course, is another systemic problem I have previously discussed and discuss further later in this report.) In all, I have not encountered anything like this case in my over 40 years of work as a correctional psychiatrist. This case is a giant red flag calling for systemic remedial action.

115. [redacted] (Penn Report at 171-172): This case, reviewed by Dr. Cervantes, reveals serious and consequential deficiencies in the provision of psychiatric care. Dr. Cervantes noted several serious problems with the psychiatric treatment provided to this patient, including: (1) the use of psychiatric medication in the absence of legitimate clinical indication; (2) the provision of potentially abusable and divertible medications without clinical justification; and (3) the use of medication for opiate withdrawal in the absence of a history of opiate use. These are serious lapses in the psychiatric standard of care and place patients at substantial risk of serious harm. This case, including Dr. Cervantes's findings, further confirms my opinion that there is an unacceptable lack of supervision of psychiatric nurse practitioners in this Jail's system, leading to pervasive and dangerous deficiencies in the provision of care.

116. [redacted] (Penn Report at 187-188): This case, reviewed by Dr. Huselid, reveals repeated instances of essential psychiatric medications being allowed to expire without timely reordering, causing unacceptable gaps in treatment, including as recently as [redacted] 2024, when, as documented by Dr. Huselid, the patient "submits a Health Care Request, 'Medication expire [sic],'" which was followed by a further 19-day gap in treatment before his medication was restarted (for a total of 3 weeks without provision of clinically indicated medication).

117. Dr. Penn's reviewers found even more problems with psychiatric care, including "continuity of care issues," "inappropriate and dangerous prescribing," "risky medication change," and more:

- [redacted] (Penn Report at 160): "[T]he handoffs to several [redacted]ders causes continuity of care issues."
- [redacted] (Penn Report at 176): "Overall, this chart is [redacted]ppropriate and dangerous prescribing of psychiatric medications without appropriate monitoring."
- [redacted] (Penn Report at 179): Psychiatric Nurse Practitioner [redacted]edication change which *could* have resulted in psychotic symptoms re-emerging."
- [redacted] (Penn Report at 182): Psychiatric Nurse Practitioner [redacted]practices in choosing her treatment in a correctional setting" for several listed reasons, and failed "to order regular weight checks (only three weights were do[redacted]uring the incarceration time frame examined). In fact, by [redacted] 2023, IP had gained an additional 16 lb. and was now 313 [redacted] Seroquel and Depakote are all known to contribute to weight gain and metabolic syndrome. The risks and side effects of these medications in this IP likely outweighed any benefit."

118. The number of cases with deficient psychiatric care that Dr. Penn's own designated reviewers found in their record reviews, combined with the pervasive deficiencies I found in my assessment, amount to unambiguous alarm regarding the systemic failures in psychiatric care in the San Diego County Jail system. I simply cannot understand how Dr. Penn can opine that this Jail "maintains an effective medication management system across its facilities" or that there are "no documented instances of undue delays resulting in self-harm, suicide attempts, completed suicides, or serious harm to incarcerated persons due to these medication delays." *See* Penn Report at 29. **Again, Dr. Penn's *own* report states that there are "many [] examples of expiring medications in [] charts" such that "there does seem to be a systems issue."** *Id.* at 189.

119. Records directly contradict Dr. Penn's finding that there are "no documented instances of undue delays" resulting in harm. Take the case of [redacted] a patient I reviewed as part of my assessment in this case.

Mr. [redacted] was denied his psychiatric medication for two months after his prescription was allowed to expire, during which time he became very delusional and unable to have a coherent conversation. A psychiatrist treating him documented that Mr. [redacted] had "decompensated in the context of medications expiring after last visit." This is a clear and documented example of a patient denied clinically appropriate medication management who suffered needlessly as a result. Dr. Penn's finding is troubling in its disregard of this case and many others like it.

120. This is a systemic failure that demands action. The preventable deaths of Mr. Ornelas, Mr. McDowell, and Mr. Rupard, all of whom decompensated after being denied clinically appropriate psychiatric care until they died by suicide (Ornelas, McDowell) or starvation (Rupard), represent what I consider to be the tip of the iceberg regarding the serious harm that patients at this Jail have faced and continue to face.

### G. Dr. Penn's Opinion that San Diego County Jail Provides Patients with Timely Access to Mental Health Care and a "Robust Mental Health Delivery System" Ignores the Realities of this Extremely Inadequate System.

121. I strongly disagree with Dr. Penn's opinions that "incarcerated persons presenting with current mental health needs are promptly referred to and receive timely mental health services," and that the Jail provides a "robust mental health delivery system and is able to provide timely access to care and mental health treatment to [patients] with ongoing mental illness." Penn Report at 30-43; *see also id.* at 50-52 (Dr. Penn's opinion that "The Delivery of Mental Health Care Within SDSO is not Systemically Deficient.").

#### 1. There Are Serious Deficiencies with Respect to the Timeliness of Mental Health Care at the San Diego County Jail.

122. With respect to the ***timeliness*** of mental health services, Dr. Penn simply ignores the extensive evidence, and the County's own documentation, that the system is defined by large mental health care backlogs and unacceptable delays

in access to clinically necessary care. Examples include the following:

123. First, the County documented a **persistent psychiatric appointment backlog**, resulting in psychiatric care delays. The County noted that "periodic blitzes are done 3-4 months, with no solution to maintain the rising number of sick calls." In April 2023, there were 785 pending psychiatry appointments. Despite the County's corrective action notice issued at that time, there remained 530 psychiatric pending psychiatry appointments in November 2023, with an average wait time of 18 days. Quiroz PMK Dep. Ex. 10 (Sheriff's Department Corrective Action Notice, Dec. 1, 2023). The Jail mental health coordinator identified this is as "key deficiency area" as recently as May 2024. Quiroz PMK Dep. at 186.

124. Second, the County has documented **severe sick call request backlogs** and treatment delays, with the Jail mental health coordinator explaining that such delays "illustrate that we have an overwhelmed system and we all need help." Quiroz PMK Dep. at 270-71 & Ex. 14.

125. Third, Dr. Penn's *own* designated reviewers identify (again, as set forth in his own expert report) a large number of cases with **unacceptable delays in the provision of mental health and psychiatric care**. *See, e.g.*:

- Penn Report at 187 ("**I am very concerned that [patient] didn't see a prescriber for more than two months** and was continued on haloperidol—ESPECIALLY wit[redacted]standing Cogentin/Benadryl—after his ER trip for dystonia on [redacted]/2022.") (emphasis added).
- Penn Report at 195 (patient "sends multiple requests [over 2 ½ month period] asking why someone reduced h[redacted]medications and begging for them to be restarted. For example, on [redacted]/23, he indicates that he is sending his fifth request and says, [redacted]edicine to help me sleep please. How many requests?' On [redacted]/23 he writes, 'Need to see psych doc for meds, no appointment sinc[redacted]month or more and you reduced my meds why?' **It is my opinion that this gap in care (given medication change without communication to the patient) is too long.**") (emphasis added).
- Penn Report at 190 (**"My primary concern is how long it took him to see a psychiatric prescriber for the first time. . . .** [The psychologist] indicates that he should be referred to Psych SC in one week. However, [patient] is not seen by a psychiatric prescriber [for more than one month]. In the me[redacted]re requests/grievances (dated [redacted]

requesting—then begging—to see a prescriber. . . . he writes, **'I'm feeling scared and dangerous because I need my meds…Please Help Urgent!**") (emphasis added).

- Penn Rep 203 ("In a LMFT note dated /22, the clinician notes that Mr. should be 'refer[red] to Psyc D for PS eval.' However not seen by a prescriber (Psych NP) until /23. . . . **[It] doesn't look good.**") (emphasis added).

126. Fourth, my report details the evidence of **dangerously untimely access to inpatient (PSU) mental health care** in the Jail system. This deficiency was confirmed by a PSU psychiatrist, who told me during my site visit that there is "always a wait list" of acutely ill patients requiring PSU placement. Stewart Report ¶ 128. Ms. Quiroz also confirmed this fact. Quiroz PMK Dep. at 70-71. Aseel Ross, who served as an Administrative Separation clinician, testified that she was aware of patients waiting for a PSU placement ***for more than one month***. Ross Dep. at 89-90. The lack of timely access to an inpatient level of care placement is well established, and it puts patients at substantial risk of serious harm, including further decompensation, self-harm, and suicide.

127. My records review confirms the persistence of these extreme access-to-care delays for patients who need acute mental health placement and care. As additional examples:

128. This patient with serious mental illness was placed at Central Jail after receiving inpatient treatment at the Department of State Hospitals. Without the continued level of care he needed (and that had helped him to stabilize on medication at the state hospital), he became nonadherent to medications at the Jail and was placed in Administrative Separation, where he continued to decompensate in that highly restrictive setting where meaningful mental health treatment is essentially non-existent. A psychiatry team saw him in 2023, and observed him talking to himself, naked in his cell, and unable to engage in conversation.

129. He continued to decompensate to the point of grave disability as demonstrated by him being, as documented in the record, "**constantly fully naked inside his cell and eating his own feces … flooding his cell with water mixed with fecal materials … neglecting self-care, and persistent symptoms of paranoid delusions**." A full 11 days after the psychiatry team saw him, he was finally referred to the PSU for acute level of care. But there was no PSU bed available. The patient was kept in Administrative Separation, where his symptoms continued to worsen, for another 20 days until he was finally placed in the PSU. This is an enormous, harmful, and dangerous delay in the provision of a clinically indicated acute mental health care placement.

[redacted]

130. This patient with serious mental illness and a severe movement disorder arrived at the Jail in [redacted] 2023 and was placed in Administrative Separation—an isolation placement that is extremely dangerous for a person with this patient's mental health profile and needs. When he was seen for an initial psychiatric evaluation, he was clearly decompensated, appearing "labile and unpredictable … avoidant, impulsive, bizarre, paranoid, suspicious," "disheveled and unkempt." Further adding to the concern, the psychiatric nurse practitioner who performed this evaluation recommended follow-up in four weeks, which is far too long for a patient this acutely ill and with such poor insight. Fortunately, another psychiatric provider recognized several days later that this patient needed a higher level of care and recommended transfer to the PSU. But no PSU beds were available.

131. Mr. [redacted] remained in Administrative Separation for several more weeks. Mental health staff observed his continued decompensation and poor self-care ("he is very disheveled with food on his face, his clothes, his bed, etc."; "[he is] disorganized, agitated … paranoid and lacks any insight into his current psychiatric condition") until he was placed in the PSU in [redacted] approximately 30 days

after inpatient care was clinically indicated. This is another example of an unacceptable, harmful, and dangerous delay in the provision of a clinically indicated acute care placement.

**2. There Are Serious Deficiencies with Respect to the Adequacy of Mental Health Care and Treatment Programming at the San Diego County Jail.**

132. With respect to Dr. Penn's opinion that the San Diego County Jail has a "robust mental health delivery system" that is "not systemically deficient," his discussion is incomplete and does not in any way change my conclusion that this system denies people with serious mental illness access to **adequate mental health treatment**, causing undue suffering and putting people at unnecessary and substantial risk of harm. I provide examples of Dr. Penn's problematic findings below.

133. Dr. Penn's assessment that "Mental Health Group Therapies" and other clinical activities are provided consistent with the treatment needs of the Jail population ignores critical deficiencies, and is at odds with the assessments of the Jail's mental health coordinator and the Sheriff herself. Dr. Penn's report does confirm that PSU clinicians provide as little as "one psycho educational group per week" and just one clinical "meeting with every patient individually" each week. Penn Report at 37. This exceedingly limited amount of treatment is inadequate for the needs of this population.

134. I am also aware that approximately half or more of the patients in the Central PSU are not permitted to participate in any group therapy *at all*, with several patients essentially on 24/7 lockdown with no meaningful mental health treatment at all.

135. Dr. Penn's statement on PSU treatment ("The weekly schedules provided reflect that IPs in the PSU are actively involved in creative and recreational therapy, not merely confined to their cells" (Penn Report at 33)) does not account for the reality that these activities are extremely limited, are not

facilitated by clinicians (but rather a recreational therapist), and completely exclude a substantial proportion of PSU patients who are in fact confined to their cells.

136. In contrast, Sacramento County Jail's acute inpatient psychiatric unit's policy and program schedule is designed to provide what more closely approximates clinically appropriate clinical care, with clinician-facilitated treatment group offered for at least three (3) hours per day, along with a daily out-of-cell contact with a clinician and a daily out-of-cell contact with a psychiatric prescriber. *See* Stewart Report ¶ 118.

137. The same major deficiencies exist in the Outpatient Stepdown units, which Dr. Penn's report acknowledges provide no more than two group treatment hours per week (Penn Report at 37), though I was informed on my site visit that some of these units do not receive any group treatment programming at all (and are on nearly round-the-clock isolation lockdown). Dr. Penn does not provide any analysis that would support his finding that OPSD treatment is clinically adequate.

138. In my report, I discuss in detail how, given the staggeringly high levels of acuity and treatment needs among the OPSD population, OPSD treatment programming is grossly insufficient to meet the clinical needs of the patient population. *See* Stewart Report ¶¶ 145-161.

139. In addition to the insufficient programming in OPSD units, there is also terribly inadequate capacity – that is to say, there are not enough OPSD program spots to meet the needs of the seriously mentally ill population. Ms. Quiroz estimated that, if an appropriate mental health acuity rating system was implemented at the jail, it would "highlight the need for hundreds if not thousands of mental health beds." Quiroz PMK Dep. at 90-93 & Ex. 4.

140. San Diego County Sheriff Martinez also recently acknowledged the deficits with respect to mental health treatment programming. On October 2, 2024, she presented at the San Diego County Citizens' Law Enforcement Review Board meeting, stating: "We also think that group therapy is useful in some instances and

some other things that we don't always have accommodations for currently in our structure." Sheriff Martinez, CLERB Regular Meeting, Oct. 2, 2024 (video at 1:01:00, available at https://youtu.be/4vXcub2VXTc?t=3640).

141. The San Diego County Jail's failure to provide adequate mental health treatment to patients with serious mental illness puts patients at risk and causes unnecessary harm. One case assessed by Dr. Penn's designated reviewer offers considerable insight here.

[redacted]

142. Dr. Huselid finds that the Jail failed to provide this patient "access to care" for his mental health needs, including "lapses" in the provision of treatment. Penn Report at 197-198. I also reviewed this patient's records. Mr. [redacted] has diagnosed serious mental illness. He was stabilized through treatment and a complex medication regimen to manage his severe psychotic symptoms in the Jail Based Competency Treatment (JBCT) Program that is run by the Department of State Hospitals (DSH). As I discussed in my previous report, the JBCT unit has a mental health program with robust staffing and treatment programming, and it shows positive results. The problem, as I stated, is that once a patient discharges from the DSH-run JBCT program and is placed in other San Diego County Jail units (where the treatment program is a tiny fraction of what is provided in the JBCT), patients are denied the care they need and decompensate as a result, with a new onset of psychiatric symptoms and even a new finding that they are "incompetent to stand trial" (essentially *undoing* the success of the JBCT program). Stewart Report ¶¶ 163-164. Mr. [redacted] appears to be one such example.

143. After being discharged from the JBCT program, Mr. [redacted]'s auditory and visual hallucinations worsened, with voices urging him to do things or making negative statements, as noted by a psychologist. Despite these signs of decompensation, the psychiatric prescribers were not notified, with a many-month gap in psychiatric follow-up that should have occurred much sooner. Mr. [redacted]'s

care was further complicated when, in his decompensated state, he started refusing clinical contacts and medications over a seven-month period. Shockingly, during this seven-month period, he had only had two psychiatric appointments. As Dr. Huselid notes, "one of my concerns is how long this patient went at times between seeing any mental health practitioner." She found that "he had been refusing his psychotropic medications and reporting paranoia about his food. I am concerned that no one attempted to see him cellside." Penn Report at 198. Mr. [redacted] finally resumed his medications but continued to have uncontrolled auditory and visual hallucinations.

144. Earlier this year, there was another very significant gap in care for Mr. [redacted], when mental health staff documented that Mr. [redacted] should be seen "in 2 weeks (priority due to acuity)," yet he was lost to follow-up for almost three months. Penn Report at 198. These gaps in care highlight systemic issues in tracking and providing clinically necessary psychiatric care for patients. The contrast between how Mr. [redacted]'s mental illness was managed in the DSH-operated JBCT program (with its daily mental health programming and frequent psychiatric care) and how he decompensated so severely in San Diego County Jail's system after discharging from JBCT makes plain the serious inadequacy of the Jail's mental health care system, and the harm such inadequacy causes.

145. The evidence of severe mental health programming deficits in this system, combined with the statements by Jail leadership and the Sheriff herself, directly contradict Dr. Penn's conclusion that there is "widespread availability of educational and therapeutic programming" in this system. Penn Report at 42. There is nothing close to enough mental health treatment beds and program capacity to meet the mental health population's treatment needs. It is troubling that Dr. Penn ignores all the evidence and statements pointing at this reality.

146. I further strongly disagree that this Jail system conducts adequate multidisciplinary treatment team meetings and provides "ongoing multidisciplinary,

individualized treatment planning." Penn Report at 32, 38-39. I discuss the basis for my opinions on this subject in detail in my report. Stewart Report ¶¶ 97-112.

147. Individual case records that I reviewed consistently demonstrate that the Jail's mental health system fails to ensure that patients receive clinically appropriate, individualized treatment planning that includes appropriate level of care determinations, provision of individualized medication management, and structured therapy and counseling as clinically indicated. In fact, mental health staff testimony confirms that individualized treatment planning with an appropriate level of care or acuity rating system does not exist. (Again, Ms. Quiroz testified that the County was reluctant to do this because it would "highlight the need for hundreds if not thousands of mental health beds." Quiroz PMK Dep. at 90.)

148. Ms. Ross, the clinician assigned to patients in Administrative Separation units, proposed to Jail leadership the implementation of a structured individualized treatment planning process for patients; she testified that such a practice "was not implemented." Ross Dep. at 64. Ms. Quiroz testified that "it could be helpful" for mental health staff to use an "individualized treatment plan that's a freestanding document" but such a practice was not in place. Quiroz PMK Dep. at 258.

149. It is curious that Dr. Penn concluded that the treatment planning process in the San Diego County Jail system is adequate. His finding is quite specific in its language, but it is in fact copied nearly verbatim from his Arizona state prisons expert testimony (with only the name of the detention system changed). Here is what he opined in his Arizona expert report:

> **Treatment Plans & Timely Communication:** In preparation of this report, I reviewed numerous ADCRR inmate medical records. In my view, ADCRR provides comprehensive treatment plans, timely communication, and multidisciplinary coordinated care between psychiatric and mental health staff, nursing staff, medical providers, and custody staff. Such records are kept in accordance with the correctional standard of care. This significantly reduces the risk of an inmate's risk of harm to self or others."

Joseph Penn Expert Report, *Jensen v. Shinn* (D. Ariz.), Dkt. 4172 at 55 (¶ 152).

150. Here is what he opined in his San Diego County Jail expert report:

> **Treatment Plans & Timely Communication.**
>
> In preparing this report, I reviewed numerous medical records for individuals in custody at SDSO. The records demonstrate that SDSO provides comprehensive treatment plans, ensures timely communication, and coordinates multidisciplinary care among psychiatric and mental health staff, nursing staff, medical providers, and custody staff. This level of care is consistent with correctional standards and significantly mitigates the risk of harm to individuals . . . .

Penn Report at 38.

151. Nothing in Dr. Penn's analysis changes my opinion that the San Diego County Jail's mental health system fails to provide timely, clinically adequate, or appropriately individualized mental health treatment to patients with serious mental illness.

### H. Dr. Penn's Opinion that San Diego County Jail "Provides Opportunities for Confidential Mental Health Care Encounters in Adequate Physical Spaces" Is Contradicted by the Facts, Including Statements by the Sheriff Herself.

152. Dr. Penn states that "[i]n my professional opinion, SDSO IPs are provided private meeting spaces to maintain confidentiality during mental health encounters." Penn Report at 43-44. As I have described, the lack of confidentiality during clinical mental health contacts at the San Diego County Jail is pervasive and undermines the provision of mental health care for patients. Nothing in Dr. Penn's report changes my opinion.

153. Dr. Penn's discussion on this topic is very short, and provides little insight into how he reached his conclusion. More importantly, this opinion is directly contradicted by (1) Dr. Penn's own designated reviewers, (2) the Jail's mental health coordinator and person-most-knowledgeable on these topics, and (3) the San Diego County Sheriff herself.

154. First, Dr. Penn's designated reviewer, Dr. Huselid, finds evidence that

confidential clinical contacts are not provided at the San Diego County Jail *by policy*. She discusses this in some detail in the review of patient [redacted] Penn Report at 196-97. She documents that a recent instance in which the clinician documents that Mr. [redacted] "asks to meet confidentially but [the clinician] says that she is unable to due to AdSep 'regulations/restrictions.'" Two weeks later, "Mr. [redacted] once again asks to meet in a confidential setting for privacy, but [the clinician] writes that her 'Plan' is, 'continue to be monitored cellside.'" The expert reviewer states, "I question this blanket requirement to see incarcerated persons cellside when they are in AdSep," noting that when she worked as a jail clinician, she would see such patients confidentially. She further notes that "as far as I can tell, Mr. [redacted] had been in good behavioral control." Based on his mental health needs, including a medication overdose that occurred soon after these non-confidential contacts, Dr. Huselid concludes that "**it doesn't look great that the jail was unable to meet his request to be seen confidentially**." Penn Report at 197 (emphasis added). I agree with Dr. Huselid's assessment and conclusion.

155. I repeat here what I state in my previous report about how the provision of appropriate confidentiality for mental health care does *not* mean compromising the safety of staff or anyone else:

> To be sure, the provision of adequate treatment of serious mental illness (with appropriate confidentiality) will serve to *increase* safety: good care serves to reduce psychosis-induced behaviors and to keep patients' conditions more stable. And in a jail system where confidential clinical contacts are the expectation, there will be appropriate safeguards, including the use of *individualized* assessments – based on both clinical and custodial input – to determine when a particular patient cannot safely be seen in a confidential setting. Such circumstances can, and must, be appropriately documented, reviewed for quality assurance purposes, and inform treatment planning and delivery moving forward. **In short, a jail system should not choose between necessary confidentiality and safety. They go hand in hand.**

Stewart Report ¶ 392 (bold emphasis added).

156. My patient reviews confirm the very serious and consequential deficiency of failing to provide adequate confidentiality for clinical contacts.

Stewart Report ¶¶ 397-401. As a further example:

157. [redacted] This man arrived at the Jail in [redacted] 2023. The intake screening failed to identify chronic mental health needs and his suicide risk history. A review of records from his previous incarceration, however, would have clearly revealed a history of mental illness that included suicidal ideations. About one week after his arrival at the Jail, he received a behavioral assessment in which the clinician stated: "**IP reported history of past suicide attempts but was not asked for details due to not being able to offer a confidential setting."** (He was not seen for nearly three more weeks for an initial psychiatric evaluation.) This is very serious, unacceptable, and dangerous. The clinician documents here that the patient reported a history of suicide attempts, and that more information could not be gathered because the Jail was not "able to offer a confidential setting" to discuss such sensitive information. This is a glaring example of the failure to provide for confidential mental health contacts, but it is by no means unusual in San Diego County's Jail system.

158. Dr. Penn's designated reviewers found still more examples where mental health patients were not provided confidentiality consistent with the standard of care. In addition to the widespread and even (as Dr. Huselid describes) "blanket" restrictions on confidential contacts in some settings at the Jail, there were examples where the failure to provide appropriate language interpreters led to the denial of confidentiality and appropriate care. *See, e.g.*, Penn Report at 171 (**Patient** [redacted]: "Several of the mental health counselors noted that they used a deputy to help interpret, as IP was Spanish-speaking. This is not usually considered best practice."); *id.* at 177-78 (**Patient** [redacted]: "[M]any of the NP notes (at least [redacted]/23, [redacted]/23, [redacted]/23, [redacted]/23, [redacted]/23, 1[redacted]/23) indicate that deputies were used to translate for the encounters for this Spanish speaking patient. Using deputies to translate/interpret for patients is generally discouraged but was routinely done here."); *id.* at 180-81 (**Patient** [redacted]: psychiatric provider documents that

another incarcerated person being called to "help communicate" and noting that using another incarcerated person "to interpret . . . would not be best practices as it does not keep the interview confidential and accuracy cannot be ensu[r]ed").

159. Let me be clear: the use of custody staff for translation for a patient's mental health care contacts is strictly prohibited under the standard of care, absent the most serious of emergencies. This practice breaks the core principles of confidentiality. If the jail does not have mental health staff who can communicate with a patient in their preferred language, then a confidential interpretation service *must* be utilized.

160. Second, Jail mental health coordinator Melissa Quiroz has agreed in her testimony that maximizing auditory privacy for clinical contacts is an important goal. Quiroz PMK Dep. at 78. And she acknowledged that clinicians working at the Jail have "expressed concern about [the] lack of confidentiality with cell-front interactions with their patients." *Id.* at 77. She further confirmed that it remains the case to this day that clinical contacts occur at cell-front and in spaces where custody deputies can overhear the conversation, while dismissing the concern because in her "experience usually they're not interested." *Id.* at 78-79. She did, however, agree that the patients could have concern about the presence of custody deputies when they are meeting with a mental health staff member:

> Q: [J]ust from the patient's standpoint do you think that they may still have the concern that a deputy is standing nearby and can overhear what they're saying to their clinician?
>
> …
>
> A: I think a patient could possibly feel that way, but I don't know -- no patient has told me, hey, make that person go away. I think that they understand that that deputy can't go away.

*Id.* at 79.

161. Ms. Quiroz also confirmed that additional space and staffing resources to provide confidential clinical contacts would be helpful:

Q: If there were more space and staffing resources, would the jail

> mental health [staff] be providing more one-to-one clinical contacts in confidential settings?
>
> A: Phrased in that way, having more deputy assistance and having more clinical space, we would definitely be utilizing it.

*Id.* at 80-81.

162. Third, San Diego County Sheriff Martinez acknowledged that there is a lack of confidential clinical space in the San Diego County Jail system, less than one month ago. On October 2, 2024, she presented at the San Diego County Citizens' Law Enforcement Review Board (CLERB) meeting. When asked about what improvements the Jail needs to work on regarding people with mental health needs, she stated:

> One of the auditor recommendations which we agree with is that **there's not enough private spaces at intake for people to share personal information or have those private conversations with a mental health professional**. We've expanded that a little bit at the Vista Jail that was where we had the largest problem and we hope with new construction and some of the other improvements to our facilities, we can build spaces where there's more safe space and treatment areas for individuals who have, who have that need.
>
> …
>
> Where we're at now, what's left really of the implementation of the audit recommendations are infrastructure . . . the one thing, the therapeutic space for mental health, a lot of that's going to take infrastructure and funding for the construction work.

Sheriff Martinez, CLERB Regular Meeting, Oct. 2, 2024 (video at 1:01:00 and 1:09:00, available at https://www.youtube.com/watch?v=4vXcub2VXTc).

163. Dr. Penn's opinion that the San Diego County Jail provides confidential mental health care in adequate physical spaces is at odds with my findings, his own designated reviewers' findings as stated in his report, the County's Jail mental health coordinator's testimony, and the Sheriff herself. This is a systemic deficiency that must be remedied, through appropriate policies and procedures, specific training, allocation of adequate clinical and custody/escort staffing, and provision of adequate clinical space.

/ / /

## I. Dr. Penn's Opinion that San Diego County Jail Does Not House Patients at Risk of Suicide in Punitive Isolation and that "Strategies Are Employed to Avoid Unnecessary and Undue Risk of Decompensation and Harm" Is Not Supported by the Facts of the Jail's Operations.

164. Dr. Penn provides numerous statements about the Jail's systemic use of solitary confinement housing for people with mental illness. Penn Report at 44-46. It is very difficult to tell what specific facts or information he relies on in reaching his opinions, as all are set forth in conclusory fashion. For purposes of this rebuttal report, I provide examples where Dr. Penn's statements are factually incorrect and/or extremely misleading.

165. First, Dr. Penn asserts: "To mitigate risks while housed in Ad Sep, there are robust medical and mental health safeguards in place." Penn Report at 45. He states that health care staff are asked to "to check for any medical or mental health contraindications for an IP being housed in Ad Sep. . . . This ensures that all potential medical or mental health concerns are addressed promptly, contributing to the overall safety and appropriateness of housing decisions." *Id.* This finding is inaccurate, both in terms of policy and actual practice. *See* Stewart Report ¶¶ 207-226.

166. The National Commission on Correctional Health Care (NCCHC) evaluated San Diego County Jail and specifically found that the Jail's "mental health staff does not [] screen inmates for any contraindications to placement in segregation, which is an NCCHC requirement." *Id.* ¶ 221. The Jail's policy continues to omit the practice standard required by the NCCHC, *id.* ¶ 210, and the Jail mental health coordinator confirmed that it remains the policy and practice that there is no mental health clinical assessment done for a person being placed in Administrative Separation to identify whether there are mental health contraindications for a person being housed in Administrative Separation. Quiroz PMK Depo. at 250-251. Dr. Penn's report is factually incorrect in this regard.

167. Dr. Penn further ignores the many examples of people with serious

mental illness being placed and retained in Administrative Separation despite clear evidence that such placement was clinically contraindicated and dangerous, including several deaths that resulted. *See, e.g.*, Stewart Report ¶¶ 266-274 (Rupard death, determined to be a "homicide" due to "neglected schizophrenia" after patient was placed and retained in Administrative Separation despite clinical contraindications), ¶¶ 275-281 (Marroquin death following re-placement in isolation after suicide precautions, with no clinical input considered), ¶¶ 282-283 (Godfrey death following manifest deterioration in isolation). I provide several additional individual examples in my report, all of which entail enormous and undue harm to patients. *Id.* ¶¶ 229-238 ([redacted]), ¶¶ 239-241 ([redacted]), ¶¶ 242-243 ([redacted]).

168. Dr. Penn also provides a confusing discussion as to whether and when a qualified mental health professional (QMHP) will see a patient placed in Administrative Separation. He writes that the policy is for a QMHP to see the patient "not longer than one week after placement into Ad Sep." Penn Report at 45. He then states that Ms. Quiroz told him that the "average duration is within two days." Without providing any data or case examples to confirm Ms. Quiroz's statement, he then misrepresents the statement by concluding: "In summary, IP's placed into Ad Sep are evaluated by a QMHP within 24-48 hours of any IPs' placement into the unit." *Id.*

169. To be clear, this makes no sense. The basis of this conclusion is a general policy that states such an evaluation must occur within one week, and a staff member's unverified statement that the "average" time is two days (meaning that, for some number of people, the actual time is longer than two days). Dr. Penn's conclusion then introduces a new "fact" that the evaluation is actually completed "within 24-48 hours" of Administrative Separation placement.

170. To be sure, even Dr. Penn's misrepresented "fact" about the San Diego County Jail's practice (evaluation 24-48 hours after isolation placement) puts this Jail system in a state of non-compliance with United States Department of Justice

standards and the generally accepted standard of care for a jail system's placement of people with serious mental illness in isolation, which require that a clinician assess a patient with serious mental illness **before** they are placed in Administrative Separation to prevent undue risk and actual harm.

171. I have found repeated examples of patients placed in extraordinarily harsh, isolating, and punitive-feeling settings that harmed their mental health and resulted in serious harm, including suicides and other deaths.

**Administrative Separation**

172. I have previously discussed the staggeringly high number of patients with serious mental illness being housed in the enormously restrictive and anti-therapeutic Administrative Separation. *See* Stewart Report ¶¶ 182-283 (harmful conditions and consequences for patients in Administrative Separation/solitary confinement). Here is yet another example, from Dr. Penn's own report. [redacted] **(Penn Report at 157-158)**

173. Dr. Penn's designated reviewer provides an extremely brief assessment, noting that a clinician "took steps to improve very poor hygiene" on one day in [redacted] 2024," finding this to be a "[v]ery difficult case, managed well," and indicating that this patient "had very poor insight and [was] quite sick." Having reviewed this patient's records, my strong assessment is that this case's challenges stem from systemic treatment failures and the long-term placement of an extremely mentally ill patient in solitary confinement **for more than four years** without anything close to clinically adequate mental health treatment. This patient reported intermittent psychotic symptoms, such as hallucinations and paranoia, which appear to have complicated and prolonged his criminal legal proceedings. He was hospitalized twice at Patton State Hospital related to competency proceedings.

174. While at the Jail, he spent more than four years in the solitary confinement conditions of Administrative Separation, where he was not managed with the appropriate level of psychiatric treatment, monitoring, and assessment.

175. I found no evidence in his records showing development and implementation of a treatment plan with multidisciplinary collaboration, which is essential for addressing a patient with this level of complexity. Much of his psychiatric care was delivered by nurse practitioners with inadequate supervision given the complexity of this case. Due to these various factors, he received unnecessary treatments based on his self-reported symptoms. For instance, he was started on medication for "mood and energy" with no evidence of a diagnoses to support this treatment. Another time, his antipsychotic dosage was increased after he reported psychotic symptoms to a telepsychiatrist who had seen him only once, despite a psychologist familiar with his history finding no signs of psychosis in a recent assessment. A psychiatrist, Dr. Badre, stated that this patient "would be best served by staying in the state hospital during his proceedings … to prevent the erroneous accumulation of notes by providers who are not familiar with his history." Instead, he remained in a solitary confinement setting – again, for more than four years – where he did not receive clinically appropriate treatment.

176. It is very difficult to understand how Dr. Penn's report, which claims to consider the experience of this person with serious mental illness, subjected to more than four years in Administrative Separation without meaningful or clinically necessary mental health treatment, can conclude that "it is my professional opinion that SDSO effectively minimizes prolonged restrictive housing for IPs with mental disorders." Penn Report at 46. I strongly disagree with Dr. Penn's finding, and nothing in his report changes my opinions on this topic.

**"Wellness Rounds" in Administrative Separation**

177. Dr. Penn describes the "Wellness Rounds" that the Jail has reportedly begun to implement. These are described as a "weekly practice" by which "a multidisciplinary team enters a specific Ad Sep restrictive housing pod" and "walks individually to each IP's cell, engages with the IPs, and asks if they need any assistance. They encourage the IPs to exit their cells if appropriate and oversee the

cleaning of cells by trained IPs, performing additional cleaning as needed. The team assesses the IP's cell condition, mental status, clinical functioning, and daily living activities." Penn Report at 52. It is my assessment that this reported practice does *not* address the very serious harms and risks of harm inflicted on people with serious mental illness who are housed in the Jail's Administrative Separation units.

178. Dr. Penn states that the "Wellness Rounds" practice has been in place for two years, but it is oddly not memorialized or described in the Jail's health care policy regarding Administrative Separation patients (Medical Services Division MSD Policy G.2.1). *See* Quiroz PMK Dep. at 259 (confirming that MSD Policy G.2.1 is the only "policy document[] or directive[] that [is] foundational to understanding MSD's policies for segregated inmates" and that no NaphCare policy regarding segregated inmates has been implemented). Without any written policy or directive regarding Wellness Rounds, any such *ad hoc* practice gives me little confidence in its efficacy to ensure adequate evaluation, treatment, and supervision of people with serious mental illness in Administrative Separation units.

179. I am glad to hear that Wellness Rounds, even as an unwritten practice, might be something happening in the San Diego County Jail system. Given the extraordinary acuity of mental illness I observed among so many patients in the Administrative Separation units, the level of isolation there, and the overall lack of meaningful activity and treatment, *any* additional observation of and engagement with these patients is a good thing.

180. But to be clear, these "Wellness Rounds" do *not* mitigate my grave concerns about the harmful conditions and lack of treatment in Administrative Separation units. These "Wellness Rounds" do *not* provide for clinician-patient confidentiality, are *not* a meaningful clinical contact, are *extraordinarily limited* in their use as a mental health evaluation tool, and do *not* constitute meaningful treatment. By their design and in their implementation, these Wellness Rounds do *not* provide the mental health treatment and clinical interventions that the patients

with serious mental illness so clearly need.

181. Based on my in-person observations and review of records, Wellness Rounds – to the extent they are occurring – are not achieving the stated goal of ensuring appropriate cleanliness in people's cells. I observed Administrative Separation cells housing people with serious mental illness that were extremely filthy and cluttered with trash in the cell. Many cells reeked of urine and feces. Two years of Wellness Rounds do not seem to have addressed this serious issue, which is both inhumane and unacceptable from a basic sanitation perspective.

182. In my review of patient records, I analyzed the documentation of Wellness Rounds. In the aggregate, the Wellness Rounds are superficial in the issues that they address and clinically unhelpful. I did not find evidence of meaningful multidisciplinary collaboration. There is also great variability in the way Wellness Rounds are documented, which is a reflection of this being an *ad hoc* practice. Attendance of different disciplines is quite variable. Significantly, the privately contracted (NaphCare) mental health staff (*i.e.*, psychologists, nurse practitioners, psychiatrists) do not participate in these rounds – that is, the one consistency that I do see is that psychiatry is not involved.

183. The Wellness Rounds, as documented, provide no clinically significant interventions. Often, they are simply an opportunity for a patient to complain about the long waits they are facing to be seen by a psychiatric provider, a reflection of the very problematic backlogs for psychiatry appointments and mental health sick call requests. Patient records of the Wellness Rounds do not include meaningful assessment or clinical interventions.

184. Despite Dr. Penn's assertion that the Wellness Rounds team "encourage[s] the IPs to exit their cells if appropriate and oversee the cleaning of cells by trained IPs, performing additional cleaning as needed," I found that the documentation consistently makes no reference to patients exiting their cells or being assisted with necessary cell cleaning.

185. As one example, [redacted] who I discuss earlier in this report, was provided a Wellness Round in [redacted] 2023. As noted in my earlier discussion of this patient, during this time period, Mr. [redacted] was clearly decompensated, appearing "labile and unpredictable … avoidant, impulsive, bizarre, paranoid, suspicious," "disheveled and unkempt." At the time of this Wellness Round, he was in fact waiting for a placement in the acute care Psychiatric Services Unit. The documentation of the Wellness Round states:

> Writer participated in wellness rounds with multidisciplinary team members including CNA, facility admin sworn staff, and reentry services correctional counselors. IP reported he has been eating. This writer tried to engage IP in conversation and IP continued to shake his head and finger. Writer observed empty food trays and debris in his cell. IP denied to clean his cell. IP did not want new clothes when writer asked and walked away from cell door yelling.

186. This brief note illustrates the extremely limited purpose and impact of Wellness Rounds. The clinician observes that the patient's cell is filled with debris and that the patient is demonstrating symptoms of mental illness. This Wellness Round was entirely unhelpful for a patient who had been identified as being very decompensated and requiring a higher level of care. It is remarkable that the Wellness Round team does not acknowledge that this patient was waiting for an acute care bed, and that it took no apparent steps to expedite such a placement.

187. In sum, it is my strong opinion that "Wellness Rounds" do not address the harsh, dangerous, and countertherapeutic conditions in Administrative Separation units that put large numbers of patients with serious mental illness at risk every day.

**EOH, Safety Cells, and PSU Observation Cells**

188. I have discussed at length the exceedingly harmful conditions and clinically inappropriate use of Enhanced Observation Housing (EOH) cells, safety cells, and PSU Observation Cells in the San Diego County Jail system. Stewart Report ¶¶ 288-316 (EOH and safety cells); *id.* ¶¶ 120-123 (PSU Observation Cells).

189. Dr. Penn's report has very little to say regarding the exceedingly harsh

conditions in and practices around these extremely restrictive placements, other than to conclude – without analysis – that "Watch cells and Enhanced Observation Housing (EOH) are not punitive isolation units but are designed for short-term, closely monitored care of IPs who are at imminent risk of self-harm or suicide. Their use is strictly for maintaining safety and preventing severe harm, not for punishment." Penn Report at 68. I strongly disagree with Dr. Penn's finding that these exceedingly harsh and punitive-feeling placements are clinically appropriate, much less effective at "preventing severe harm." Below are additional examples of patients I reviewed who were placed at unacceptable risk and in fact harmed by placement in these settings.

[redacted]

190. This patient had a near-fatal suicide attempt while in custody at the Jail in [redacted]. His records show that, due to this history, custody staff frequently made the unilateral decision (without appropriate clinical input) to place him in observation cells with severe restrictions on his property, privileges, and daily activities. Mr. [redacted] himself expressed, "I don't deserve to be treated like this, this is totally unfair" as he denied any suicidal ideations. At other times, Mr. [redacted] did require enhanced monitoring, as when he engaged in self-harm triggered by poor distress tolerance and other signs of mental illness. He would be placed in the safety cell or EOH cell to ensure his physical safety, but these environments were so isolating and restrictive, and devoid of any meaningful therapeutic treatment, that it is no surprise that Mr. [redacted] perceived these placements as punishment, which only led to further agitation and poor engagement with the care team.

191. In my professional opinion, more therapeutic treatment settings and the provision of meaningful treatment would have been far more effective in treating this patient's mental illness, addressing his self-harming behaviors and psychiatric symptoms, and mitigating unnecessary distress and harm to him in the process.

[redacted]

192. This patient has a psychiatric history of serious mental illness, and experienced multiple traumatic and harmful medical and psychiatric incidents at the Jail that could have been prevented if he was provided timely access to mental health services and was placed in a more therapeutic setting. Instead, he was subjected to what amounted to punitive and anti-therapeutic conditions of confinement that made things far worse, not better, for him.

193. When he arrived at the Jail in [redacted] 2023 with a significant psychiatric history, he was not seen by a psychiatric provider for approximately one month. Before he ever received a psychiatric evaluation, he tried to hang himself in his cell, requiring overnight hospitalization. Subsequent evaluation found that his suicide attempt was driven by command-type auditory hallucinations that instructed him to hurt himself. This suicide attempt could have been prevented if the patient was assessed sooner and received appropriate treatment for his psychosis.

194. After [redacted]'s suicide attempt and return from the hospital, he was placed in EOH, the extremely restrictive setting that I criticized in my previous report. Stewart Report ¶¶ 304-311. In that setting, he reported trouble breathing and lethargy requiring closer medication monitoring. He was moved to a medical observation cell, but was irritable due to feeling like his reported physical symptoms were misinterpreted by nursing team which led him verbalizing expletives towards staff. In response, the medical team moved the patient back to EOH. (It was later determined that the patient had COVID, which likely contributed to his shortness of breath and agitation.) This move seemed punitive as there were no behaviors indicating an imminent risk to self or others. Further suggesting that this placement to the extremely restrictive EOH unit was punitive rather clinically-based, the Detention Safety Program clinical team was not even informed or called to assess the patient to determine the safest housing option. After he tested positive for COVID, he was placed in medical isolation, where he did not receive any visits

from the mental health team. Within a few days, he was found in his cell with a noose around his neck, and again requiring overnight hospitalization. Upon his return to the Jail, he reported to a psychiatric provider that the source of his distress was primarily driven by feeling stigmatized for his mental health symptoms and the punitive environment in EOH.

195. I found it deeply troubling to then see that, when Mr. [redacted] was next booked at the Jail in [redacted] 2023 for a parole violation, he disclosed his history of hanging himself but (according to the records) did not indicate any current suicidal ideations with plan or any other behaviors suggesting imminent safety concerns. Despite the fact that there was no clinical indication for it, he was placed back in EOH, the enormously restrictive and punitive-feeling setting that had contributed to the increased distress culminating in his last suicide attempt at the Jail.

196. These cases, and so many others I have reviewed, illustrate how the San Diego County Jail's system denies clinically appropriate care, imposes clinically contraindicated, punitive-feeling, unduly harsh conditions for people with serious mental illness, and imposes avoidable harm and risks of harm to patients' physical safety and psychological well-being.

### J. Dr. Penn's Opinion that the San Diego County Jail System Has an Adequate Suicide Prevention System Is Inconsistent with the Facts, and His Analysis Omits Critical Information.

197. Dr. Penn opines that the "SDSO Sheriff's Office [sic] has adequate policies and procedures to identify, treat, track, and supervise IPs at risk for suicide and provides clinically appropriate mental health and psychiatric services to SDSO IPs who are potentially suicidal and/or engaging in self-harm." Penn Report at 46-50. I strongly disagree with this opinion and have grave concerns about Dr. Penn's analysis and methodology in reaching such an opinion.

198. First, it must be reiterated that Dr. Penn did not review materials pertaining to *any* in-custody suicide or mental health-related death. His analysis is

limited to extremely general data that offers little insight into the adequacy of the suicide prevention system at the San Diego County Jail. Penn Report at 46 ("All individuals who completed suicides were male."; "Nine of these suicides were carried out by asphyxiation, while one was completed through water intoxication."; "The distribution of these incidents across facilities shows that two occurred at the George Bailey Detention Facility, two at the Vista Detention Facility, and six at the Central Jail.").

199. Dr. Penn makes the factually inaccurate statement that "there has been no concentration of completed suicides at any particular SDSO Complex (or custody level)." Penn Report at 49. This appears to be another example of a direct copy-and-paste finding from Dr. Penn's Arizona prisons case expert testimony, where he stated: "There is no concentration of completed suicides at any particular ADCRR Complex (or custody level)." Joseph Penn Expert Report, *Jensen v. Shinn*, No. 2:12-cv-00601-ROS (D. Ariz.), Dkt. 4172 at 83 (¶ 233). His finding is identical in the two cases (with only the name of the detention system changed from "ADCRR" to "SDSO").

200. This finding may have been accurate in the Arizona prison system, but it is *not* accurate in this case. Dr. Penn's own report (at 46, 49-50) indicates that, across San Diego County's 7 jail facilities, since 2019, **60% of completed suicides have occurred at Central Jail.** His data does not include still other horrific and most certainly mental health-related deaths at Central Jail during that time period. *See, e.g.*, Stewart Report ¶¶ 266-274 (Rupard death by pneumonia, malnutrition, and dehydration in the wake of extreme and untreated psychiatric decompensation at Central Jail, ruled a "homicide" due to "neglected schizophrenia"); *id.* ¶¶ 169-170 (Baker death by homicide at Central Jail, after he was excluded from clinically appropriate mental health placement and was instead housed in a cell with a violent cellmate without mental illness). Dr. Penn's finding here is inconsistent with the facts, and even his own data.

**Inadequate Suicide Risk Screening**

201. I strongly disagree with Dr. Penn's finding that "the Sheriff's department adequately screens and identifies IPs at risk for suicide." Penn Report at 46. Here, it is notable that Dr. Penn does not consider the findings of deficiency that have been documented by other independent parties about San Diego County Jail's suicide prevention policies, procedures, and practices. Stewart Report ¶¶ 26-30 (describing my own findings of deficiency regarding suicide risk screening and findings made by nationally recognized jail suicide prevention expert Lindsay Hayes); DRC Report Appendix A at 6 ("Of the twelve (12) San Diego County Jail inmates who died by suicide from December 2014 through 2016, we identified a number of problems with the initial suicide risk screening and referral process. . . . One particularly troubling case stood out. The inmate had a diagnosis of bipolar disorder and was screened, but even though he demonstrated signs and symptoms of florid psychosis and mania, he was not referred for evaluation and admission to the Psychiatric Security Unit. He was placed in a Safety Cell, was later released to general population, and died on Day Six of his confinement while still floridly psychotic and manic, despite a request to custodial staff earlier in the day for safety cell placement. Jail staff did not complete a separate assessment of suicide risk despite this inmate's extreme mental state and need for evaluation and treatment.").

202. Through my assessment, I considered these previous findings of deficiencies by other reviewers. I concluded that these deficiencies have not been remedied and remain prevalent in this Jail system.

203. Dr. Penn does not consider these findings at all. Dr. Penn's designated reviewers *did* find deficiencies in suicide risk screening, a fact with which his report's findings and opinions do not engage. *See, e.g.*, Penn Report at 186 (Designated expert reviewer finding "I did not notice much difference among all the suicide risk assessments, suggesting a 'cut and paste' for much of the documentation.").

**Inadequate Monitoring of Patients at Risk of Suicide**

204. I strongly disagree with Dr. Penn's opinion that "the Sheriff's Department adequately monitors IPs at risk of suicide." Penn Report at 47. The primary basis for this finding, according to Dr. Penn's discussion, appears to be that incarcerated people are "informed that they could alert custody staff of any developing suicidal ideation by pressing the intercom button in their cell" and are "encouraged to communicate any mental health concerns or urgent requests for mental health involvement by pressing the button, informing custody staff, or submitting a written sick call request." *Id.* These practices do not remotely constitute an adequate system of monitoring patients at high risk of suicide in a jail setting. Numerous case examples and systemic deficiencies inform my strong disagreement with Dr. Penn's conclusion.

205. Here, Dr. Penn's choice not to review any of the suicides or mental health-related deaths that have occurred in the San Diego County Jail is notable. For example, take the horrific death of Ivan Ortiz, who died by suicide in a Central Jail PSU Observation Cell. In Mr. Ortiz's case, a deputy left a plastic bag in Ortiz's cell and staff failed to adequately monitor him despite his placement in what the Jail system considers to be its *most intensive* level of mental health observation. *See* Stewart Report ¶ 122.

206. Deficiencies in the monitoring of high-risk suicidal patients persist to this day. The San Diego County Jail has refused to implement the repeatedly recommended practice of "constant observation" for high-risk suicidal patients. *See* Stewart Report ¶¶ 317-319 (describing how this practice was recommended by national suicide prevention expert Lindsay Hayes following his assessment of the Jail in 2018, Disability Rights California's similar recommendation to the Jail in 2018, and NCCHC's criticism of the Jail on this topic in 2017).

207. Dr. Penn's opinion is also wrong insofar as it ignores the serious deficiencies in the Jail's system of "safety checks" for patients in settings known to

house patients at elevated risk of suicide. These deficiencies have been documented repeatedly by outside auditors, consultants, and investigating bodies, and have been shown to have played a role in multiple suicides that have occurred in the San Diego County Jail system. Stewart Report ¶¶ 320-335. This is a notable omission in Dr. Penn's assessment.

**Inadequate Mental Health Follow-up for Patients at High Risk of Suicide**

208. I strongly disagree with Dr. Penn's opinion that "the Sheriff's Department provides adequate mental health follow-up care for IPs released from suicide precautions." Penn Report at 47.

209. Here again, Dr. Penn's choice not to review any of the suicides or mental health-related deaths that have occurred in the San Diego County Jail skews his assessment. There are multiple suicide deaths that strongly indicate deficiencies with respect to mental health follow-up care. *See e.g.*, Stewart Report ¶¶ 82-85 (Ornelas 2023 suicide where Jail health care contractor NaphCare's death review asserts need for "Closer Psychiatric follow-up/care"); *id.* ¶¶ 258-265 (McDowell 2023 suicide in which patient reporting "mental breakdown" and having auditory hallucinations not seen by psychiatric provider for 3 ½ months, with no follow-up done in the six weeks leading up to his suicide Jail health care contractor NaphCare's death review asserts need for "Closer Psychiatric follow-up/care"); *id.* ¶ 297 (patient placed in Enhanced Observation Housing unit, cleared from suicide precautions with recommendation for mental health follow-up within 24 hours, but patient is not seen for two days, at which time he jumped off the top tier of his housing module, fell an estimated 20 feet, landed on the cement floor, and was found in a pool of his own blood, suffering pelvic, facial, and rib fractures, kidney, liver, and lung lacerations, and traumatic brain injury).

210. Patient cases reviewed by Dr. Penn's own designated reviewers illustrate similar and further systemic deficiencies in the San Diego County Jail's system for identifying, monitoring, treating, and conducting necessary follow-up for

patients at high risk of suicide. For example:

[redacted] **(Penn Report at 188-189)**

211. Mr. [redacted]'s case illustrates several aspects of the Jail's deficient suicide prevention and mental health care system, including delays in psychiatric care, failures to order timely suicide risk follow-up, failures to even timely complete the untimely scheduled follow-up, and medication continuity failures. Dr. Penn's designated reviewer, Dr. Huselid, notes "significant lapses/concerns" with the care that this patient received, concluding that the Jail failed to provide him "access to care" for his mental health needs and suicide risk.

212. When this patient arrived at the Jail, he reported suicidal ideations with a plan. The booking nurse scheduled a psychiatric appointment and was referred to the Detention Safety Program. The psychiatric appointment did not occur for five weeks. I agree with Dr. Huselid's finding here: "[O]ver a month to see a prescriber is too long for someone this high risk." When he was discharged from the Detention Safety Program, a follow-up appointment was ordered for one week later. Again, Dr. Huselid accurately concludes: "I think that this [one-week follow-up] is too long given his risk of suicide." But the actual follow-up was much worse than even the inappropriately ordered follow-up, with the patient going almost *four weeks* until he was seen again. Timely follow-up for a person discharging from suicide precautions in a jail setting is essential. This is an example of an unacceptable and dangerous delay for such follow-up.

213. Dr. Huselid further found that this patient's psychiatric medications expired at least twice. She noted that this was not an isolated incident: "[G]iven that I've seen many other examples of expiring medications in other charts, there does seem to be a systems issue."

[redacted] **(Penn Report at 196-197)**

214. The care of this patient, who I discuss elsewhere in this report regarding other significant treatment failures, illustrates the alarming failures in the

suicide prevention system in the San Diego County Jail system. This patient was started on antidepressant medication that must be taken consistently, and it is standard practice to ensure adherence to medications before adjusting dosage. He initially adhered to taking the medication, but began refusing in [redacted] 2023. His care was deeply complicated by being seen by five different nurse practitioners across six appointments, who appear to have different assessment styles and prescribing practices. This negatively impacts continuity of care and clinical engagement, particularly for this kind of patient.

215. The lack of monitoring culminated in an incident on in [redacted] 2024, when the patient overdosed on pills and needed to be sent to the emergency room for medical evaluation. Shockingly, and as noted by Dr. Penn's designated reviewer, Dr. Huselid, there was minimal documentation and insufficient clinical intervention upon his return to the Jail. A prudent psychiatric prescriber would urgently follow up with this patient to address the overdose and ensure appropriate medication management moving forward. The only action taken was a psychiatrist chart review several days after the incident, and an order that medications be crushed. The patient was not seen by a psychiatric prescriber until a full month after his overdose. This is an unacceptable and dangerous failure to follow up with a patient with a high suicide risk, and a case example where the Jail did not meet the standard of care.

216. Dr. Penn does not address the serious deficiencies in treatment and suicide prevention in these patient cases, or in any other patient cases. He fails to review, and ignores altogether, critical incidents like in-custody suicide deaths and serious suicide attempts. This is a consequential and glaring omission, as the above examples demonstrate. Nothing in his report changes my opinion on this topic. The patient cases assessed by Dr. Penn's designated reviewers only elevate my concern about the systemic suicide prevention-related failures in this Jail system.

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### K. Dr. Penn's Opinion that the Sheriff's Department Does Not Discriminate and Unfairly Punish People with Mental Illness Is Contradicted by the County's Own Staff and Its Own Experts.

217. I strongly disagree with Dr. Penn's opinion that the "Sheriff's Department does not discriminate and unfairly punish IPs with mental illness in housing placements." Penn Report at 52. His analysis does not reference any data, records review, or other specific materials on which such an opinion should be based.

218. As mentioned earlier in this report, Dr. Penn's opinion on this topic is directly contradicted by the Jail's own mental health leadership, who confirm that there are no policies or procedures at the Jail for mental health care staff to provide input regarding disciplinary processes. *Compare* Penn Report at 58 ("When an individual shows acute mental health deterioration, potentially linked to a disciplinary infraction, SDSO custody staff collaborate closely with mental health care staff" *with* Quiroz PMK Dep. at 178 ("Q: Does mental health staff play any role in the administration of discipline for people with serious mental illness? A:No").

219. The involvement of mental health staff in disciplinary procedures for people with mental health needs is an essential practice for any jail system to avoid the wrongful discrimination and unfair (and potentially dangerous) punishment of people with mental illness for behaviors that are manifestation of their mental health disability. San Diego County Jail fails to have such a policy, procedure, or practice.

220. As I have noted, the County's own expert on disability discrimination issues looked closely at this issue, and made a finding directly in contradiction to Dr. Penn's statement on this point:

> ***The SDCSO does not have a process for a clinician to provide his/her professional recommendations*** (e.g., whether the incarcerated person fully understood the nature of his/her actions at the time of the disciplinary charge and alleged actions) ***to the hearing official so they can give consideration to the recommendations prior to ruling on the charge and issuing any sanctions.*** The SDCSO should develop policies and a process for clinicians to provide their professional recommendations regarding the incarcerated persons understanding of their actions and for the hearing official to consider the clinical input of

sanctions that should be avoided based on the clinician's assessment. Defs.' Expert Report of Julian Martinez at 75 (emphasis added).

221. Nothing in Dr. Penn's report changes my strong opinion that the San Diego County Jail improperly and dangerously punishes people with serious mental health treatment needs or an intellectual disability. Stewart Report ¶¶ 418-424.

222. An additional note is warranted here. During my on-site tours of the San Diego County Jail facilities, I observed very clearly that the Administrative Separation isolation units are filled, to an overwhelming extent, with people who showed signs of serious mental illness. My review of records strongly indicates that people with serious mental illness are placed into Administrative Separation isolation units for reasons directly related to their mental illness and the symptoms of their illness. This practice directly contravenes the standard of care, along with the guidance of the United States Department of Justice on this topic. Stewart Report ¶¶ 184-186 (discussing DOJ guidance that an "inmate with [serious mental illness] should not be placed in restrictive housing" except in specific exceptional circumstances).

### L. Dr. Penn's Opinion that the "Sheriff's Department Provides IPs with Adequate Mental Health Discharge Planning and Resources" Is Not Supported by the Facts and Is Contradicted by the County's Own Jail Mental Health Coordinator.

223. Dr. Penn's opinion that the Jail has implemented adequate discharge planning services is not supported by the facts in this case. Penn Report at 53-54. My report describes in some detail the deficiencies with respect to this aspect of the Jail's inadequate mental health care system. Stewart Report ¶¶ 431-439.

224. Most significantly, the Jail's mental health coordinator agrees that "we do need more" mental health discharge planning staffing resources to meet the needs of the Jail mental health population. She testified that the County has not done a "needs assessment to determine what staffing resources are necessary" to meet discharge planning needs of the seriously mentally ill population, and that while

"it's challenging without the data to know," she could say that "more [discharge planning staff] is certainly better." Quiroz PMK Dep. at 171-172.

225. My review of patient records revealed that discharge planning services are extremely limited to the point that the basic clinical needs of the Jail's seriously mentally ill population are not being met. There is insufficient discharge planning to ensure that patients have continuity of psychiatric medications and mental health services, with appropriate and effective linkages to community service providers – which are essential to adequate discharge planning in a jail system.

226. The example of patient [redacted] is an illustrative one. His discharge planning records indicate that he "was provided [Medication Assisted Treatment] program information," and was "aware of pending status with RCC [Rehabilitation Care Coordination] and current Medi-Cal." There is *no* indication of proactive efforts to ensure actual and timely linkages to community service providers or access to care upon release. Stewart Report ¶¶ 437-438. This is inadequate and constitutes a failure in the provision of care.

227. I can discern no meaningful involvement of the County's Behavioral Health Services or Public Health Services agencies in discharge planning of incarcerated patients at San Diego County Jail. This is in stark contrast to comparable and nearby County systems—like that of Orange County, Los Angeles County, and Santa Barbara County—in which the county mental health and public health agencies play a significantly more active role in discharge planning for patients in jail detention. Effective coordination between a jail system and the county mental health and public health agencies on the subject of discharge planning for people with serious mental illness is a critically important practice, to ensure that people have timely and meaningful access to the services they need when they are released from detention. This is an area on which San Diego County must improve through multi-agency collaboration and coordination.

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## IV. CONCLUSION

228. The information and opinions contained in this report are based on 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 is a fair and accurate representation of the subject of my anticipated testimony in this case.

Dated: October 31, 2024

Pablo Stewart, M.D.