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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

v.

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

Defendants.

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

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

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

Trial Date: None Set

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I, Jeffrey E. Keller, M.D., declare:

1. I am a physician licensed to practice medicine in the State of Idaho, with a particular focus on correctional medicine. I am also a businessperson with significant knowledge about the private correctional healthcare industry. I am currently the President of the American College of Correctional Physicians ("ACCP"). The ACCP is the only international membership organization committed to the professional development and fellowship of doctors and mid-level practitioners who practice in the field of correctional medicine—*i.e.*, providing medical care to patients incarcerated or confined in jails, prisons, and juvenile facilities. A true and correct copy of my *curriculum vitae* is attached hereto as **Exhibit A**. My background and experiences relevant to my expert testimony in this proceeding are set forth below.

EDUCATION AND QUALIFICATIONS

2. I received my medical degree from the University of Utah in 1985. I began my career as a residency trained emergency physician. I practiced for 25 years at an Emergency Department in a busy Level-2 Trauma Center. The majority of my professional medical career has been focused on correctional healthcare, including both the clinical and business aspects of providing medical care to incarcerated persons confined in jail and prison facilities.

3. I have significant business experience in the private correctional healthcare industry. When I use the term private correctional healthcare industry, I am referring to profit-seeking companies, like NaphCare, Inc. and its many competitors, whose business model centers on contracting with states, counties, and other municipalities to provide healthcare to incarcerated or confined citizens in return for money from which the companies endeavor to earn profits for their owners.

4. From 1997 to 2021, I was the President and Medical Director of a company called Badger Medical PA. Badger Medical PA was a for-profit jail

medical company that provided medical and mental health services to people incarcerated in 17 Idaho jails and juvenile facilities. As CEO and Medical Director of this company, I was responsible not only for overseeing medical care to incarcerated people but also for overseeing all business components of the company, including gaining and keeping contracts, making budgets, overseeing and controlling costs, and running the company with the goal of maintaining a profitable business while, at the same time, providing quality correctional healthcare that met the company's contractual commitments. I also supervised all medical care, wrote policies and procedures, oversaw quality improvement programs, and provided direct clinical care to patients in jails until I retired from clinical practice in 2021.

5. I am also the former Chief Medical Officer ("CMO") of a correctional company called Centurion, LLC. I was CMO of Centurion from 2013 to 2018. Centurion is one of the nation's largest for-profit correctional medical companies. As CMO for Centurion, I supervised medical services for tens of thousands of incarcerated people in Massachusetts, Tennessee, Minnesota, Mississippi, Vermont, Florida, and New Mexico where Centurion had contracts. As CMO for Centurion, I also supervised Centurion's Quality Assurance Program, wrote medical guidelines for people incarcerated in prisons in states serviced by Centurion, and regularly interacted with Centurion upper-level management about issues relating to budgeting and other matters relating to Centurion's obligations to provide quality correctional healthcare and fulfilling the company's contracts while, at the same time, seeking to maintain profitable operations.

6. I am currently a consultant in the correctional medical industry. I consult with both public entities and private entities on issues that include setting and maintaining realistic budgets for providing acceptable healthcare for incarcerated people. Throughout my experience, up to and including the present time, I have regularly interacted with upper managers of private correctional healthcare companies. I am very familiar with the industry as a whole based on my

personal business experience and my regular interaction with leaders and managers of these companies.

7. The opinions set forth in this report are based on my own training, research, and experience as a Board-Certified Emergency Medicine Physician and as a long-standing correctional physician.

8. I am Board Certified in Emergency Medicine through 2028. I have been elected to be a Fellow of the American College of Emergency Physicians. I have also been elected to be a Fellow of the American College of Correctional Physicians. As noted above, I currently serve as the President of ACCP. I have lectured and published frequently on the practice of Correctional Medicine, including a book entitled *The Best of Jail Medicine: An Introduction to Correctional Medicine*.

SUMMARY OF OPINIONS

9. It is my opinion, based on a reasonable degree of certainty, that inadequate medical care at the Jail has resulted in preventable deaths and will continue to result in preventable deaths, because the Jail does not have adequate mortality and morbidity review procedures.

10. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department's screening and intake process is inadequate and fails to identify and treat medical care problems of newly arriving incarcerated people. This systemic failure, which in my opinion is a root cause of the Jail's high mortality and morbidity rates, places incarcerated people at substantial risk of serious harm.

11. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department fails to continue medically necessary medications and treatments after people are booked into the Jail, placing incarcerated people at a substantial risk of serious harm. The Sheriff's Department also fails to ensure continuity of care after patients return from off-site hospitalizations and medical visits, placing incarcerated people at substantial risk of serious harm. This systemic

failure is, in my opinion, a root cause of the Jail's high mortality and morbidity rates.

12. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department does not provide incarcerated people with a reliable and timely way to alert health care staff of their medical needs—whether emergent, urgent, or routine—placing incarcerated people at a substantial risk of serious harm. This lack of communication with incarcerated people in need of medical care is particularly challenging and dangerous for people with serious mental illness and developmental disabilities, who are more even more likely to have their medical needs neglected and suffer serious harm, including death. This systemic failure is, in my opinion, a root cause of the Jail's high mortality and morbidity rates.

13. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department improperly documents "refusals" of medical care, resulting in the denial of care to incarcerated people and placing them at a substantial risk of serious harm. This systemic failure is, in my opinion, a root cause of the Jail's high mortality and morbidity rates.

14. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department does not provide adequate examination of patients before prescribing treatments, either because the practitioners providing care are exclusively remote (rather than on-site) or because on-site practitioners do not perform physical examinations, placing incarcerated people at a substantial risk of serious harm. In addition, it is my opinion that the Sheriff's Department relies on nurses to operate outside their scope of practice to provide care, also placing incarcerated people at a substantial risk of serious harm. This systemic failure is, in my opinion, a root cause of the Jail's high mortality and morbidity rates.

15. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department uses inappropriate processes to refer or deny outside medical appointments and lacks sufficient contracts with outside providers for specialty

medical care, placing incarcerated people at a substantial risk of serious harm.

16. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department provides inadequate diagnostic and chronic care to incarcerated people and provides inappropriate care for a number of common medical conditions, placing incarcerated people at a substantial risk of serious harm. This systemic failure is, in my opinion, a root cause of the Jail's high mortality and morbidity rates.

17. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department fails to provide medically necessary vision care, placing incarcerated people at a substantial risk of serious harm.

18. It is my opinion, based on a reasonable degree of certainty, that custody staff routinely interfere with the provision of healthcare, including by denying incarcerated people confidentiality in their interactions with healthcare providers, which places incarcerated people at a substantial risk of serious harm.

19. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department fails to maintain adequate, accurate, and complete medical records, compromising the delivery of healthcare and placing incarcerated people at a substantial risk of serious harm.

20. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department does not provide adequate discharge planning to people being released from custody, placing incarcerated people at a substantial risk of serious harm.

21. It is my opinion, based on a reasonable degree of certainty, that the Sheriff's Department does not conduct adequate continuous quality improvement programs, meaning that critical errors (including but not limited to those described in this Report) go unaddressed, placing incarcerated people at a substantial risk of serious harm.

22. It is my opinion, based on a reasonable degree of certainty, that the

Sheriff's Department has failed to maintain adequate levels of healthcare staff relative to the incarcerated population, placing incarcerated people at a substantial risk of serious harm. This systemic failure is, in my opinion, a root cause of the Jail's high mortality and morbidity rates.

METHODOLOGY

23. I was asked by the attorneys representing the Plaintiffs in this case to render an opinion as to the health care system, the general medical conditions, and the adequacy of the medical care offered to the people incarcerated at the San Diego County Jail (the "Jail").

24. Prior to visiting three of the Jail facilities, I reviewed documents pertinent to my objective. These included the sections of the Third Amended Complaint dealing with medical care, previous audits and inspections done of the jail since 2017, contracts negotiated by San Diego County dealing with medical care, and various other reports dealing with CQI, contract compliance, etc.

25. I visited the Jail on February 6 through 8, 2024. During the visit, I toured the Central Jail, George Bailey Detention Facility ("George Bailey"), and Las Colinas Detention and Reentry Facility ("Las Colinas"). At these facilities, I visited medical housing units, intake units, medical clinics, a pharmacy, lab and storage areas, and other housing units. During the three days, I was able to speak briefly with approximately 50 patients. I also reviewed over 500 photographs taken during the tour. However, I was unable to interview many of the medical staff members that I would have liked to. Three different nurses at the Jail told me that "I was told by my supervisor not to answer any of your questions," or "I was told not to talk to you."

26. After the tour, I reviewed 80 patient charts chosen by Defendants as being representative of the following medical categories: patients with opioid use disorder (5), patients on opioid withdrawal protocols (5), patients with alcohol withdrawal protocols (5), patients with HIV (5), patients with Hepatitis C (5),

patients with Type 2 Diabetes(5), patients with hypertension(5), patients with cancer (5), patients who received gynecological care (5), emergency room referrals (5), patients who had submitted five or more requests for medical care (5), patients housed in medical overflow segregation cells (5), patients on dialysis (5), patients receiving orthopedic care (5), and optometry referrals (5). I also reviewed seven patient charts of individuals with whom I spoke during my inspection of the Jail. Many of the charts I received had technical issues that made them difficult to read. In particular, the records, which were in some cases thousands of pages long, were not text searchable, even after attempts to OCR them. In addition, the charts were generally missing all lowercase letter Is and Ls. I was unable to review a complete set of grievances (and their associated responses) relating to medical care, though some grievances were produced within the charts described above.

27. A complete list of the materials I reviewed is attached hereto as **Exhibit B**.

28. I compared and contrasted my findings with accepted standards of correctional medical care found in the following published guidelines and source material: the National Commission on Correctional Health Care ("NCCHC"); published guidelines from nationally recognized medical specialty groups, such as The American Society of Addiction Medicine, the American Diabetic Association, American Association for the Study of Liver Diseases, and the Infectious Diseases Society of America; standard medical textbooks, such as *Uptodate*; and San Diego specific reports, including the NCCHC "Technical Assistance Report" commissioned by the Jail in 2017 and Dr. Homer Venters' "Review of Best Practices for Jail Operations for San Diego County" commissioned by the Jail in 2020.

29. I also relied on my own training, research and experience.

30. I am receiving compensation at a rate of $250.00 per hour plus expenses for this work.

31. My opinions have a reasonable degree of medical certainty based on

the evidence outlined above. The information contained in this report and the accompanying exhibits are a fair and accurate representation of the subject of my anticipated testimony in this case. I reserve the right to modify my opinions in the light of new, additional information.

BACKGROUND

I. Multiple Expert Entities Have Reported on the Inadequate Healthcare at the Jail

32. The San Diego Sheriff's Department ("Sheriff's Department") has been on notice for several years that people in its custody are not receiving adequate healthcare. Multiple reports issued by organizations with expertise in correctional medicine have documented practices in the Jail which fall below accepted standards and jeopardize the health and safety of incarcerated people. I found the following reports and findings to be especially significant.

33. In January of 2017, the Sheriff's Department received a technical assistance report from the NCCHC. NCCHC Report, January 2017, DUNSMORE0260620. The NCCHC is a leading nonprofit organization that publishes correctional healthcare standards and accredits jails or prisons that meet those standards. DUNSMORE0260621. Jails and prisons often seek technical assistance from the NCCHC as a preliminary step towards accreditation. A team from the NCCHC visited four Jail facilities in San Diego: Central Jail, George Bailey, Las Colinas, and Vista Detention Facility. DUNSMORE0260620. During its audit, the NCCHC documented dozens of failures to meet what it describes as "essential" or "important" standards for the delivery of medical care to incarcerated people. DUNSMORE0260621-22. Seven years after this report, the Jail is still not accredited by the NCCHC. The most important NCCHC findings and recommendations are described below.

34. First, the NCCHC documented that people who arrived at a Jail facility with significant health conditions were often not identified or treated in a timely

manner. For example, individuals booked into Central Jail sometimes did not receive a full medical screening for several hours, placing those with unidentified conditions at risk of a health "crisis." DUNSMORE0260636. None of the facilities conducted initial health assessments during the first two weeks of incarceration to further identify individuals in need of treatment. DUNSMORE0260637, 0260671, 0260704, 0260738. And auditors found little evidence that medical staff were reviewing the charts of incarcerated people transferred from one jail facility to another to ensure continuity of care. DUNSMORE0260637, 0260670, 0260704, 0260738.

35. Second, incarcerated people who themselves requested medical attention were not seen and treated in a timely matter. The NCCHC described understaffing at the Jail and a resulting "serious" backlog of hundreds of medical requests which had not been answered with a face-to-face evaluation by a medical professional. DUNSMORE0260658, 0260672-73, 0260706. Nurses attempted to manage this backlog by assigning triage levels to patients based only on the symptoms they reported on their sick call slips. DUNSMORE0260639, 0260672-73, 0260706, 0260739-40. The NCCHC warned that this is a dangerous practice because seemingly minor symptoms may signify an urgent condition which would not be identified without a face-to-face assessment. *Id.* The average wait time for such an assessment far exceeded the NCCHC standard of 48 hours. *Id.* Patients were waiting an average of eight days to see a nurse (with some waiting 12-18 days) and an average of five days to see a physician (with some waiting 8-12 days). *Id.* Further delays occurred in some instances when there were not enough deputies to escort patients to appointments. DUNSMORE0260640, 0260672-74. And even after patients were seen and treatments were prescribed, there were delays in administering essential medications to those who were new to the facility or who were on lockdown. DUNSMORE0260623, 0260633-34, 0260657, 0260667-68, 0260700-01.

36. Third, the NCCHC documented that care was too often delivered by nurses acting outside the scope of their license. Nurses were called on to make diagnoses, create care plans, prescribe medications, and administer prescription-strength doses of over-the-counter medications without physician oversight. *See, e.g.*, DUNSMORE0260634, 0260636, 0260640-41, 0260667, 0260678, 0260701, 0260707. Nurses were even tasked with diagnosing and ordering medications for some chronic diseases, which the NCCHC described as "not an acceptable practice." DUNSMORE0260643. The NCCHC also noted that the way nurses administered medications—by pulling the doses from larger stock bottles without pharmacist or provider oversight—was a "serious and a violation of the Nurse Practice Act." DUNSMORE0260634.

37. Fourth, patients with both acute and chronic conditions received sporadic care, often only seeing medical staff for follow-up appointments and monitoring of their condition if they themselves initiated a visit. DUNSMORE0260641, 0260674, 0260708, 0260741-42. This is problematic because providers—not incarcerated people—are in the best position to know when and how a chronic condition should be monitored. There were no guidelines in place to ensure consistent and quality treatment of patients with any chronic disease besides hypertension. DUNSMORE0260643, 0260676, 0260710, 0260743-44. And there was little to no documented discharge planning for individuals with known release dates to ensure that they understood how to receive the medical care they needed in the community. DUNSMORE0260641-42, 0260675, 0260708, 0260742.

38. Fifth, the Jail lacked systems which would allow medical staff to identify and correct deficiencies with individual providers or the system of care as a whole. Medical grievances were mixed in with other grievances, making it difficult to identify trends in complaints. DUNSMORE0260627, 0260661, 0260694, 0260728. Health staff were not informed of the results of death reviews.

DUNSMORE0260627, 0260661, 0260694, 0260727-28. And there was no peer review process whereby the work of individual clinicians could be reviewed by others trained in their field. DUNSMORE0260630, 0260664, 0260697 0260730.

39. Other deficiencies also resulted in incarcerated people receiving substandard care. Clinical encounters often occurred in non-confidential spaces, which the NCCHC warned could lead to less thorough and accurate assessments. DUNSMORE0260626-23, 0260661, 0260693-94, 0260727. There was no policy ensuring that healthcare staff were present for refusals of care so that they could counsel patients appropriately about the consequences of not attending a medical appointment. DUNSMORE0260650, 0260684, 0260717-18, 0260751. And nurses did not adequately document the condition of incarcerated people whom they checked on in segregation. DUNSMORE0260640, 0260673, 0260706-07, 0260740-41.

40. In short, the NCCHC report made clear that the Sheriff's Department failed to meet standards that were essential for accreditation and, more importantly, for the provision of adequate healthcare to those in its custody.

41. On March 20, 2020, three years after the NCCHC documented significant issues with the healthcare system at the Jail, Darryl Dunsmore filed his lawsuit, which he later amended to allege that the medical care he received at the Jail was not constitutionally adequate. *See Dunsmore v. California, et al.*, Case No. 3:20-cv-00406-AJB-WVG, Dkt. No. 19. In his First Amended Complaint, Mr. Dunsmore asserted that his medical diet and diabetic insulin injections had been discontinued when he transferred to the Jail from the California Health Care Facility. *See id.* at 3. Mr. Dunsmore's complaint as well as the ongoing high death rate illustrated that many of the deficiencies which the NCCHC described had gone uncorrected, placing the health and lives of incarcerated people at risk.

42. On March 30, 2020, Dr. Homer Venters, then president of the nonprofit technical assistance organization Community Oriented Correctional Health Services,

provided the County of San Diego (the "County") with further recommendations on ways to improve healthcare delivery at the Jail. Venters Report, March 30, 2020, SD_215361. This document was prepared at the County's request for the express purpose of "reduc[ing] the rate of mortality and morbidity in the San Diego Jail system." SD_215379. Dr. Venters conducted a literature review and met with staff at the jail before preparing his recommendations. SD_215362.

43. Dr. Venters' report reiterated the importance of several best practices, such as identifying health conditions early through a thorough intake, making immediate referrals to providers for further evaluation when an urgent issue is identified, SD_215369-72, and ensuring that medications are ordered by a physician or mid-level provider and delivered in a timely manner, SD_215374. Other recommendations addressed the need for monitoring the effectiveness of the healthcare system. Dr. Venters suggested using an electronic medical record to track and evaluate performance, reviewing "sentinel events" such as "deaths, injuries, and self-harm," "surveying staff and patients about their engagement with the correctional health service," including enforceable performance standards in contracts with vendors, and possibly enlisting independent agencies to further monitor performance. SD_215364-67.

44. As the Venters Report shows, the County was aware of a need to reduce morbidity and mortality and was advised four years ago of several ways to accomplish this goal.

45. On February 3, 2022, the California State Auditor issued a report of its investigation into the alarming number of deaths that occurred in the Jail from 2006 to 2020. California State Auditor Report ("State Audit"), February 2022, SD_174794. The State Audit confirmed that the Jail had a higher rate of suicides and natural deaths (which can include deaths where deficient medical care is a factor) than jails in any other comparable county in the State. SD_174812-13. This remained true even taking into account adjustments based on jail population size and

number of bookings. *Id.* The State Audit showed that the Jail's mortality rate remained high even after the NCCHC's 2017 warning of serious deficiencies in the Jail's healthcare system. SD_174811.

46. The State Audit also included an in-depth review of 30 in-custody deaths, with an emphasis on cases that occurred between 2016 and 2020. SD_174815. It concluded that "deficiencies with how the Sheriff's Department provides care for and protects incarcerated individuals" had "likely contributed to in-custody deaths" and that the Sheriff's Department had "not consistently taken meaningful action when such deaths have occurred." SD_174794. I discuss some of the more specific State Audit findings below.

47. First, the State Audit found that "[i]n at least eight of the 30 cases … individuals had serious medical or mental health needs that heath staff did not identify or communicate to detention staff at intake." SD_174816-17. Possibly as a result, "[f]ive of these individuals died within four days of their arrest." *Id.*

48. Second, the State Audit found that medical staff failed to respond appropriately to some incarcerated persons' repeated requests for help during the weeks preceding their deaths. SD_174818. In two illustrative cases, individuals reported worsening symptoms "over the course of one to three weeks" but were only evaluated by a nurse and not a physician. *Id.* These individuals eventually died of the conditions that jail staff failed to adequately assess and treat. *Id.* The State Audit also observed that some individuals were not receiving essential care because they refused appointments. SD_174820-21. Like the NCCHC, it recommended that health staff be present for refusals so that they could counsel patients. *Id.*

49. Third, the State Audit identified cases where sworn and medical staff failed to appropriately respond to medical emergencies. Deputies often conducted cursory safety checks on the jail population and therefore potentially missed signs of medical distress. SD_174821-23. Oftentimes, incarcerated people were dead for several hours before a deputy realized something was wrong. *Id.* In several

instances where deputies did realize that a person was unresponsive or otherwise in distress, they "did not perform or delayed lifesaving measures" like CPR. SD_174824. Medical staff also took too long to arrive and assist deputies. SD_174824-25. The State Audit emphasized that minutes can make a difference to survival during a medical emergency, SD_174283-84, and noted that a fifteen minute delay in one case was "detrimental to the individual's likelihood of survival." SD_174825.

50. Finally, the State Audit found that following these deaths, "[t]he Sheriff's Department has not responded … in a manner that demonstrates its commitment to improving health and safety at its detention facilities." SD_174830. For example, although the Sheriff's Department had a policy requiring that its top medical staff review all deaths "to determine the appropriateness of clinical care" that the decedent had received, "the Sheriff's Department did not sufficiently document the results or recommendations from its 30-day medical reviews." SD_174831. The Sheriff's Department's Critical Incident Review Board ("CIRB") did not examine any deaths deemed "natural" by the medical examiner to determine whether deficient medical care could have been a factor. SD_174834. And although the internal affairs unit has the power to investigate both sworn and medical staff, it looked into only four of the thirty cases the State Audit reviewed. SD_174835. This was despite "a number of potential violations or concerns in some of the other 26 cases that could justify further investigation." *Id.* The lack of internal review mechanisms was particularly concerning because the County's Citizen Law Enforcement Review Board ("CLERB") has been stymied in its efforts to independently gather evidence about deaths at the jail. SD_174839-44.

51. In response to the State Audit, the Sheriff's Department attacked the report's death count methodology and claimed that there was no evidence its policies or practices contributed to high mortality in its facilities. San Diego Sheriff's Preliminary Comment on State Audit, January 14, 2022, SD_174883-84,

174893-97. The Sheriff's Department implied that deaths were inevitable without acknowledging the role of longstanding issues highlighted by the State Audit, like the inappropriate use of nurses to direct patient care. SD_174893-94. The Sheriff's Department also disputed the qualifications of the auditors, comparing their expertise unfavorably to that of the NCCHC, while failing to mention that the NCCHC had raised similar concerns in its own audit five years earlier. SD_174889-92. After disputing the State Audit's findings, the Sheriff agreed that it should implement many of the Audit's key recommendations, but provided few details on when or how this would occur. SD_174902-09.

52. On February 9, 2022, Mr. Dunsmore was joined by seven other individuals in filing the Second Amended Class Action Complaint for Declaratory and Injunctive Relief ("SAC") in this case, Dkt. No. 81, converting the individual case into a class action. The class action complaint asserted, among other things, that the Jail failed to provide adequate medical care in violation of the 8th and 14th Amendments of the United States Constitution and Article 1, Sections 7 and 17 of the California Constitution. At the time the SAC was filed, Defendants were managing their healthcare system through Correctional Healthcare Partners, Inc. ("CHP") and Tri-City Medical Center. The SAC alleged a number of deficiencies in the provision of medical care, including the failure to maintain sufficient numbers of adequately trained healthcare professionals, the ability of custody staff to interfere with and undermine the healthcare professionals, inadequate screening and intake processes, inadequate care of people with substance use disorders and those experiencing withdrawal, the failure to continue medically necessary medications and treatments upon arrival, the lack of any timely or reliable way to alert healthcare staff of medical needs, the failure to maintain adequate, accurate, and complete medical records, the lack of sufficient contracts with community providers for outside medical care, the lack of confidential spaces for medical care and adequate diagnostic care, the lack of referrals to outside specialists when necessary, the lack

of medically necessary eyeglasses, inadequate follow-up healthcare, inadequate discharge instructions and medication, and the failure to maintain an adequate quality assurance and quality improvement process. *See* SAC at pp. 29-65. The operative Third Amended Complaint, filed November 18, 2022, Dkt. No. 231, has similar allegations to the SAC. I understand that this case was later certified into a class action on behalf of all adults who are or will be incarcerated in any of the San Diego County Jail facilities.

53. A few months after the SAC was filed, that the County entered into a contract for Jail medical care with the private medical provider NaphCare. I have reviewed the June 2022 NaphCare contract and its February 2024 amendment as part of my work in this case and discuss them later in this report.

54. In February 2023, the Sheriff's Department released its Progress Report Update on the State Audit. The Sheriff's Department claimed to be making changes in response to the State Audit's findings and recommendations. Progress Report: Update on State Jail Audit, February 2023, SD_184480-82. But the Sheriff's Department has in fact failed to implement many policies and practices which the State Audit advised could reduce mortality in the jail. For example, the Sheriff's Department claimed that nurses were conducting face-to-face evaluations within 24 hours of receiving a request for medical services as of December 2022. *Id.* SD_184484. The Sheriff's Department also claimed that it was requiring medical staff to counsel patients who refused a medical appointment and sign off on the refusal. SD_184485. However, as discussed elsewhere in this report, a review of medical records produced by the Jail shows that staff are not implementing either of these changes.

55. In sum, multiple experts and entities—the NCCHC, Dr. Venters, and the State Audit—have pointed out the systemic failures in the Jail's healthcare system. As explained throughout this Report, it is my opinion that those problems and others persist.

II. The Sheriff's Department's Contracts with Multiple Private Companies to Provide Healthcare at the Jail

56. In the face of the many deaths, the State Audit, and this class action, the County decided to change private healthcare providers. On April 26, 2022, the County signed a contract with NaphCare to provide healthcare at its seven jail facilities. County Contract No. 566117, April 26, 2022, NAPHCARE000001. The contract is for five years with another five-year renewal term, for an amount not to exceed $620,778,261.65. *See* NAPHCARE000023.

A. Background on NaphCare

57. NaphCare signed its first contract to provide comprehensive health care services in Alabama in 2001. NaphCare currently provides medical services to more than 100,000 incarcerated persons in 32 states.[1] The company has more than $300 million in annual revenues and 2,000-plus employees.[2]

58. In 2020, a Reuters investigation revealed that jails where NaphCare provided health care had the highest death rates in the nation over a three-year period.[3] Since then, according to federal court records, NaphCare has been sued for medical neglect over 100 times.[4] While some government entities have renewed

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[1] *See* John Washington, *Pima County has docked NaphCare $3.1 million for jail medical deficiencies* ("Pima County Docking NaphCare"), ARIZONA LUMINARIA, Aug. 9, 2023, https://azluminaria.org/2023/08/09/jail-deaths-pima-county-docking-naphcare/.

[2] *See* Erica Wright, *Humble Beginnings for Local Firm that Offers Correctional Health Care*, THE BIRMINGHAM TIMES, May 28, 2020, https://www.birminghamtimes.com/2020/05/humble-beginnings-for-local-firm-that-offers-correctional-health-care/.

[3] *See* Jason Szep et al., *Special Report: U.S. Jails Are Outsourcing Medical Care—and the Death Toll Is Rising* ("Special Report"), REUTERS, Oct. 26, 2020, https://www.reuters.com/article/us-usa-jails-privatization-special-repor/special-report-u-s-jails-are-outsourcing-medical-care-and-the-death-toll-is-rising-idUSKBN27B1DH/

[4] Chamian Cruz, *Fulton Extends Contract with Jail's Medical Provider Amid Allegations of Medical Neglect* ("Fulton Extends Contract"), WABE, Jun. 28, 2023, https://www.wabe.org/fulton-extends-contract-with-jails-medical-provider-amid-allegations-of-medical-neglect/.

contracts with NaphCare despite the lawsuits and deaths, others have terminated their contracts.

59. Alabama is one such example. In 2001, when Alabama's correctional facilities healthcare provider raised the bill from $26 million per year to $38-$46 million per year, the state sought bids for another provider. NaphCare won the contract with a bid of $30 million. NaphCare had never before provided comprehensive care to a state prison system, so "[c]ritics immediately questioned how NaphCare could possibly provide adequate health care for 25,000 prisoners for $30 million and still make a profit."[5]

60. Numerous lawsuits followed. Incarcerated individuals at Alabama's Tutwiler Prison for Women named NaphCare as a defendant in a class action suit, alleging long delays in health care services, dangerous lapses in providing prescription medication, and a severe shortage of qualified medical personnel. Another lawsuit challenged the medical care NaphCare provided to incarcerated persons with HIV at Alabama's Limestone facility, where the death rate among incarcerated persons with HIV was twice the national rate. *Id*. Another class action suit challenged the health care provided to individuals with serious mental illness; "[a]mong the most serious complaints in the suit include prisoners lying in beds unable to control their bowels that sometimes go for hours without being changed or cleaned." *See* NaphCare in Alabama.

61. In 2003, an Alabama state audit concluded that NaphCare was supplying "dangerous and extremely poor quality health care." *Id*. Amid the lawsuits, the audit, and $6.9 million in cost overruns caused by off-site medical visits, Alabama canceled NaphCare's contract in 2003.[6]

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[5] *See* Lonnie Burton, *The Deadly Health Services of Naphcare in Alabama* ("NaphCare in Alabama"), PRISON LEGAL NEWS, October 15, 2023, https://www.prisonlegalnews.org/news/2003/oct/15/the-deadly-health-services-of-naphcare-in-alabama/; *see also* Special Report; Fulton Extends Contract.

[6] *See* Casey Turner, *Sick for a Decade: Alabama's Prison Health Care Continues to Face Scrutiny*, AL.COM, Nov. 22, 2014,

62. A similarly dire outcome occurred in Gwinnett County Jail in Lawrenceville, Georgia.[7] And in 2022, after at least three deaths in 15 months, the Onondaga County Jail decided not to renew its contract with NaphCare.[8]

63. NaphCare is still providing health care to the Arizona prison system which has been the subject of extensive litigation and found to be unconstitutional. *See Jensen et al. v. Thornell et al.*, No. CV-12-00601-PHX-ROS, 2023 WL 2838040 (D. Ariz. April 7, 2023). NaphCare has also been roundly criticized for its staffing shortages and medical request backlogs at the Pima County Jail in Arizona. For example, a former NaphCare employee at Pima County jail said they were often behind in responding to "kites" (medical requests). The employee said, "it got to the point where we were from 300 to 1,800 deep in the queue."[9]

64. As described above, NaphCare got its first contract in Alabama correctional facilities by bidding ridiculously low. Whereas the average state spent $2,500 to $3,000 per incarcerated individual per year in 2001, under the terms of NaphCare's bid, Alabama was going to spend a little over $1,000. *See* NaphCare in Alabama.

65. Relatedly, in 2015, weeks after winning the renewal bidding process for a contract with Suffolk County, NaphCare claimed it had underbid and wanted to

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https://www.al.com/news/2014/11/sick_for_a_decade_alabamas_inm.html.

[7] *See* Randy Travis, *Lawsuit: Jail Medical Contractor Ignored Treatable Illness that Led to Inmate's Death*, FOX 5 ATLANTA, Apr. 17, 2023, https://www.fox5atlanta.com/news/deion-strayhon-gwinnett-county-jail-death-lawsuit.

[8] *See* Chris Libonati, *Onondaga county jail gets different health care provider after report finds 'serious' issues*, CENTRAL CURRENT, Dec. 21, 2022, https://centralcurrent.org/onondaga-county-gets-different-health-care-provider-after-report-finds-serious-issues/.

[9] John Washington, *Medical care in Pima County jail is dangerously delayed as pleas for help are ignored and mismanaged, say inmates and employees* ("Medical Care in Pima County Dangerously Delayed"), ARIZONA LUMINARIA, Apr. 19, 2023. https://azluminaria.org/2023/04/19/medical-care-in-pima-county-jail-is-dangerously-delayed-say-inmates-and-employees/.

renegotiate its contract—the sheriff's office denied the request.[10]

66. In June 2021, NaphCare agreed to pay nearly $700,000 to settle a False Claims Act case the United States government brought against NaphCare, alleging that the company submitted inflated claims for evaluation and management services at BOP's Terre Haute, Indiana, facility between January 2014 and June 2020. The United States alleged that when certain physicians did not indicate the type of service performed on onsite visit sheets, NaphCare charged the government for higher-level services than were provided.[11]

67. The 2022 contract with Arizona allowed NaphCare a profit of $1.095 in the prisoner per day cost. "A 25,000 prisoner population would therefore generate an annual profit for NaphCare of $9,991,875."[12]

68. NaphCare has faced staffing shortages. For example, in Pima County from February 2022 to April 2023, NaphCare was understaffed for hundreds of hours for medical care positions, including for Registered Nurse Supervisor (271 hours short), Licensed Practical Nurse (2,463 hours short), Psychiatric Nurse Practitioner (114 hours short), and Psychiatric Registered Nurse (653 hours short). *See* Pima County Docking NaphCare.

69. Consistent with concerns about understaffing, I have also been made aware of a number of claims that NaphCare provided substandard medical care. For example, in February 2022, Pima County's audits found that NaphCare had

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[10] *See* Beth Healy and Christine Willmsen, *Pain And Profits: Sheriffs Hand Off Inmate Care To Private Health Companies* ("Jail Health Companies Profit"), WBUR, March 24, 2020, https://www.wbur.org/news/2020/03/24/jail-health-companies-profit-sheriffs-watch.

[11] *See* U.S. Department of Justice, *Prison Health Care Provider Naphcare Agrees to Settle False Claims Act Allegations*, June 25, 2023, https://www.justice.gov/opa/pr/prison-health-care-provider-naphcare-agrees-settle-false-claims-act-allegations.

[12] *See* Jimmy Jenkins, *Health Care Company Expects to Earn Nearly $10 Million in Annual Profits from AZ Prisons Contract*, ARIZONA REPUBLIC, June 2, 2022, https://www.azcentral.com/story/news/local/arizona-health/2022/06/02/correctional-health-care-company-expects-earn-nearly-10-million-annual-profits-arizona-prisons-contr/7491553001/.

"appropriately managed" only one of the 22 people who were undergoing withdrawal. That same month, the county gave NaphCare a score of 5%, or five on a scale of 100, for dealing with withdrawals. *See* Pima County Docking NaphCare. One former staff member said "the NaphCare standard is to supply opioid addiction medication for a maximum of three days, if it's given at all." *See* Medical Care in Pima County Dangerously Delayed.

B. NaphCare's 2022 Contract with San Diego County

70. Notwithstanding the problematic incentives of privatized correctional medical care in general, San Diego chose NaphCare to provide comprehensive healthcare services at the Jail. *See* Contract No. 566117. Under the contract, NaphCare receives approximately $60 million per year and is supposed to provide comprehensive mental and medical health care, medication assisted treatment ("MAT"), dental care, discharge treatment training, specialty services and outside referrals, and discharge planning to people incarcerated at the Jail. NaphCare subcontracted physicians, physician's assistants, and nurse practitioners to the previous medical contractor, CHP.[13] *See* Contract, NaphCare of San Diego LLC Agreement with Correctional Healthcare Partners, Inc. for on-site Physician and Mid-Level Provider Staffing, effective June 1, 2022, NAPHCARE040868-040878.

C. The Sheriff's Department Continued to Work With, and Pay, NaphCare, Despite Knowing That NaphCare Was Not Living Up to Its Contractual Obligations

71. The underbidding, understaffing, and requests for more money that have characterized NaphCare's operations elsewhere, as detailed above, have hurt NaphCare's performance in San Diego as well. Beginning in 2023, the Sheriff's

[13] The history of private contractors at the Jail is complex. For example, Coast Correctional Management Group ("Coast") used to provide physicians and mid-levels, followed by CHP, and then NaphCare—now this is done by a combination of NaphCare and CHP plus County nurses. When asked how many of the approximately 30 prisons and jails NaphCare serves have a similarly hybrid model in which nursing is separately managed, NaphCare representative Angela Nix replied that only one other did. Nix II Tr. at 74:11-15.

Department issued a series of Corrective Action Notices ("CANs") to NaphCare pointing out multiple failures in its delivery of health care to incarcerated people. In total, I am aware of several CANs being issued and updated before discovery in this case closed. NaphCare responded to these, and CAN meetings were held in an attempt to solve the problem. Freedland Tr. at 156-160. However, NaphCare's Rule 30(b)(6) witness, Angela Nix, testified that the Sheriff's Department has never approached NaphCare about a reduction in payment for its contractual violations, Nix II Tr. at 62-63, notwithstanding that the contract allows the withholding of funds for failure to perform.[14]

72. As far as I can tell, the CANs begin on April 28, 2023; as of that date the County criticized NaphCare for having $9.3 million of unpaid bills due to hospitals, with $4.6 million of that past the 30-day threshold. *See, e.g.*, SD_120686. According to the CAN, "Due to a lack of payment, some community providers do not want to see or accept our patients." Among the many other deficiencies noted by the CANs are the following: a lack of gynecologists at Las Colinas, failure to provide MAT, relying on unlicensed staff, failing to replace or repair medical equipment, understaffing of medical and dental providers, failure to create policies and procedures that comply with NCCHC standards, and the lack of M&M and CQI review. *See* SD_1572154; *see also* Freedland Tr. at 161:4-169:10. The lack of adequate obstetrical and gynecological care at Las Colinas was of particular concern to Dr. Montgomery. *See* SD_120627.

73. Dr. Montgomery acknowledged in a May 26, 2023 email to Sheriff's Department administrators that "[i]t has been shown that far more staff members are needed than [NaphCare] initially estimated" to "meet the clinical demand."

[14] *See* NaphCare Contract § 4.1.7, NAPHCARE000007; *see also* Jeff McDonald, *Repeated failures by San Diego County jail health provider prompt sheriff to order it to fix deficiencies*, SAN DIEGO UNION-TRIBUNE, April 2, 2024, https://www.sandiegouniontribune.com/2024/03/31/repeated-failures-by-san-diego-county-jail-health-provider-prompt-sheriff-to-order-it-to-fix-deficiencies/.

Dr. Montgomery further suggested that NaphCare had been staffing at an "arbitrary level." SD_227522. He stated: "Naphcare has gone through the RFP process … not once, but twice. They have familiarity with California, as they have already been engaged with several Counties. They have been performing services in San Diego for a year. They know, or should have known, that the number of pro-offered staff positions would be inadequate to meet the clinical demand … a fact that has been borne out by the growing MH/BH clinical backlog." SD_227522.
Dr. Montgomery also said: "The staffing model is wrong and requires fixing. It appears that we can either force Naphcare to hire staff to meet demand, do it ourselves (carve out clinical services from the contract), or find more money to pay for the services." SD_227522.

74. Dr. Montgomery further stated: "My point is … the staffing matrix needs to be elevated as a significant point of contention in the CAN/CURE process in order to elicit some form of response or action. We can discuss how we wish to proceed internally, but I think we need to elevate it to the Friday meetings and introduce the concept that Naphcare is responsible for clinical performance and completion, not staffing to an arbitrary level." SD_227522.

75. In these internal discussions and in CAN meetings with and notices to NaphCare, the County expressed increasing frustration with its new contract. Concerns included a lack of radiology staffing, sick-call backlogs associated with CHP departures, and failures to get outside specialty care for patients. By the end of 2023, the County decided to put out a new bid for medical services—even though it had signed what should have been a comprehensive five-year contract with NaphCare in April 2022. Dr. Freedland testified that he was forced to provide a physician at Rock Mountain without any pay for months. Freedland Tr. at 115:17-120:18. He also testified that, in the summer or fall of 2023, many staff left his employ due to stress. *Id.* at 102:6-103:16.

76. While the bids for the new medical services contract were pending,

NaphCare negotiated an increase in funding for itself. Contract, County of San Diego – Department of Purchasing and Contracting, Amendment, Contract 566117 with NaphCare, Inc. Modification 01, February 1, 2024 (NAPHCARE040852-040862). This contract amendment added over $24 million in payments to NaphCare. Nix II Tr. at 59:25-61:5. I discuss the cycle of bidding low and then renegotiating more payments in more detail below.

D. The Sheriff's Department Recently Contracted with Correctional Healthcare Partners to Provide Additional Health Care Staff

77. In around April or May 2024, I learned that the County had awarded a new medical services contract to CHP—the very entity that was subcontracting with NaphCare for medical services.[15] The new contract increases the County's annual spending on physicians and nurse practitioners in the Jail from approximately $8.3 million to $22.6 million per year, though I understand that Dr. Freedland's bid asked for $27 million worth of medical care providers.

78. CHP was founded by Peter J. Freedland M.D., a former executive at Coast Correctional Medical Group (sometimes referred to as "Coast"). Coast was the County's previous medical provider. Coast had been sued multiple times while delivering healthcare services to the Jail, including in connection with the tragic preventable deaths of Elisa Serna and Michael Wilson. Coast was replaced by CHP through a contract with the Sheriff in 2020—a $24 million deal that spanned three years; this contract was later superseded by the NaphCare-CHP subcontract. I have some concerns that the very entity that has been providing substandard medical care at the Jail for the last four years is somehow supposed to bring it into constitutional compliance now.

79. The contract that the Sheriff's Department recently negotiated with CHP is specific in what its objective is: "Contractor shall provide the services

[15] I did not receive a copy of this contract, which states it is effective June 28, 2024, until July of this year.

described herein to accomplish the following goal: provide on-site Health Care Providers for primary care and urgent care at specified County detention facilities." *See* CHP 2024 Contract, p. 20. The contract increased physician and midlevel staffing at the Jail facilities by almost 300%. For example, medical practitioner staffing at the Central Facility increased from 124 hours a week to 336 hours a week. Las Colinas staffing increased from 84 hours a week to 242 hours per week. And staffing at the George Bailey facility increased from 84 hours per week to 196 hours per week. While this is good news for the incarcerated patients at the Jail, this increase in staffing alone will not, in my opinion, be sufficient to solve the Jail's medical problems.

OPINIONS

80. Seven years after the NCCHC Report finding the Sheriff's Department policies and practices put the health and lives of incarcerated people at risk, two years after the State Audit concluded that the "Sheriff's Department has failed to adequately prevent and respond to the deaths of individuals in its custody," and scores of deaths and poor outcomes later, the Sheriff has failed to take sufficient corrective action necessary to prevent further unnecessary suffering or death in its jails.

81. In light of the State Audit's damning conclusion, I would have expected the Sheriff's Department to have done its own detailed internal medical investigation into the excessive deaths in an attempt to find one or more other root causes of this problem. I have seen no evidence that the Sheriff's Department made any such investigation or came to any conclusions about potential root causes.

82. In fact, testimony from the medical contractors who provide healthcare at the Jail indicates that the Sheriff's Department has not discussed with them any need to reduce in-custody deaths or asked them their opinions about ways to reduce in-custody deaths. Dr. Peter Freedland, the Chief Executive Officer at CHP, which staffs the onsite medical practitioners at the Jail, stated in his deposition: "I've

heard that there was an audit, but I have not read it." Freedland Tr. at 47:11-12. When asked, "Have you been asked to make any recommendations to the County about how to lower the death rate, medically, at the jail?" Dr. Freedland responded, "No one has asked me specifically, how do we do this." *Id.* at 74:2-3. Similarly, Angela Nix, testifying as a Rule 30(b)(6) witness on behalf of NaphCare, testified that she had met with Sheriff Kelly Martinez on approximately three or four occasions to discuss the NaphCare contract, but could not recall discussing the need to reduce the high death rate at the Jail. Nix II Tr. at 18:18-22.

83. This is astounding to me. Why would the Sheriff's Department not immediately launch an "all hands on deck" investigation into the causes and potential solutions of this critically important high death rate after the State Audit so publicly pointed it out? Why not publish the results of an extensive internal investigation along with a detailed plan on how to reduce the death rate?

84. In February of 2023, the Sheriff's Department did publish a response to the State Audit entitled "Progress Report: Update on State Jail Audit." In it, the Sheriff's Department indicated that it disagreed with the conclusions of the Audit in some respects but claimed to be attempting to implement the changes recommended within the original Audit.

85. In my opinion, the Sheriff's Department has failed to implement most of the changes mentioned in their Progress Report, and it has failed to address the many flaws in its healthcare delivery system that have been pointed out repeatedly in the last several years, by the NCCHC and Dr. Venters, in addition to the State Audit. As a result, people incarcerated in the Jail have died preventable deaths, and those still in the Jail are subjected to risk of serious harm from the denial of appropriate healthcare.

I. Inadequate Medical Care at the Jail Has Resulted in Preventable Deaths

86. It is my opinion, based on a reasonable degree of certainty, that inadequate medical care at the Jail has resulted in preventative deaths and will

continue to result in preventative deaths, in part because the Jail does not have adequate mortality and morbidity review procedures.

87. It is important here not to "miss the forest because of the trees." The conclusion of the initial State Audit was that the San Diego Jail has an excessively high death rate among its incarcerated population. In determining how the Sheriff's Department is doing in response to the State Audit report, we need to look at the incarcerated death rate since the Audit was released.

88. In fact, the death rate among people incarcerated at the San Diego jail has significantly *increased* since the time period discussed in the report. The State Audit reviewed statistics from 2006 to 2020 and determined the overall death rate at the Jail to be **2.39 deaths per 1,000 people**, with the rates in individual years ranging of a low of 1.57 in 2012 to a high of 3.0 in 2014. SD_174856. Since then, from January 2021 through December 2023, the Jail has reported 50 in-custody deaths.[16] The Jail reported an Average Daily Population ("ADP") of 3,984 during these three years, which calculates to a death rate of **4.18 deaths per 1,000 per year**. Broken down by year, the death rate was **4.5 deaths per 1,000 in 2021** (18 deaths, with ADP 3,987), **4.75 deaths per 1,000 in 2022** (19 deaths, with ADP 4,055), and **3.27 deaths per 1,000 in 2023** (13 deaths, with ADP 3,971).

89. In fact, all three years exceed not only the average for the years 2006 to 2020, but also exceed the death rate of the worst year, 2014, which was 3.0 deaths per 1,000 ADP.

90. Based on my review of documents, including but not limited to medical records and mortality reviews, my inspections of Jail facilities, and interviews with patients and providers, it is my opinion that the healthcare delivery system at the Jail harms many patients and places all incarcerated people at a substantial risk of serious harm. The Sheriff's Department clearly has not taken significant steps to

[16] The ADP and in-custody death numbers are pulled from: https://www.sdsheriff.gov/resources/transparency-reports.

reduce the death rate; the Jail death rates have gotten worse since the State Audit. The problems with the Jail's healthcare system have resulted in permanent harm to patients, including avoidable deaths.

91. The starting place in any attempt to reduce the Jail's astounding death rate would be an analysis of *every* death to see if certain patterns emerge that point to serious shortcomings in the Jail's healthcare system leading to excessive deaths so that appropriate reforms of the system can be undertaken. However, the Jail's mortality review process is so flawed that no such reforms are likely to be implemented. And, unsurprisingly given these failures, people have continued to die avoidable deaths in the San Diego County Jail.

A. The Jail's Flawed Mortality Review Process

92. All hospitals and most large medical practices have a mechanism for review of deaths of patients in their care, known as Mortality and Morbidity ("M&M") committees. M&M committees investigate deaths (mortality) and also investigate unexpected severe adverse events that do not lead to death but nevertheless cause unexpected harm, suffering, and/or permanent problems (morbidity).[17]

93. The goal of an M&M program is to identify medical errors that led to the adverse outcome, so that those errors can be avoided in the future. In any individual M&M review, the most important of these identified errors is termed the "root cause." The root cause can be either a human error, *e.g.*, when an individual physician or nurse makes a significant medical mistake, or a systemic problem, *e.g.*, technical problems in the medical record, lack of appropriate policies and procedures, etc. When human error is identified, an M&M committee can direct that medical professionals be trained and incompetent performers dismissed. When systemic issues are identified, an M&M committee can direct that policies and

[17] These unexpected negative outcomes are also sometimes termed "Sentinel Events."

procedures be updated and improved. The overall goal, of course, is to learn from past mistakes in order to prevent future bad patient outcomes.

94. M&M reviews typically occur in two stages. First, a standing committee of physicians, nurses, and administrators identifies and analyzes all deaths and adverse outcomes and prepares important cases, such as all unexpected deaths, for presentation. Second, a meeting occurs where the standing committee's findings are discussed *with the medical staff who were involved in care of the patient*. M&M reviews usually result in some type of action plan to improve patient care.

95. The NCCHC Technical Assistance Report, Venters Report, and State Audit each directed the Sheriff's Department to improve its M&M process. NCCHC emphasized that "[t]reating and general health staff *must* be informed of [mortality] review findings," which reportedly had not been occurring at the time of their investigation. DUNSMORE0260627. Dr. Venters directed that: "The review of sentinel events including deaths, injuries and self-harm is also an important best practice in reducing mortality and morbidity in jail settings, and these reviews and their corrective action plans can be included in the service-wide quality meetings." SD_215365. And, the State Audit concluded that the Sheriff's Department's "reviews of in-custody deaths have been insufficient and have not consistently led to significant corrective action." SD_174794.

96. When Dr. Montgomery was asked in his deposition: "So following an in-custody death there's still some type of review done by medical, nursing, and sworn. Is that accurate?" He answered "Yes." Montgomery I Tr. at 16:4-7. He clarified that he himself does the medical review, the Director of Nursing (Serina Rognlien-Hood at the time) does a separate nursing evaluation, and one of the jail Lieutenants does a review of the actions of sworn staff. *Id.* at 16:18-19:1. Per Dr. Montgomery, all of these are independent and uncoordinated. They also are informal, in that there is no written record that summarizes all of these reviews and

what conclusions were reached.

97. [redacted]

98. [redacted][18][redacted]

[redacted].

B. NaphCare's Flawed Mortality Review Process

99. Instead, the Sheriff's Department has contracted the main responsibility

[18] As discussed in more detail later in this Report, the term "medical practitioner" applies to doctors and nurse practitioners, but it does not include nurses, including Director of Nursing Ms. Rognlien-Hood who did attend this meeting.

for M&M reviews to NaphCare. NaphCare's contract requires NaphCare to conduct a "thorough clinical mortality review" for "[a]ll patient deaths," including "a review of the incident and preceding treatment, a root cause analysis, review of relevant procedures and documentation, pertinent service reports, and recommendations for corrective action." County Contract No. 566117, §§ 2.3.47.4, 2.3.47.5, 2.3.47.7. The contract also calls for NaphCare to establish the process for identifying Sentinel events and performing a Root Cause Analysis for Sentinel Events. *Id*., §§ 2.3.47.9, 2.3.47.10. "The goal for critical incident analysis is to solve problems before they escalate and prevent future problems through promotion of a risk avoidance attitude among the healthcare staff." *Id*., § 2.3.47.13.

100. On their face, this contract complies with the recommendations of the State Auditor, the NCCHC, and Dr. Venters. In addition, NaphCare has a policy, called A-09, Procedure in the Event of Patient Death. NAPHCARE000735 *et seq*.

101. However, it is my opinion that NaphCare does not fulfill those obligations in practice, based on my review of the NaphCare mortality reviews and minutes from the 2022 and 2023 M&M committee meetings.

102. For one thing, death summaries, by contract, are supposed to be compiled by "[t]he advanced clinical provider in the patient's overall treatment." County Contract No. 566117, § 2.3.47.12. However, the death summaries in the reviews I saw were prepared by CHP's medical director, Dr. Nas Rafi, and NaphCare's Health Services Administrator ("HSA"), Michael Farrier, neither of whom directly interacted with the majority of these patients. The cases are then reviewed by Dr. Elliott Wade, NaphCare's Regional Medical Director of the Western States. Dr. Wade is based in Las Vegas. Dr. Wade's review and recommendations are then sent to the NaphCare Clinical Mortality Review Committee.

103. The Clinical Mortality Reviews are held in Birmingham, Alabama by the NaphCare M&M Review Committee. No members of NaphCare M&M Review

Committee are from the San Diego Jail. The attendees instead are from NaphCare corporate. Dr. Freedland testified that he has never participated in the M&M reviews for the San Diego Jail, although he would be a logical choice to be on such a committee, as would the Sheriff's Department's Chief Medical Officer, Dr. Jon Montgomery. The CHP Medical Director of the Jail, Dr. Rafi, prepares death summaries but otherwise does not participate in death reviews. Freedland Tr. at 73.

104. As one example, the NaphCare M&M committee that convened in Birmingham, Alabama on October 16, 2023 consisted of the following NaphCare employees: Dr. Rita Armitage, Physician/Ophthalmologist; Crystal Alexander, Director of Utilization Management; Dr. Jeffery Alvarez, Chief Medical Officer; Justin Barkley, Chief Legal Officer; Hannah Burgess, Vice President of Psychiatric Services; Marsha Burgess, Senior Vice President, Clinical Operations; Brad Cain, CEO NCF, Inc.; Jane Dickerson, Director of Pharmacy – 3rd Party Operations; Dr. Emily Feely, Corporate Nephrologist; Darrelle Knight, Chief Pharmacist; Dr. Jerry McLane, Corporate Medical Director, Eastern States; Candice Sherman, Senior Corporate Counsel – Litigation; Dr. Amber Simpler, Executive Director of Behavioral Health Research; Hannah Stokes, Corporate Counsel; Seetal Tejura, General Counsel – Litigation; Dr. Stuart Tieszen, Chief Medical Officer, Behavioral Health; Dr. Elliot Wade, Corporate Medical Director, Western States; Honey Lee Walker, Legal Nurse; and Kayla Washington, Corporate Counsel – Operations. Based on my review of the documents, these attendees appear to be typical. No one from the Sheriff's Department or CHP attends.

105. Notably, at each of these Committee meetings, the committee reviews deaths from NaphCare contracts around the country. San Diego cases are a small fraction of those considered. For example, on October 16, 2023, twelve cases were discussed, only one was from San Diego. NAPHCARE041856-041859.

106. When a San Diego case is considered, the M&M Committee usually simply notes Dr. Wade's conclusions and does not review the death in detail. This

may be a time consideration since they are reviewing cases from all over the country. Occasionally, the committee will review a San Diego death in detail. In these cases, a detailed timeline of the patient's medical and psychiatric care is presented in a series of slides. Based on my review of the documents, I am not sure how these cases are chosen. Notably, the cases reviewed in detail do not necessarily include those in which Dr. Rafi or Dr. Wade made recommendations; some of the detailed reviews are for cases where Dr. Wade has concluded that "[n]o action recommended."

107. By far the most common conclusion from the NaphCare M&M committee on the San Diego deaths was "No action recommended." This happens even when Dr. Rafi has recommended something in her death summary. The NaphCare M&M committee routinely disregards Dr. Rafi's recommendations. In fact, based on my review of the documents, I am not sure they are aware of them.

108. The case of Keith Galenbach, who died in the Jail on September 28, 2023, is informative in this regard. Notably, the NaphCare M&M committee did not do a detailed review (of the type I described above) of Mr. Galenbach's death.

109. Dr. Nas Rafi and HSA Michael Farrier each prepared a death summary about Mr. Galenbach. Dr. Rafi concluded:

> A more thorough, comprehensive evaluation of the cause of syncope in the Emergency Department may have prevented the event. Syncope is an extremely high risk event for this patient given his age and multiple co-morbidities and he would have greatly benefited from an admission/more thorough work up to rule out intracranial or cardiac causes of syncope.

NAPHCARE041867. HSA Michael Farrier did a separate Death Summary the next day, including different pertinent details about the case than Dr. Rafi. Michael Farrier made no recommendations. NAPHCARE041862.

110. Yet, Dr. Wade, despite allegedly reviewing these summaries, recommended "no quality improvement measures." NAPHCARE041854. He apparently disagreed with Dr. Rafi's conclusions or, alternatively, did not read them.

111. The NaphCare M&M Committee reviewed the case on October 16, 2023. This was not one of the few cases presented in detail, meaning there was a single slide in the presentation for that date, with minimal information. The slide stated: "This event was reviewed by Dr. Elliot Wade, and no quality improvement measures are/were recommended." *Id.* Based on this presentation, it appears that Dr. Rafi's recommendations were also not seen by the NaphCare M&M Committee.

112. If Dr. Rafi's recommendations were seen, they were apparently disregarded, as the M&M Committee's conclusion does not reference them. Rather, the M&M committee's conclusion regarding the Galenbach case was: "Though not related to this patient's death, it has come to the committee's attention that specific policies on management of insulin pumps need to be established by San Diego County and communicated to STATCare, so they can be prepared to address patients with these medical devices."

113. Notably, I did not find any reference to updates in the NaphCare Policies and Procedures, the County Operations Manuals, any Medical Directive Bulletins, or any training for medical staff relating to insulin pumps. This may be because, when Dr. Wade recommends no further action, NaphCare does not share its conclusions about San Diego deaths with the Jail. This was admitted in deposition testimony by NaphCare's Chief Legal Officer Justin Barkley on March 20, 2024. Barkley Tr. at 29:24-30:6.

114. Nor does it appear that any of the internal analyses conducted by Sheriff's Department staff such as those done by Dr. Montgomery and Ms. Rognlien-Hood were communicated to the NaphCare M&M Committee.

115. While the M&M Committee meetings about deaths (mortality) at the San Diego County Jail are inadequate, it is worth noting that the morbidity analyses—*i.e.*, analyses of adverse outcomes or sentinel events—do not appear to be happening *at all*. I also saw no tracking of sentinel events in CQI reports.

116. Importantly, the only mention of M&M in the new contract that the

County negotiated with CHP occurs at section 7.5: "Contractor shall designate a Physician … to collaborate with the Sheriff's CMO, or Sheriff's designee, in the following areas: … 7.5.1.3. Morbidity and Mortality (M&M)." SD_1579723. In other words, the M&M review process will continue to be managed by NaphCare, as the "Sheriff's designee."

117. In summary, the Sheriff's Department—either on its own or through its contractor—is not performing M&M reviews in a manner that complies with the standard of care done in the community, or with the recommendations of the NCCHC, Dr. Venters, or the State Audit.

118. A proper M&M review at the Jail would have the following characteristics:

- The Sheriff's Department would track Deaths but would also track other serious medical bad outcomes (Sentinel Events) via the CQI program. This is not being done presently.
- Death summaries would be prepared within seven days by an "advanced clinical provider in the patient's overall treatment," as required in the NaphCare contract.
- Deaths and Sentinel morbidity events would be investigated by a multidisciplinary M&M committee based in San Diego and consisting of San Diego Jail practitioners, nurses and security staff. There would be no need for separate uncoordinated investigations.
- Sheriff's Department M&M Committee conclusions would be shared with medical staff involved in the care of the patient in question.
- Sheriff's Department M&M Committee would make and carry out recommendations for improvements in Jail Policies and Procedures.

C. Case Studies of Deaths at the Jail Demonstrate Substandard Care

119. The below section of this report presents several case studies that show both how the Sheriff's Department's medical failures led to avoidable patient deaths and how the Jail's inadequate mortality review process failed to make needed changes following those deaths.

120. I selected this particular subset of deaths to review because the NaphCare M&M Committee minutes for each of these cases reflect that a more

detailed review, *i.e.*, more than a single slide presentation, was conducted.[19] I also reviewed these cases to determine whether these deaths were preventable and, if so, what the root cause(s) of these deaths were. In this section, I compare my impressions of these deaths with the official reports from the NaphCare M&M Committee.

1. Patricia Adamson (23706155), Died May 3, 2023

(a) Events Preceding Death

121. Patricia Adamson was booked February 13, 2023 at the age of 63. She was placed in a sobering cell but was uncooperative. On February 15, 2023, she was noted to be vomiting dark brown emesis—the brown color is usually caused by blood. Dr. Ram appropriately sent her to the hospital, where she was admitted for two days. SD_705053.

122. At the hospital, she was confirmed to have hematemesis (vomiting blood) and anemia. Her initial Hemoglobin blood count was 15; the next day, it was 11.9, probably indicative of substantial blood loss. SD_356707. Hematemesis is most commonly caused by a bleeding duodenal ulcer (an erosion in the lining of the intestine just past the stomach). The normal course of action at this point would be to do an EGD,[20] also called an "endoscopy," which means using a scope to look into the stomach and duodenum and cauterizing the ulcer (if one is found) to prevent further bleeding. The gastroenterologist at the hospital did not want to do this, which I believe was a medical mistake. In my clinical experience as an emergency physician for 25 years, essentially all cases of hematemesis with substantial blood loss result in an EGD being performed. Instead, Ms. Adamson was sent back to the

[19] This report does not address deaths caused by homicide (*e.g.*, Raymond Vogelman), overdose/withdrawal (*e.g.*, Joshua Fosbinder, Lazaro Alvarez, William Schuck), or suicide (*e.g.*, Pedro Ornejas). I leave these deaths to Plaintiffs' other experts to address in their reports. However, I note that I have overseen the care of many patients with withdrawal in jails, and it is my opinion that no one should die of withdrawal.

[20] EGD stands for EsophagoGastoDuodenoscopy.

Jail with a prescription for Protonix, a medication to reduce stomach acid and help heal ulcers.

123. Once back at the Jail, Dr. Christensen reviewed the hospital records on February 20, 2023 but did not summarize them, did not see Ms. Adamson personally, and created no ongoing care plan including no plan for check-ups. SD_705067. NP Lacey Beaston did a brief summary of the hospital records in a chart note on February 23, 2023. She specifically noted the anemia and the hospital plan to transfuse Ms. Adamson if her hemoglobin fell too much. NP Beaston also noted the hospital discharge prescription of Protonix. However, NP Beaston made no other treatment plan for Ms. Adamson. She ordered no labs to check hemoglobin levels, and no scheduled check ups. SD_705124. Ms. Adamson was also diagnosed by Jail psychiatry as having schizoaffective disorder. SD_705005.

124. According to the Jail's records, Ms. Adamson repeatedly refused her Protonix and other medications and also refused to sign the refusal form at least sixty-nine (69) times. SD_705730–SD_705799. These refusals were only signed by security staff and were not witnessed by the nurse as required by the Sheriff's Department Medical Services Division Operations Manual ("MSD Operations Manual") or NaphCare's Policies and Procedures ("NaphCare P&P"). *See* MSD Operations Manual, No. D.1.1.B; *see also* NaphCare P&P, Nos. D.02.3 and 4 (NAPHCARE001141).

125. Ms. Adamson repeatedly requested a liquid diet because she stated that eating solid foods made her feel ill. SD_705205, 705403, 705476. She complained intermittently of abdominal pain. SD_705302, SD_705537. On April 4, 2023, Psychiatrist Lauren Anderson noted: "She endorses early satiety, bloating, and nausea. She states "I am trying to eat more of the solid foods but it is difficult." SD_705529. Dr. Anderson submitted a referral asking if a medical practitioner would see Ms. Adamson to "consider GI referral."

126. On April 12, 2023, in response to Dr. Anderson's request,

Ms. Adamson was seen by NP Teresa Hurley for "ongoing early satiety, bloating, and nausea when eating solid foods; consider GI referral." SD_705537. Ms. Adamson also told NP Hurley she had rectal bleeding which she assumed was from hemorrhoids. NP Hurley diagnosed constipation and abdominal bloating. NP Hurley did no examination, including no examination to confirm the presence of hemorrhoids and/or rectal bleeding. NP Hurley noted that Ms. Adamson had had a GI consult during her recent hospitalization, but not the fact that GI had declined to do an endoscopy nor that Ms. Adamson was anemic from blood loss at the time of discharge. NP Hurley did not order any labs and did not refer Ms. Adamson to a GI specialist. SD_705537.

127. Ms. Adamson continued to complain of abdominal symptoms. She was seen again by a Sonya Megert, NP, on April 29, 2023 for "ongoing early satiety, nausea, and bloating" that had been going on for "months." NP Megert saw Ms. Adamson for this complaint at her cell rather than in the medical area, checked no vital signs, did no abdominal examination, and ordered no labs or x-rays—despite the fact that this was an elderly woman who had been hospitalized for similar symptoms two months before. NP Megert instead ordered Fiberlax, having evidently made the diagnosis of constipation but not documenting any basis for this diagnosis. SD_705690.

128. On May 2, 2023, a "STATCare Progress Note" stated: "Pt. complained of vomiting since after breakfast. Requesting medication for vomiting." The STATCare practitioner performed "No clinical assessment … on this patient" but ordered the antinausea drug Zofran. SD_705692.

129. The next day, May 3, 2023, Doreen Marasigan RN asked for Ms. Adamson to be sent to medical "for report of vomiting." The RN was told that "[t]here is no deputy to assist me at this time." SD_705692.

130. About an hour later, psychiatrist Lauren Anderson found Ms. Adamson severely ill. Deputies took her to the shower, where she vomited blood and became

unresponsive. During resuscitation attempts, a "constant stream of coffee ground (bloody) emesis was coming from her mouth." Resuscitation attempts were unsuccessful, and Ms. Adamson died on May 3, 2023. SD_705692. I have not seen an autopsy report for Ms. Adamson.

(b) Jail's Analysis of This Death

131. Dr. Rafi noted in her death summary of this case: "A comprehensive evaluation by the hospital with a full treatment plan of this patient's presenting complaint of hematemesis, for which she was admitted, may have aided in treatment of her underlying disorder. She was discharged with a diagnosis of hematemesis, without an underlying cause, with a plan that there was no current indication for EGD (endoscopy) or no recommendation for repeat labs or GI follow-up as outpatient in a high risk 63-year old female with history of substance use disorder and psychiatric conditions." NAPHCARE041694. In other words, Dr. Rafi faulted the hospital for not doing the correct procedure, an endoscopy, and not preparing an appropriate after-care plan. I agree with this summary, as far as it goes. Of course, there was nothing stopping the medical staff at the Jail from ordering an outpatient endoscopy, appropriate follow up labs and other after-care plans themselves.

132. The NaphCare M&M presentation reported that Ms. Adamson had no interactions with medical from her discharge from the hospital on February 18, 2023 until April 29, 2023. NAPHCARE041667, pp 7-12. However, Ms. Adamson had several interactions in this time that were important, such as the visit with a Nurse Practitioner on April 13, 2023 with the specific question of whether a GI consult (for an endoscopy) should be ordered. Her repeated complaints of inability to eat solid foods, bloating, and abdominal pain should have triggered a more thorough work up especially considering the fact that Ms. Adamson was a frail elderly woman.

133. After reviewing this case, the NaphCare M&M Committee wrote "Quality Improvement Plan: Committee reviewed and found care and treatment to

[redacted]" NAPHCARE041678.

(c) My Analysis of This Death

134. I strongly disagree with the M&M Committee's assessment. I find Dr. Rafi's conclusion that the hospital did a poor job accurate; however, Dr. Rafi did not critique the performance of her own medical team after Ms. Adamson returned from the hospital.

135. I find numerous gross medical errors in the medical care provided to Ms. Adamson once she returned to the Jail. This was an elderly woman who had had a two-day stay at the hospital for vomiting blood along with documented anemia, indicating significant blood loss. Upon her return to the Jail, she should have been automatically seen face-to-face by a medical practitioner and had an ongoing care plan established. This did not happen.

136. While Dr. Rafi is correct that an endoscopy should have been conducted at the hospital, there was nothing preventing the Jail physicians from arranging an outpatient endoscopy upon Ms. Adamson's return to the Jail and creating a treatment plan with follow-up evaluations and labs, especially when she repeatedly complained of ongoing symptoms. The Jail medical staff should have (a) advocated on her behalf in the hospital to have the endoscopy done before she was discharged or (b) arranged the endoscopy and follow-up care plan themselves. They did neither. They should have scheduled medical wellness checks and done follow up labs. Moreover, both Dr. Rafi and the M&M committee did not express any concern over the fact that no ongoing treatment plan was created.

137. The nurse practitioner who saw Ms. Adamson on April 12, 2023, specifically to "consider GI referral" did no physical examination even though Ms. Adamson complained of rectal bleeding from hemorrhoids. Rectal bleeding can also be caused by a bleeding duodenal ulcer. Let's say that the NP had done a rectal exam and found no hemorrhoids but did find obvious rectal bleeding. Would that have been important information? Of course it would, which is why it is essential to

do a physical examination in such patients.

138. The NP also did not review the medical records from Ms. Adamson's recent hospitalization thoroughly enough to note that Ms. Adamson had had a significant documented blood loss. She ordered no blood test to determine if the anemia from blood loss was ongoing, especially in light of the fact that Ms. Adamson was complaining about bleeding from the rectum. The NP had been prompted to refer Ms. Adamson to a GI specialist for an endoscopy but declined to do so. This NP made several serious medical mistakes including not doing a physical examination, not reviewing medical records thoroughly, making diagnoses (constipation) without basis, and not realizing that Ms. Adamson should see a GI doctor for an endoscopy even when this was pointed out. In my opinion, this interaction violated the medical standard of care.

139. The nurse practitioner who visited Ms. Adamson at her cell on April 29, 2023 also violated the medical standard of care. This nurse practitioner did not take vital signs, performed no examination, and performed no diagnostic tests. The medical standard of care for an elderly woman, recently hospitalized for hematemesis and now with similar abdominal complaints, must include the taking of vital signs, an abdominal examination, and diagnostic studies, such as labs and imaging studies. The nurse practitioner did none of this and instead appeared to diagnose Ms. Adamson with constipation without documenting any basis for making this diagnosis.

140. When Ms. Adamson continued to complain of vomiting, STATCare ordered anti-nausea medications again without any examination or labs. All of this was poor medical care.

141. Finally, the registered nurse who wanted to see Ms. Adamson on May 3, 2023 was told "No" because of no deputy availability—in other words, security short-staffing negatively impacting medical care. These issues were ignored by CHP's Dr. Rafi and the NaphCare Corporate death review.

142. Ms. Adamson's death was, in my opinion, preventable. Had she received appropriate evaluation and care at the Jail, she more likely than not would have survived.

2. Raymond Dix (22737506), Died September 13, 2022

(a) Events Preceding Death

143. Raymond Dix was booked on September 6, 2022, at the age of 56. He had a medical history that included congestive heart failure, chronic atrial fibrillation, hypertension, COPD, and others. He was taking multiple medications for these conditions. He was sent to the hospital for a clearance prior to incarceration, but returned the same day.

144. On September 7, 2022, during his medical screening, Mr. Dix was noted by the nurse to have "profuse sweating." Mr. Dix asked to see a medical practitioner about his history of atrial fibrillation and what he felt were abnormal vital signs. He was not scheduled to see a practitioner. SD_002714.

145. On September 8, 2022, Katrina John, MD reviewed Mr. Dix's admission chest x-ray because it was abnormal, showing an enlarged heart. The physician noted that this was "consistent" with Mr. Dix's cardiac history and wrote: "Patient needs to see a medical provider if he is experiencing chest pain, dizziness, shortness of breath, altered mental status." The physician did not see Mr. Dix herself and did not note that Mr. Dix had already requested to see a practitioner. SD_002715.

146. On September 9, 2022, a nurse practitioner reviewed Mr. Dix's September 6, 2022 hospital record, but did not see Mr. Dix personally. SD_002715.

147. On September 10, 2022, a nurse practitioner went to Mr. Dix's cell. The totality of the physical exam was "Pt. seen moving arms and legs in bunk. Unlabored respiratory effort." The nurse practitioner did not check vital signs, and did no examination of Mr. Dix's lungs, heart, or anything else. Mr. Dix reportedly refused an examination, probably related to the fact that the security staff had to

wake him up for the nurse practitioner visit. SD_002715.

148. From September 7 through September 13, Mr. Dix reportedly refused some of his medications. SD_002841, SD_002840, SD_002842, SD_002844. These refusals, along with the refusal to sign the refusal form, were witnessed only by security staff, not nurses, and Mr. Dix received no counselling about these refusals of essential medications. *See* SD_002746-002761.[21]

149. On September 12, 2022, Mr. Dix complained of being dizzy and was seen in the medical clinic by a registered nurse. Mr. Dix thought that his dizziness was due to a low blood sugar, however, his blood sugar was normal at 127. He did have an abnormally low heart rate of 59, especially taking into consideration his history of atrial fibrillation, which typically causes rapid heart rate. The registered nurse did not call a medical provider about his symptoms despite the instructions of the medical doctor on September 8, 2022 that Mr. Dix was to see a medical provider if he reported dizziness. The nurse treated him by giving him a snack and some water and told him to keep drinking water. In other words, the registered nurse made a diagnosis that Mr. Dix's dizziness was due to dehydration or not eating and had nothing to do with his heart. SD_002716.

150. Five days later, on September 13, 2022, Mr. Dix was found down. Resuscitation was attempted but was unsuccessful. He was pronounced dead at the hospital. SD_002717. An autopsy determined that Mr. Dix had died of "Atherosclerotic and Hypertensive Cardiovascular Disease." SD_050219.

(b) Jail's Analysis of This Death

151. I have not seen the death summary prepared by Dr. Rafi. However, I reviewed a summary prepared by Dr. Montgomery. Dr. Montgomery noted that two of Mr. Dix's medications, Farxiga and Anoro Ellipta, had been determined to be

[21] I critique the Jail's approach to reported refusals in more detail later in this Report.

nonformulary by NaphCare and therefore not approved for his use.

Dr. Montgomery also noted that Mr. Dix had been identified as having alcohol abuse disorder but had never been monitored with alcohol withdrawal scoring or offered treatment for this. I agree with Dr. Montgomery that these both were serious problems with the care that Mr. Dix had received at the Jail. SD_055188.

152. As far as I can tell, Dr. Montgomery's observations were not shared with the NaphCare M&M Committee. After reviewing the case, the NaphCare M&M committee had no critique and no recommendations. NAPHCARE041499-041507.

(c) My Analysis of This Death

153. To my review, Mr. Dix's death was preventable. There are four glaring problems with the medical management that may have contributed to his death at the Jail.

154. First, two of Mr. Dix's medications were inappropriately discontinued at booking because they were non-formulary. Farxiga is a drug used to treat both Type 2 Diabetes and congestive heart failure. Anoro Ellipta contains two bronchodilators used to treat chronic lung disease (COPD). Requests for authorization of these non-formulary medications were sent in. *See* SD_055186. Mr. Dix received one dose of Farxiga seven days after he was booked; he never received the Anoro Ellipta prescription. In my opinion, not receiving those medications for six days may have contributed to his death on September 13, 2022. I also note that arbitrarily discontinuing those medications simply because they were non-formulary violated NaphCare's contractual obligations: "the formulary shall allow medical practitioners and psychiatrists to follow generally accepted clinical practice patterns in their medical management of incarcerated individual patients," and, "[c]ontractor typically approves non-formulary orders." Contract § 2.3.30.35, SD_125283.

155. Second, Mr. Dix was never examined by a Jail medical practitioner

during his incarceration even though he had a significant heart history, asked to see a doctor and had concerning symptoms. The visit by a nurse practitioner to his cell is problematic in several ways—including, but not limited to, her failure to take vital signs. In the end, no practitioner ever did a significant medical evaluation of Mr. Dix during his incarceration.

156. Third, Mr. Dix's multiple "refusals" of critical heart medications were not witnessed by an RN, and he was not counselled about his refusals of critical heart medications as required by MSD Operations Manual No. D.1.1.

157. Fourth, the registered nurse who evaluated Mr. Dix on September 12, 2022 acted as if they were a practitioner. But registered nurses have a different, more limited scope of practice than practitioners. The registered nurse did not fill out one of the Nursing Evaluation Protocol forms. And, in fact, there is no form for nurses to do an evaluation of "dizziness" in the setting of heart disease and dysrhythmias. Given his medical history and symptoms, Mr. Dix should have been seen urgently by a practitioner. He should have had a medical work up including an EKG and labs. If this could not be done at the jail due to understaffing, Mr. Dix should have been sent to the Emergency Room on September 12, 2022. Had this happened, more likely than not, Mr. Dix would have survived.

158. The NaphCare M&M committee apparently ignored each of these problems when they stated that they had no recommendations from this review.

3. Vianna Granillo (22728152), Died July 13, 2022

(a) Events Preceding Death

159. Vianna Granillo was booked on July 8, 2022, at the age of 25. At booking, she reported suffering from opioid use disorder and diabetes. She was started on opioid withdrawal three days after she was booked; in other words, she had untreated opioid withdrawal for three days. She was checked by a registered nurse on July 11, 2022 and reported to the registered nurse that she felt "like shit." "I've been here for days and I only got these meds (buprenorphine) now."

SD_003469. On July 12, 2022, she was found unresponsive. This was initially assumed to be due to opioid overdose, and she received nine doses of Narcan with no effect. CPR and bag ventilation with oxygen were started 12 minutes after she was found unresponsive and pulseless.

160. At the hospital, Ms. Granillo was found to have a large amount of air in her abdomen (pneumoperitoneum). SD_249171. She died shortly after arrival at the hospital.

161. An autopsy performed July 4, 2022 concluded that Ms. Granillo died of "septic shock, due to pneumoperitoneum with spillage of gastric/enteric contents due to perforated prepyloric ulcer." SD_061710.

162. Gastric (stomach) ulcers are caused by stomach acid and bacteria eating the lining of the stomach near where it connects to the intestines. Most patients with gastric ulcers have symptoms of "heartburn" and upper abdominal pain. Untreated gastric ulcers can sometimes erode through the entire thickness of the stomach and perforate into the abdominal cavity. This is a devastating complication because stomach acid, bacteria, and other bowel contents spill into the pristine environment of the abdominal cavity causing peritonitis (inflammation of the lining of the abdominal cavity). *Peritonitis is an intensely painful condition.* Over time, the peritonitis worsens, the gastrointestinal system stops functioning, and other organs, such as the kidneys, fail. Patients with bowel perforation and peritonitis typically have severe pain. Over time, as they get sicker, such patients can develop abdominal infections and, eventually, low blood pressure and septic shock.

163. There is always a period of time, usually days, between the rupture of the ulcer into the abdominal cavity and death, during which the patient experiences severe pain.

(b) The Jail's Analysis of This Death

164. In her death summary, Dr. Rafi was concerned with delay in beginning CPR and other resuscitation after Ms. Granillo was found unresponsive and

pulseless. SD_055302. Dr. Montgomery noted that Ms. Granillo already exhibited rigor mortis and livor mortis when found, indicating that she had been dead for some time before she was found. Dr. Montgomery also noted two errors in the resuscitation attempt: that no AED was used and that there was a delay in O2 delivery. *Id.*

165. I do not know if the NaphCare M&M committee saw either of those reports and recommendations. If they did, they discounted them. The NaphCare M&M Committee's only conclusion was "Dr. Wade will speak with DON regarding Narcan education." NAPHCARE041420. However, I do not see why nine (9) doses of Narcan was insufficient in Ms. Granillo's resuscitation attempt or how Narcan education would have saved Ms. Granillo.

(c) My Analysis of This Death

166. I have the following observations based on my review of this case. First, Dr. Rafi was right that waiting ten minutes to begin CPR and oxygen ventilations of a patient found down and pulseless is much too long. The M&M Committee did not mention this, despite the recommendation being in Dr. Rafi's death summary. As with Mr. Galenbach's death review, I am again forced to wonder whether Dr. Rafi's recommendations were reviewed by the committee at all.

167. Second, the NaphCare M&M Committee is supposed to reconsider death cases once the autopsy report is available if the autopsy sheds new light on the patient's death, such as in this case. *See* Barkley Tr. at 24:23-25. However, I have seen no record that the M&M committee reviewed Ms. Granillo's autopsy report.

168. Since a rupture of a gastric ulcer invariably causes intense pain and since there is a length of time, usually days, between the rupture and the development of infection, septic shock and death, it is likely that Ms. Granillo knew that something catastrophic had happened to her. Most likely, she would have attempted to notify staff of her distress. However, as discussed later in this Report, the emergency intercom buttons in the Jail frequently do not work.

4. Abdiel Sarabia (21118298), Died July 22, 2022

(a) Events Preceding Death

169. Mr. Sarabia was booked on May 24, 2021, at the age of 35. During booking, staff noted that he had hypertension and opioid use disorder. Lisinopril, a medication to treat hypertension, was prescribed for him the next day without any practitioner seeing him. He was not scheduled for blood pressure checks or hypertension chronic care visits.

170. On July 8, 2021, nurse practitioner Frederick Wycoco "cancelled" Mr. Sarabia's diagnosis of hypertension. "Reason: not on meds, BP normotensive," meaning his blood pressure was normal. SD_011457. However, Mr. Sarabia was taking lisinopril for blood pressure and continued to take it until he died. SD_011907. Also, Mr. Sarabia's blood pressure was not normal. His blood pressure was elevated at 141/84 on June 3, 2021, and it was elevated again at 153/77 on June 18, 2021. SD_011588; SD_011487.

171. On October 16, 2021, blood labs were drawn on Mr. Sarabia, which showed a markedly elevated level of triglycerides at 932 (normal is less than 150), elevated cholesterol test of non-HDL cholesterol at 157 (therapeutic goal of less than 100), and an elevated Thyroid Stimulating Hormone (TSH) indicating the possibility of hypothyroidism. Mr. Sarabia had other abnormal labs, too, such as elevated liver tests indicating liver damage. SD_011629.

172. No one reviewed these labs until a psychiatric Nurse Practitioner noted the elevated triglyceride and TSH levels *four months later* and notified the medical practitioners to look at the labs. SD_011546. At that point, Joseph Molina, MD, reviewed the labs on February 8, 2022 and ordered fenofibrate, a medication for high triglyceride levels. Dr. Molina did not address the abnormal thyroid test, although it was mentioned on the task list in TechCare. He did not address the other lipid abnormalities or elevated liver enzymes. He also did not see Mr. Sarabia in person. SD_011551. In fact, no Jail medical practitioner ever saw Mr. Sarabia to

discuss any of this.

173. Mr. Sarabia's medical records document at least forty eight (48) refusals of prescribed medications over the course of his incarceration. None of his refusals (or his refusals to sign the refusal form) were witnessed by a nurse. *See* SD_011655-011703. I see no evidence that he was counselled about these refusals in accordance with the MSD Operations Manual or NaphCare P&P. *See* MSD Operations Manual No. D.1.1.B; *see also* NaphCare P&P Nos. D.02.3 and 4, NAPHCARE001152.

174. On May 20, 2022, Mr. Sarabia was seen by a registered nurse due to the complaint of "hard time breathing." His shortness of breath was so intense that he used another person's albuterol inhaler despite not having a history of asthma. Vital signs at this visit included an abnormally high blood pressure of 157/104 and an abnormal heart rate of 125. SD_011583.

175. The same day, he was seen by nurse practitioner Frederick Wycoco. NP Wycoco did not repeat Mr. Sarabia's vital signs. NP Wycoco did an EKG that he interpreted as "sinus tachycardia." (I cannot find this EKG in the records). NP Wycoco noted "Elevated BP without diagnosis of HTN" (hypertension), despite the fact that the diagnosis of hypertension was in Mr. Sarabia's history. NP Wycoco attributed Mr. Sarabia's elevated BP and heart rate to "Likely albuterol induced." In other words, NP Wycoco thought these symptoms were caused by the fact that Mr. Sarabia had used someone else's inhaler. NP Wycoco diagnosed a muscle strain and muscle spasm and prescribed Flexeril and "Deep breathing exercises." SD_011584.

176. On May 21, 2022, Mr. Sarabia was seen at his cell by Joseph Molina, MD to reassess "HR elevated during (last) assessment." Dr. Molina did not repeat any vital signs, including the heart rate. He did no examination. SD_011585.

177. Mr. Sarabia was not seen again by any other medical personnel before his death.

178. On July 22, 2022, Mr. Sarabia was found unresponsive, not breathing and without a pulse. His arms were "rigid and fixed," indicating that he had rigor mortis and so had been dead for some time. NAPHCARE041401.

179. An autopsy concluded that Mr. Sarabia died of "Hypertensive Cardiovascular disease" and that a contributing factor was "hypothyroidism." SD_001362.

(b) The Jail's Analysis of This Death

180. The NaphCare M&M committee reviewed this case on August 15, 2022. The only action that they initiated was "Dr. Wade will speak with site regarding need to have refusals signed by patients." Otherwise, they found no fault with the care provided to Mr. Sarabia.

(c) My Analysis of This Death

181. I disagree. I believe that this was a potentially preventable death. Potential contributing "root causes" include the following:

- Mr. Sarabia had hypertension. It was uncontrolled by 5mg of Lisinopril once a day. This is a tiny dose; the typical minimal dose given to an adult hypertensive patient is at least 10 mg a day. Nevertheless, this dose failed to control his blood pressure as evidenced by high blood pressure readings on many occasions and especially on May 20, 2022.
- NP Wycoco discontinued Mr. Sarabia's diagnosis of hypertension even though he had multiple high blood pressure readings and was on a blood pressure medication. That led NP Wycoco ten months later to write that Mr. Sarabia had a high blood pressure without a diagnosis of hypertension—not true.
- Mr. Sarabia's medical record contains forty-eight refusal forms, all of which say that Mr. Sarabia not only refused his medication but also refused to sign the refusal form. None of these was witnessed by a nurse. I question whether this is credible. Did Mr. Sarabia really refuse all of these medications when offered? Did he really refuse to sign the form when offered the opportunity to do so? Or was something else going on here? Nobody from medical ever took the time to ask why he was refusing medications (if this was even true) or to counsel Mr. Sarabia that his medications were important.
- The medical staff failed to confirm that Mr. Sarabia's elevated blood pressure and heart rate on May 20, 2022 ever improved back to normal. I suspect that they did not.

- NP Wycoco wrote that taking albuterol (an inhaler) caused Mr. Sarabia's high blood pressure and heart rate. In my experience as an emergency physician, this is extremely unlikely.
- NP Wycoco and Dr. Molina failed consider that Mr. Sarabia's chest pain and shortness of breath while exercising on May 20, 2022 might well have been anginal-type heart pain. Had they considered this, they would likely have done a work up consisting of an EKG and repeat vital signs and observation or simply have sent Mr. Sarabia to the emergency room.
- The opportunity to diagnose and treat Mr. Sarabia's hypothyroidism—which the autopsy determined to be a contributing factor in his death—presented itself on October 16, 2021 in the form of an abnormal thyroid test. It was never investigated or treated either then or four months later when a psychiatric nurse practitioner alerted the medical staff of their oversight. The abnormal blood test was simply ignored.
- A very high "non-HP lipid" level was evident in Mr. Sarabia's October 16, 2021 labs. High lipid levels such as these increase the risk of cardiovascular disease. The lab form itself indicated the need to treat this abnormality. Mr. Sarabia should have been treated with a statin lipid lowering medication that would have reduced his risk for atherosclerotic heart disease. However, like the abnormal thyroid test, this abnormal lab test was ignored, and the opportunity to treat Mr. Sarabia with a statin drug was lost.

182. Most people who have a cardiac event like the one that killed Mr. Sarabia have severe crushing chest pain and shortness of breath for minutes or even hours before they succumb. It is likely that Mr. Sarabia knew that he was having a medical crisis before he died but likely had no way to alert security or medical staff of this emergency because the emergency intercom buttons in the cells do not work. I note that he was not found after his death until lividity had set in—a process that usually takes hours, indicating that no one checked on him for a prolonged period of time.

183. In my opinion, more likely than not, had Mr. Sarabia received appropriate medical care while he was incarcerated in the Jail, he would not have died on July 22, 2022.

5. Aaron Bonin (22736636), Died November 1, 2022

(a) Events Preceding Death

184. Aaron Bonin was booked on September 1, 2022, at the age of 43. After

booking, he was immediately admitted to the medical observation unit for multiple medical and psychiatric problems, most notably end stage renal failure requiring dialysis. He was also taking medications to treat HIV infection.

185. Mr. Bonin reportedly refused to take his many medications on at least 21 occasions (see, for example, the Medication Administration Record for Darunavir, an anti-HIV drug). He also reportedly always refused to sign the refusal form. No nurse ever witnessed these refusals. SD_002267-002287, SD_002293. Per the MSD Operations Manual No. D.1.1, he should have been counselled for these refusals of essential medications. However, I see no indication that these counselling sessions occurred.

186. On October 20, 2022, Mr. Bonin was found to have a critically high potassium level (hyperkalemia). SD_002075, SD_002237-39. This is important because potassium is a critical element in heart function. High potassium levels can cause the heart to suddenly stop beating effectively (called fibrillation) which leads to death. Mr. Bonin's potassium level was rechecked the following day, when it was even higher; so high, in fact, as to be immediately life threatening. *Id.* This was noted by a medical doctor, who discussed the need for immediate full dialysis to reduce the potassium to a normal level with the dialysis nurse. However, the dialysis nurse discontinued dialysis early: "Pt strongly insisted to stop the treatment." SD_002504. From that moment until his cardiac arrest two days later, Mr. Bonin was not seen by a practitioner or any other medical staff member to ask why he was refusing full dialysis and discuss why that dialysis session was particularly important. SD_002075-76. His potassium level was never rechecked after the aborted dialysis. Mr. Bonin had a cardiac arrest on October 24, 2022, determined at the hospital to be due to very high potassium levels. He died one week later, on November 1, 2022.

187. Mr. Bonin's autopsy report concluded that Mr. Bonin had died of "End stage renal disease" and "Hypertensive and atherosclerotic cardiovascular disease."

However, the immediate cause of the initial cardiac arrest was clearly hyperkalemia, as was evidenced by the EMT records and the emergency department resuscitation. This fact was not mentioned in the autopsy. SD_055144.

(b) The Jail's Analysis of This Death

188. Dr. Montgomery's evaluation noted the concern with Mr. Bonin's dangerously high potassium levels on October 20 and October 21, 2022 and the abnormally short dialysis on October 22, 2022. SD_055139-055141.
Dr. Montgomery also noted that the hospital had diagnosed the cause of Mr. Bonin's cardiac arrest as being hyperkalemia. Dr. Montgomery was also concerned about Mr. Bonin's multiple refusals of dialysis. SD_055143. I have not seen the review completed by Dr. Rafi or the NaphCare Health Services Administrator Mr. Farrier.

189. Mr. Bonin's death was reviewed at the NaphCare Mortality and Morbidity Committee meeting on November 21, 2022. NaphCare 041596. The only Quality Improvement Plan offered by the M&M committee was "Dr. Wade, Darrell Knight, and Felicia Self are working with site regarding backup pharmacy education." NAPHCARE041630. I do not see why back up pharmacy issues would be considered important in Mr. Bonin's death.

(c) My Analysis of This Death

190. In my opinion, this was a preventable death.

191. Mr. Bonin experienced the initial cardiac arrest due to hyperkalemia (high potassium levels). Hyperkalemia is a condition that all dialysis patients are at risk to develop. The treatment for life-threatening hyperkalemia in someone with kidney failure is immediate dialysis. However, Mr. Bonin's dialysis was discontinued early, and his potassium level was not checked again until after his cardiac arrest.

192. The root causes of Mr. Bonin's preventable death included:

- Mr. Bonin's medical record contains at least twenty-one (21) refusal forms, all of which say that Mr. Bonin refused his medications and also refused to sign the refusal form. None of these was witnessed by a

nurse. I question whether this is credible. Did Mr. Bonin really refuse all of these medications when offered? Did he really refuse to sign the form when offered the opportunity to do so? Or was something else going on here? Nobody from medical ever took the time to ask Mr. Bonin why he was refusing or to counsel Mr. Bonin that his medications were important.

- Dr. Montgomery noted several refusals of dialysis that were not appropriately documented in the medical record.
- Lack of adherence to the policy of a face-to-face interaction with a practitioner following a refusal of a critical medical therapy. The dialysis on October 21, 2022 was such a critical therapy because Mr. Bonin's Potassium level was so high. Mr. Bonin may not have understood how important that particular dialysis was. Had that counselling session occurred, Mr. Bonin more likely than not would have survived.
- Lack of communication between medical professionals. Since the dialysis nurse knew that that dialysis was critical due to Mr. Bonin's dangerously high potassium level, when the dialysis was terminated early, the nurse should have communicated that fact to the physician. Had that been done, Mr. Bonin likely would have survived.
- A repeat potassium level should have been done either the same day or the day after the aborted dialysis to determine what Mr. Bonin's potassium level was. That potassium level should have been obtained even if Mr. Bonin had had a complete dialysis but especially more so after an aborted dialysis.
- Had that level been drawn, Mr. Bonin likely would not have died.

6. Roselee Bartolacci (23713442), Died May 29, 2023

(a) Events Preceding Death

193. Ms. Bartolacci was booked April 6, 2023, at the age of 32. At admission, she weighed 250 pounds. SD_711592. Ms. Bartolacci had severe mental illness that resulted in a lack of self-care, as described on April 11, 2023 by this psychiatric admission note: "she is seen in her cell, which is dirty and littered with trash. Shaking while sitting naked on the cell floor, sucking on her finger. Her clothes are scattered on the floor and appear to be covered in her feces." This is corroborated by several nursing notes describing her appalling lack of self-care. One example: Registered Nurse Dennis DelRio documented on April 14, 2023 "Dried feces on her body and face. Blankets are soaked with urine." SD_711687.

194. Ms. Bartolacci's main medical problem was that she ate and drank very

little. She also was noted on several occasions to be vomiting. *See, e.g.*, SD_711704. Dr. David Christensen prescribed the anti-nausea medication Zofran for her on April 14, 2023 without seeing her. SD_711698.

195. NP Teresa Hurley went to Ms. Bartolacci's cell on April 15, 2023 and noted her to be "naked/dirty" and actively vomiting. SD_711703.

196. Ms. Bartolacci reportedly "refused" a medical doctor evaluation from Dr. Connie Orem on April 18, 2023 at her cell. Dr. Orem noted that she had done only a "[l]imited exam due to evaluation from cell door per request of deputy for personal safety." SD_711732. No vital signs were done. Notably, multiple notes in Ms. Bartolacci's records from this time period state that "she is ***not*** physically aggressive." SD_711778; *see also* SD_711715 ("verbally aggressive but not physically aggressive towards staff"). I therefore do not understand why Dr. Orem could not enter Ms. Bartolacci's cell "for personal safety" reasons.

197.

198. On April 26, 2023, the psychiatrist noted that "Pt has been lethargic, laying on the floor of cell with minimal po (oral) intake," *i.e.*, she had little intake of food or water. The psychiatrist (*not the medical staff*) initiated a transfer to the hospital, where Ms. Bartolacci was diagnosed with acute renal failure with tubular necrosis (which is caused by severe dehydration), severe protein calorie malnutrition, sepsis, and cardiac rhythm problems, among others. Importantly, at the hospital, Ms. Bartolacci weighed 217 pounds, SD_712599, representing a weight loss of 33 pounds in 20 days. Ms. Bartolacci was very sick; sick enough to require a two week stay at the hospital to recover.

199. Ms. Bartolacci returned to the Jail on May 10, 2023. NP Lacey Beaston reviewed her hospital records the day before. NP Beaston noted that Ms. Bartolacci had been anemic at the hospital and recommended "repeat labs to ensure (hemoglobin) levels are not dropping." SD_711873. However, repeat labs were never drawn at the Jail

200. One day after she returned from the hospital, Ms. Bartolacci was noticed again to be vomiting and not eating. Dr. Christensen ordered the anti-nausea medicine Zofran. SD_711886.

201. On May 11, 2023, a registered nurse "noted bilateral hand/feet swelling. Reported this to nurse practitioner Hurley." SD_711887. I do not see any indication that a practitioner ever addressed this concern.

202. On May 18, 2023, Ms. Bartolacci was seen by Dr. Orem, who noted "poor po intake, concern for dehydration renal failure, electrolyte abnormality." SD_711906. Dr. Orem sent Ms. Bartolacci back to the emergency room due to concerns about "possible hydration and nutrition." "Pt has not ate or drank fluids for the past 48 hours. Refusing all care. Has a foul smelling urine that is dark brown." SD_299696.

203. The ER doctor noted that Ms. Bartolacci was "covered in urine and feces" SD_595490. CT scan and labs were normal. Ms. Bartolacci was not weighed at the emergency room. Because her labs at that time were normal, she was discharged from the hospital back to the Jail the same day, May 18, 2023.

204. On May 24, 2023, a progress note from Dr. Christensen stated "Given my inability to examine the patient, obtain vital signs or follow reliable I/O [intake out], I am unable to assess her hydration status. If patient is 5150 and unable to refuse care, then obtaining (labs) would be helpful." "I will order above labs. It will be incumbent upon the psychiatry team to determine if UOF [use of force] is indicated to obtain them." SD_711982. I see no evidence that the mandate for the psychiatry team to determine whether a use of force should be initiated for the purpose of obtaining labs was ever communicated to the psychiatry team.

205. On May 24, 2023, Ms. Bartolacci was "force medicated" and "required use of force by tac team." SD_711988; *see also* SD_711983. This would have been a great time to draw the labs that Dr. Christensen wanted, but no labs were drawn, probably because the psychiatry team had never been told of Dr. Christensen's

order.

206. On May 25, 2023, a dietician recommended weighing Ms. Bartolacci, stating, "IP has no current weight since bk weight. Please consider weight check." SD_711989. This recommendation was ignored. No attempt was made to weigh Ms. Bartolacci. SD_711988.

207. On May 29, 2023, Ms. Bartolacci was found unresponsive and without a pulse. CPR and other resuscitation efforts failed, and she was declared dead.[22]

(b) The Jail's Analysis of This Death

208. On May 30, 2023, Dr. Rafi prepared a death summary but made no recommendations. NAPHCARE041734. However, Dr. Rafi did not mention the fact that Ms. Bartolacci had been hospitalized for ten days one month before she died, which, to my mind, was critically important information.

209. NaphCare's Health Services Administrator Mr. Ferrier also prepared a death summary in which he noted "patient had history of sparse food and liquid

[22] An autopsy was done on Ms. Bartolacci by Debra Berry, MD on May 30, 2023. Her death was determined to be "Complications of dilated cardiomyopathy" with the contributing factor of "obesity." The diagnosis of dilated cardiomyopathy was based on "Dilatation of the right (5.6 cm) and left (5.5 cm) ventricles of the heart." The term "obesity" was based on a weight at death of 210 pounds. This is a troubling autopsy result for a couple of reasons.

First, when Ms. Bartolacci was hospitalized one month before her death, she had a cardiac work up including an echocardiogram done on May 1, 2023. The echocardiogram showed no dilated cardiomyopathy. Specifically, the echocardiogram report states "The left ventricle is normal size" and "The right ventricle is normal size." SD_595140. The cardiologist who reviewed this noted "The echocardiogram is reassuring. SD_595140. If Ms. Bartolacci did not have dilated cardiomyopathy on May 1, 2023, but died of it on May 29, 2023, how did she develop this lethal medical problem in four weeks? I suspect that Dr. Berry did not know that Ms. Bartolacci had been hospitalized for two weeks within a month of dying or that she had had a cardiac work up at that time.

Second, Dr. Berry did not note in her autopsy report that Ms. Bartolacci had weighed 250 pounds when she was booked on April 6th. She therefore had a documented weight loss of 40 pounds in less than two months. Could that have contributed to her death? Dr. Berry does not say, probably because she did not know about the profound weight loss.

In my opinion, the autopsy result does not excuse the medical management errors made by the Jail medical team, as I describe here.

intake and medication refusals." Mr. Ferrier also made no recommendations. NAPHCARE041728.

210. The NaphCare M&M committee reviewed this case in detail on June 19, 2023. NAPHCARE041703. I do not know if they saw either death review; if they did, they did not mention it. The only recommendation of the NaphCare M&M Committee was Quality Improvement Plan: "Seetal Tejura, Dr. Wade, and Dr. Kelly to participate in a meeting with HSA & possibly San Diego County corrections regarding documentation and monitoring of patients receiving [redacted] injections." NAPHCARE041718.

211. Although documentation and monitoring of patients receiving [redacted] injections is important, I do not see how this was a Root Cause or even an important factor in Ms. Bartolacci's death.

(c) My Analysis of This Death

212. In my opinion, Ms. Bartolacci's death was preventable. In fact, I find Ms. Bartolacci's case to be is a particularly egregious case of medical neglect. All the elements of collective neglect and inaction are present.

213. First, the failure to track her weight. No one noted that Ms. Bartolacci had lost 33 pounds between the time she was admitted to the jail and when she was admitted to the hospital 20 days later. She was never weighed again at the Jail after returning from the hospital on May 10, 2023, despite the recommendation of the dietician that she be weighed. Had this been done, Ms. Bartolacci's ongoing starvation may have been noticed. If it had been and a corrective care plan incorporated into her overall treatment plan, Ms. Bartolacci may have survived.

214. Second, the lack of communication between the medical and mental health teams. Caring for complex patients with both psychiatric and medical problems is difficult and requires communication, usually at a weekly case conference to discuss the difficult patient and create a comprehensive care plan. This was never done for Ms. Bartolacci. As an important example, Dr. Christensen

never communicated with the attending psychiatrist on May 24, 2023 that he needed lab work to be drawn to evaluate Ms. Bartolacci's medical status. I note that the hospital ERs never had any difficulty drawing any needed labs or obtaining needed imaging studies like a head CT. Likely, no psychiatrist ever read Dr. Christensen's note that "It will be incumbent upon the psychiatry team to determine if UOF is indicated to obtain" labs. Had that note been read or if Dr. Christensen had called the psychiatrist to discuss the case and need for labs, those labs would have been drawn, abnormalities noted, and Ms. Bartolacci may have survived.

215. Third, the failure to advise or intervene following refusals of necessary care. To refuse necessary medical care, patients must be cognitively able to understand why the medical test was ordered, and what the potential risks are of not having that test. In my opinion, Ms. Bartolacci was clearly unable to meet this cognitive hurdle. I again note that the emergency room personnel did not have any problems obtaining necessary diagnostic labs.

216. Fourth, the failure to examine the patient. During Ms. Bartolacci's entire stay, no medical practitioner ever examined her. Medications like Zofran were prescribed for her without any examination. This violated the medical standard of care.

217. Fifth, the lack follow-through. For example, on May 10, 2023, NP Beaston recommended "repeat labs to ensure (hemoglobin) levels are not dropping." This was never done. On May 11, 2023, a registered nurse "noted bilateral hand/feet swelling." Bilateral hand and feel swelling can be an important finding and a "red flag" of a serious underlying hydration or electrolyte problem. However, although the abnormal swelling was reported to a Nurse Practitioner, no practitioner ever examined Ms. Bartolacci or even addressed this finding in any way.

218. Overall, the medical staff documented her medical decline and death without significantly intervening—with the exceptions of sending Ms. Bartolacci to the hospital in April and on May 18, 2024. In my opinion, this was death by

medical neglect.

219. Ms. Bartolacci's death is particularly disturbing in light of the similarities to the death of another patient, Lonnie Rupard, who died at the San Diego Central Jail on March 17, 2022. *See* SD_025987-026008. Mr. Rupard was a 46-year-old male, booked at the San Diego Central Jail on December 19, 2021. During intake, his weight was 165 pounds. His initial psychiatry sick call evaluation progress note reported that he had a history of unspecified Schizophrenia and other psychotic disorders. Mr. Rupard's weight at autopsy was 105 pounds and the forensic pathologist described him as "cachectic," meaning affected by extreme weight loss and muscle wasting. This indicates that Mr. Rupard had lost 60 pounds from the time of arrest until his death three months later. The medical examiner's report also documents that malnutrition and dehydration in the setting of neglected Schizophrenia as contributing factors in Mr. Rupard's death. Despite Mr. Rupard's mental health problems, he was permitted to remain in his cell without any medical intervention while he lost 60 pounds between the time of his arrest and date of death. It is unclear if medical/mental health staff even observed that he was losing weight between December 19, 2021, and their last progress/sick call note on February 22, 2022. According to medical records, Mr. Rupard was not seen by medical/mental health staff between February 23, 2022, and his date of death, March 17, 2022. In the autopsy report the medical examiner wrote, "Ultimately this decedent was dependent upon others for the care; therefore, the manner of death is classified as homicide."

220. Mr. Rupard's case is clearly very similar to Ms. Bartolacci's case. Yet the Jail apparently learned no lessons from Mr. Rupard's case—as they allowed another patient, Ms. Bartolacci, to die under similar circumstances.

7. Erica Wahlberg (22726497), Died July 2, 2022

(a) Events Preceding Death

221. Erica Wahlberg was booked into the Jail on June 27, 2022, at around

3:00 p.m., at the age of 41. Ms. Wahlberg had a past history of uncontrolled hypertension, known from previous Jail stays.

222. At her Medical Clearance, Ms. Wahlberg was found to have a blood pressure of 169/119. Her urine drug screen was positive for fentanyl, methamphetamine, and MDMA (Ecstasy). SD_014720. MSD Operations Manual No. E.2.1 ("Receiving Screening") states that an "Elevated diastolic blood pressure of (equal or greater than) 120" will result in a gate refusal, which means the person must be sent to the emergency room without being admitted into the Jail. Ms. Wahlberg's diastolic blood pressure was recorded at 119, just one point under the cut-off for a gate refusal. SD_014683. In other words, had Ms. Wahlberg's blood pressure been one point higher, she would have been sent immediately to the emergency room.

223. Later the same day, Ms. Wahlberg was seen by a registered nurse whose evaluation "noted elevated blood pressure but asymptomatic, also with multiple positive drug test results." This RN did not remeasure Ms. Wahlberg's blood pressure, though this is standard in any medical setting to see how the blood pressure is trending over time. SD_014704.

224. Just over an hour after she was booked, a STATCare nurse practitioner ordered five days' worth of blood pressure checks and "Clonidine 0.1mg po BID." Clonidine is a medication used in this circumstance to treat high blood pressure. SD_014707. Ms. Wahlberg reportedly refused to take any of her evening medications, including clonidine, when they were offered to her at 8:26 p.m. SD_014708. The refusal form leaves blank the reason for the refusal. SD_014740.

225. On June 28, 2022 at 12:32 a.m., Ms. Wahlberg's blood pressure was 164/107. A STATCare Corporate physician's assistant ordered Buprenorphine but no other treatment for hypertension and did not address high blood pressure. SD_014708.

226. On June 28, 2022 about 2:15 a.m., Ms. Wahlberg's blood pressure was

higher at 174/121, and she was noted to be "sweating, drowsy but arousable." She was given buprenorphine and clonidine. The nurse did not contact a practitioner. SD_014710.

227. Later that day, Ms. Wahlberg's blood pressure was higher still at 171/136 (SD_014714), and it was noted that "the patient has further decompensated with altered mental status." A STATCare nurse practitioner authorized a transfer to the emergency room at around 3:55 a.m. SD_014712.

228. At the hospital, Ms. Wahlberg was noted to be "significantly hypertensive" and had admitted methamphetamine use. She was treated with Ativan and a labetalol drip for her hypertension (Labetalol given by intravenous drip is a medication used to treat blood pressures so high as to constitute a medical emergency). SD_014751. At around 5:35 a.m., Ms. Wahlberg went into cardiac arrest. SD_014753. She was transferred to the ICU. Despite efforts at treatment in the ICU, she deteriorated over several days and was declared dead on July 2, 2022.

229. On June 30, 2022, Dr. Christensen reviewed Ms. Wahlberg's blood pressure readings: "BP reviewed. Essential HTN. Lisinopril ordered." However, at that time, Ms. Wahlberg was dying in the ICU. SD_014713.

230. Ms. Wahlberg's autopsy report listed the cause of death as "Acute Fentanyl … and methamphetamine intoxication." SD_050229.

(b) The Jail's Analysis of This Death

231. Dr. Rafi made no pertinent recommendations in her Death Review. NAPHCARE041358.

232. The NaphCare M&M Committee reviewed Ms. Wahlberg's case on July 18, 2022. They also had no recommendations.

(c) My Analysis of This Death

233. In my opinion, Ms. Wahlberg's death was preventable. Several mistakes in medical management were made. These mistakes should have been identified by the M&M Review process and acted on to ensure that they would not

be repeated in the future.

234. First, Ms. Wahlberg should have been sent to the ER at 2:15 a.m., when her blood pressure was 174/121, and she was "sweating" with an altered mental status. This blood pressure and presentation at booking (less than 12 hours previously) should have resulted in a Gate Refusal. However, the nurse did not contact a practitioner at that time or at 2:15 a.m. This was a medical mistake. Since time is important in resuscitating patients like Ms. Wahlberg, it is possible that she may have survived had she been sent to the Emergency Room at 2:15 a.m. rather than approximately two hours later.

235. Second, Ms. Wahlberg's very high blood pressure readings were medically mismanaged. Ms. Wahlberg had a very high blood pressure at booking and throughout her time at the Jail. The therapy prescribed for this, clonidine 0.1mg po BID was clearly ineffective in lowering her blood pressure. This is not surprising since clonidine is a poor blood pressure medication. The hypertension guidelines of the America Heart Association do not recommend clonidine as a first line option for treating hypertension or even a second line option. It is a "last line" agent. *See* Guideline-Driven Management of Hypertension, An Evidence-Based Update. American Heart Association, p. 44. There are several reasons that clonidine is a poor choice for blood pressure management, but one especially important reason in the case of Ms. Wahlberg is that clonidine has a short half life. If used as a blood pressure medication, it needs to be given four times a day. Giving it twice a day results in its effects wearing off at around four to six hours—resulting in rebound hypertension for the next six hours until it is given again. First line medications for high blood pressures are (1) Calcium channel blockers like amlodipine, (2) ACE inhibitors/ARBs like lisinopril or losartan , and (3) Thiazide diuretics like Hydrochlorothiazide (HCTZ). With especially high blood pressures like Ms. Wahlberg's, proper medical therapy would be to begin two of these three, such as lisinopril and HCTZ, which are conveniently packaged together in a single

pill that is on the NaphCare formulary. NAPHCARE037056.

236. Third, no medical practitioner ever examined Ms. Wahlberg at the Jail face-to-face. She was clearly very sick, barely missing the criteria for a Gate Refusal by 1 point (her diastolic blood pressure was 119, where 120 would have mandated a gate refusal). There was a practitioner on-site at that time (3:00 p.m.). That practitioner should have seen Ms. Wahlberg. However, the Jail's practice is to rely on remote STATCare practitioners rather than those practitioners who are on site. As discussed later in this Report, I believe that the Jail over-relies on STATCare to the detriment of some patients, like Ms. Wahlberg.

237. Finally, Dr. Christensen reviewed Ms. Wahlberg's blood pressures and ordered lisinopril for her on June 30, 2022. However, Ms. Wahlberg had been hospitalized for two days at that point. This points to communication problems within the electronic medical records, TechCare. How is it that Dr. Christensen was not automatically notified that Ms. Wahlberg was in the hospital? This was not a factor in her death, but it did point to a weakness in the electronic medical record that could have been identified by the M&M Committee and potentially fixed.

D. Repeated Root Causes of Death in These Case Studies

238. I identified several root causes that appear again and again in these seven cases. These include:

a. Patients who were clearly ill were not ever examined by a medical practitioner during their stay at the Jail.

b. Practitioners do medical evaluations at the patient's housing cell instead of seeing the patient in the medical clinic. As a result, the practitioners do inadequate evaluations.

c. Practitioners order medications and diagnose medical conditions without seeing or examining the patient.

d. Reported refusals are a big problem in the Jail that leads to inadequate medical care. Nurses do not witness refusals when the patients allegedly

refuse to sign the refusal form. They rely on security staff, in violation of Sheriff's Department Policies and Procedures. Medical staff accept refusals from patients who are not competent to refuse necessary medical care and do not follow the Jail's own policies and procedures regarding counselling patients who refuse necessary medical care.

e. Communication errors have resulted in unnecessary medical deterioration of patients. This includes communication errors between nurses and practitioners, between practitioners and other practitioners, between medical and mental health staff, between medical staff and security staff.

f. When patients go to the hospital and return, the Jail medical staff do not adequately review the hospital records, and do not create a care plan for the returning patient based on the hospital findings and recommendations.

239. Notably, many of these observations are not new. For example, the Jail's problem of inappropriately documenting refusals has been noted by multiple experts and entities in reports since 2017. However, the Jail still has not fixed this problem, nor do they even appear to register it as a root cause of these deaths. As a result of the Jail's persistent failures to address these known problems, preventable deaths continue to occur.

E. Additional Deaths in the Jail

240. In addition to the deaths I studied and described above, I am aware of a number of deaths at the Jail reported in the press and to the Citizens Law Enforcement Review Board.[23]

a. In March 2023, **Hayden Schuck**, age 22, died in Central Jail approximately five days after his booking. Although his blood pressure and pulse rate were abnormally high at intake, Mr. Schuck was placed in a temporary holding cell for nearly five days without medical attention. He was removed for his

[23] These summaries are based on the news articles cited herein, not on my own analysis of the medical records.

arraignment, during which Mr. Schuck was unable to confirm his name or date of birth and fell to the floor multiple times. Nevertheless, upon return to the jail, he was placed in a single occupancy cell and found unresponsive the following morning. Mr. Schuck's family has filed a lawsuit.[24]

b. In February 2023, **Gilbert Gil** died in a holding cell at Vista Detention Facility within 20 hours of intake. Mr. Gil was arrested on suspicion of being under the influence. His family says early on-set dementia and diabetes caused his erratic behavior. At intake, Mr. Gil was unable to sign paperwork. His blood sugar was found to very high. He was given insulin and placed in a holding cell because the sobering cell was occupied. No one checked on him in the fourteen hours between when he was given the insulin and when he was found unresponsive in his cell. His daughters filed a wrongful death lawsuit in May 2023.[25]

c. In April 2022, **Jarrell Lacy** died in Central Jail. Mr. Lacy was suffering shortness of breath in his cell for 30 to 45 minutes before deputies responded. A nurse was in the process of alerting medical staff of the need for an emergency room transport, but Lacy was instead returned to his cell via wheelchair and found unresponsive minutes later.[26]

d. In July 2021, **Saxon Rodriguez**, age 22, died at Central Jail four

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[24] Kelly Davis, *What happened before Hayden Schuck, 22, died in San Diego jail? Family's lawsuit says warning signs were missed*, SAN DIEGO UNION-TRIBUNE, May 4, 2023. https://www.sandiegouniontribune.com/news/watchdog/story/2023-05-04/hayden-schuck-death-lawsuit-jail.

[25] Kelly Davis, *Despite known medical problems, 67-year-old was ignored for hours before he died in Vista jail, lawsuit argues*, SAN DIEGO UNION-TRIBUNE, May 19, 2023. https://www.sandiegouniontribune.com/news/watchdog/story/2023-05-19/despite-known-medical-problems-67-year-old-was-ignored-for-hours-before-he-died-in-vista-jail-lawsuit-argues.

[26] Jeff McDonald, *Minutes before dying in jail, man was sent back to cell instead of ER, independent probe finds*, SAN DIEGO UNION-TRIBUNE, October 17, 2023. https://www.sandiegouniontribune.com/2023/10/17/minutes-before-dying-in-jail-man-was-sent-back-to-cell-instead-of-er-independent-probe-finds/#:~:text=Minutes%20before%20dying%20in%20jail,jail%20in%20Downtown%20San%20Diego.&text=Minutes%20before%20Jerrell%20Dwayne%20Lacy,the%20results%20of%20his%20electrocardiogram.

days after his arrest. The CLERB report concluded "there is no doubt that Rodriguez, while as an incarcerated person in the custody and under the care of the Sheriff's Department, acquired and took fentanyl and methamphetamine, which resulted in his death." One to two hours elapsed between when deputies last saw Mr. Rodriguez alive and when he has found unresponsive in his bunk. According to the autopsy report, medical staff believed there was a chance he could have been revived.[27]

e. In January 2021, **Omar Moreno Arroyo** died at Central Jail hours after his arrest. During booking, Arroyo underwent a body scan to determine if he had ingested anything improper. The results of the scan appeared to show an anomaly, but the deputy did not appear to review the results, nor did he order a secondary scan. Had the material been identified as an illicit substance, Arroyo would have been placed under closer observation. Instead, Arroyo was placed in a cell where more than an hour elapsed between when he collapsed and when deputies found him. The autopsy revealed he died from an airway obstruction with acute methamphetamine intoxication as a contributing factor. His family filed a wrongful death lawsuit.[28]

f. In February 2019, 32-year-old **Michael Wilson** died in the custody of the San Diego Sheriff's Department. Despite the Sheriff's Department's undisputed awareness of his medical condition, and Mr. Wilson's need for four necessary heart medications, Mr. Wilson died of congestive heart failure after Jail staff failed to administer the required medications to Mr. Wilson. *See Estate of*

[27] Kelly Davis, *Oversight Board Blames Overdose Death on Sheriff's Department Failure to Keep Drugs out of Jails*, SAN DIEGO UNION-TRIBUNE, Dec. 15, 2022. https://www.sandiegouniontribune.com/news/watchdog/story/2022-12-15/saxon-rodriguez-jail-death-drugs-clerb.

[28] Kelly Davis and Jeff McDonald, *Four sheriff's deputies faulted in San Diego County jail death*, SAN DIEGO UNION-TRIBUNE, March 8, 2022. https://www.sandiegouniontribune.com/news/watchdog/story/2022-03-08/four-sheriffs-deputies-faulted-in-san-diego-county-jail-death-l.

Michael Wilson v. County of San Diego, S.D. Cal. No. 3:20-cv-00457-RBGM-DEB.

g. In November 2019, **Elisa Serna** died at Las Colinas Detention Facility. Upon booking, Ms. Serna reported that she was addicted to heroin and alcohol and that she had used drugs two hours prior. Initially, despite vomiting for multiple consecutive days, Ms. Serna was not placed on withdrawal protocol. Four days after booking, she was transferred to a medical observation bed and given medication for her withdrawal. Two jail personnel watched as she suffered a seizure, struck her head and fell unconscious onto the floor of her cell. They left the cell without providing any medical treatment. Ms. Serna died shortly thereafter.

h. Ms. Serna's death was the subject of two unsuccessful criminal prosecutions. Her family's wrongful death lawsuit resulted in the largest wrongful death settlement ever approved by the San Diego County Board of Supervisors, $15 million, plus promises by the County to change the way it addresses withdrawal.[29]

241. Multiple other lawsuits are still pending against the Jail seeking damages for deliberate indifference, including by the families of Roselee Bartolacci, Brandon Yates, Michael Wilson, and Lonnie Rupard.[30]

242. As these individual deaths illustrate, despite being the subject of scrutiny for several years, the Jail's system for the delivery of medical care is still broken.

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[29] *See* Jeff McDonald, *San Diego County settles Elisa Serna jail death lawsuit for $15 million, and limited federal oversight*, SAN DIEGO UNION-TRIBUNE, July 2, 2024 https://www.sandiegouniontribune.com/2024/07/01/san-diego-county-settles-elisa-serna-jail-death-lawsuit-for-15-million-and-limited-federal-oversight/.

[30] Jeff McDonald, *After record $15 million settlement, San Diego County still confronts a slew of other jail-death lawsuits*, SAN DIEGO UNION-TRIBUNE, July 7, 2024 https://www.sandiegouniontribune.com/2024/07/07/after-record-15-million-settlement-san-diego-county-still-confronts-a-slew-of-other-jail-death-lawsuits/.

II. The Sheriff's Department's Inadequate Screening and Intake Process Fails to Identify and Treat Medical Care Problems of Newly Arriving Incarcerated People, Placing Them at Substantial Risk of Significant Harm

243. It is my opinion that the Sheriff's Department fails to timely and adequately identify and treat the medical issues of newly arriving incarcerated people during the screening and intake process, and it fails to adequately train or supervise intake staff to do the same.

244. The accepted *minimum* standard for the evaluation of the health needs of newly booked incarcerated people is laid out in the NCCHC's *Standards for Health Services in Jails*.

245. These standards require first: a medical evaluation of patients at booking to establish whether they are medically able to be incarcerated and what urgent health care needs they have. Second, a more thorough Health Assessment should be done within 14 days of incarceration at the latest.

246. It is worth emphasizing that these are minimal standards designed for small jails that do not have medical personnel on site 24/7. Large jails that have medical personnel onsite 24/7 should aspire to do more than the minimal standards designed for small jails. In particular, it is my opinion that waiting 14 days to do a health assessment is not appropriate and constitutes substandard care in a jail with medical staff onsite 24/7.

247. Unfortunately, the San Diego Jail has consistently failed to comply with even the bare minimal requirements of the Standard of Care.

248. There are three sets of policies and procedures for intake screening and health assessments in the Jail: the MSD Operations Manual on "Receiving Screening" (No. E.2.1); the Sheriff's Department Detention Services Bureau policies and procedures on "Receiving Screening" (DSB P&P M.9); and NaphCare's policies and procedures on "Receiving Screening" and an "Initial

Health Assessment." NaphCare P&P E-02, E-04.[31]

249. The NaphCare Contract has similar provisions. Section 2.3.2.1 of that contract states: "This Health Assessment will typically be completed during the intake process for each patient and will always be completed within 14 days." But based on my chart review, as discussed below, the Health Assessment is never completed during the intake process and is regularly not completed within 14 days around of the time. Section 2.3.2.4 of the contract refers to some patients having a Health Assessment completed by a medical practitioner. This does not ever happen per my review. The NaphCare contract, section 2.3.1.1, also states: "Patients with chronic illnesses will be identified during the Receiving Screening and enrolled in a chronic care clinic." This rarely happens based on my review of charts.

250. As explained above, the fact that different policies and procedures apply to different Jail staff, and that there is confusion as to whether or how these policies and procedures conflict, contributes to significant dysfunction in the Jail's health care system. For example, the Detention Services Bureau policy states that "[c]ertain types of medications" that someone has with them at the time of their arrest "may be allowed into the detention facility with prior approval from health staff." DUNSMORE0039683. However, the Medical Services Division policy does not provide *any* indication that medications in the arrestee's possession might be allowed into the facility, or what standards healthcare staff should apply when deciding whether to approve a medication; the policy states only: "An inventory of the individual's prescription medication (if any) will be completed by the RN and stored in the individual's property." MSD Operations Manual No. E.2.1, November 4, 2022, SD_027121. Similarly, although the NaphCare policy requires that a patient's receiving screening include "[o]bservation of … lesions, jaundice, rashes,

[31] Some versions of NaphCare's "Health Care Policy & Procedure Manual," including the version as of August 30, 2023, omit Policy E-02 ("Receiving Screening").

infestations, bruises, scars, tattoos, and needle marks or other indications of drug abuse," NaphCare P&P E-02, February 23, 2022, NAPHCARE001178, the Medical Services Division policy requires "observation and a physical assessment" only "if necessary." MSD Operations Manual No. E.2.1, Section II.B, May 11, 2022, SD_367461.

251. The documents I reviewed show that the medical intake process at the Jail in practice can be divided into four parts. Three of the four have a corresponding form in TechCare consisting mainly of check boxes. I found problems with the Sheriff's Department's practices at each step of the process.

A. Step One: Medical Clearance

252. The first part of the intake process is "medical clearance," in which an RN evaluates the incoming arrestee to see if they are medically able to be admitted to the jail. The Sheriff's Department Operations Manual Medical Services Division defines "Medical Clearance" as "a documented clinical assessment of medical, dental, and mental status before an individual is admitted into the facility." MSD Operations Manual, No. E.2.1, November 4, 2022, SD_000343. The Operations Manual lists several conditions and findings (such as abnormal vital signs) that must be sent to the hospital emergency department before further evaluation is done. SD_000344. This process is guided by the short "medical clearance" form in TechCare that the RN on duty fills out. NaphCare P&P, A-08, May 29, 2023, NAPHCARE000715. In that form, the RN must measure vital signs and ask about specific incidents which would trigger a need for an ER visit prior to incarceration. If the RN determines that the patient must go to the hospital ER first for an urgent evaluation of a medical condition, this is called a "gate refusal."

253. The RN also has the option of referring the patient directly to a sobering cell or to the Inmate Safety Program ("ISP") before the patient proceeds to a receiving screening. While there are written guidelines in the MSD Operations Manual and the NaphCare policies and procedures about when to issue a "gate

refusal," I have seen no specific policies and procedures about the criteria that must be met for a patient to skip the receiving screen and go directly to a sobering cell or ISP. This, evidently, is left to the discretion of nursing.

B. Step Two: Receiving Screening

254. If the patient passes the medical clearance, the same RN who did the medical clearance performs a "receiving screening." The receiving screening consists of more questions about the patient's medical history, mental health history, and medications. The patient's answers are documented by checking boxes on the "receiving screening" form in the electronic medical record. The receiving screening does not entail any significant physical examination. At the end of the receiving screen, the RN can refer the patient for a "second stage nursing evaluation," send the patient to a sobering cell, or "clear to classification." I have seen no specific policies and procedures about what triggers each of these outcomes; the decision appears to rely mostly on the RN's discretion.

255. The reliance on nursing discretion in the first two steps of the intake process is problematic. It is problematic because anything that is left solely to discretion without adequate training or guidance in written policy invariably leads different nurses to make different decisions. This in turn leads to patients who should receive the same care instead receiving different care depending on who happens to see them. It can harm patients when certain nurses exercise poor judgement, whether because they have not been adequately trained, have no guidance in written policy, or are just having a bad day. In addition, I have seen no mechanism set forth in policies and procedures to track the performance or decisions of nursing staff.

256. Further, the referral for a second stage nursing evaluation is made by simply checking a box on the "receiving screening" form. I saw nothing on the form requiring nurses to identify exactly why a second stage evaluation had been ordered, which will lead to a lack of sufficient documented information for nurses

conducting second stage evaluations. A haphazard system of communication like this can lead to confusion about why the patient needs to be seen, and so lead to poor medical care.

C. Step Three: Second Stage Nursing Evaluation

257. After the receiving screen, some patients go through the "second stage nursing evaluation." This typically is conducted by a different RN than the one who completed the medical clearance and receiving screen, and who is supposed to have more time to ask follow up questions about positive answers to the receiving screening, such as details about medications and medical problems. The second stage nurse *may* conduct a physical examination, but is not required that they do so. The second stage nurses do not consistently document why a patient is referred for a second stage evaluation, nor is there a TechCare form for RNs to complete at this stage. Rather, the nurse completing the second stage evaluation documents the evaluation in a SOAP note.

258. The "Second Stage Nursing Evaluation" is not mentioned by name in the Sheriff's Department Operations Manual, but may be referenced in E.2.1.V NURSE ASSESSMENT PROTOCOL. MSD Operations Manual, No. E.2.1, Section V, November 4, 2022, SD_000348. However, the Nurse Assessment Protocol requires that the nurse "[p]erform a focused physical assessment based on the individual's clinical presentation," and this happens rarely in Second Stage Nursing Evaluations.

259. For example, my review of the records showed that RN Maria Tamayo did the Receiving Screening on patient [redacted] on [redacted] 2023. San Diego County Sheriff's Department, Receiving Screening, [redacted] 2023, SD_747298. RN Tamayo referred Mr. [redacted] for a Second Stage Nursing Evaluation, but there is no indication of why this referral was made. *Id.* SD_747321. Whatever the reason was, the Second Stage Nursing Evaluation did not occur because it was "cancelled due to earlier scheduled appointment." *Id.*

260. The second stage nurse is also responsible for communicating with a practitioner to get medications approved. This is exclusively done electronically via STATCare using remote practitioners elsewhere in the country. If contacted, the remote STATCare practitioner fills out a "STATCare Intake Assessment and Orders" form. This form has dropdown menus with checkboxes for orders for various conditions. At the end of the second stage evaluation, medical patients are sent to a sobering cell or other housing. At this point, the nurse may schedule the patient on for a future evaluation by a practitioner (*e.g.*, a doctor, nurse practitioner or physician assistant), or not, at the nurse's discretion.

D. Step Four: 14-Day Health Assessment

261. The fourth stage of the intake process is the "health assessment." This evaluation is also done by an RN. The minimal standard of care under the NCCHC standards requires that the Health Assessment be done within 14 days *at the latest*. However, that 14-day grace period is meant for small jails without 24/7 medical personnel. In my opinion, jails with 24/7 availability of medical personnel should not delay the full Health Assessment for 14 days.

262. The NCCHC Technical Assistance Report recommended that the Jail take either a "full population assessment" approach, which requires a health assessment within 14 days, or an "individual population assessment" approach, which requires a health assessment within two days of the initial booking. NCCHC Technical Assistance Report, DUNSMORE0260637-0638. Dr. Homer Venters acknowledged that these two approaches were available, but noted that "jail systems that take a public health approach" conduct an assessment "routine[ly] for every newly admitted patient at the time of intake." Venters Report, SD_214372. He further explained that "wait[ing] up to 14 days" for this full assessment "generally results in at least half of all people admitted to the jail leaving without this encounter." SD_215361. I agree that performing an individual health assessment for every incarcerated person as part of the initial booking would be a far superior

process to ensure adequate care for incarcerated people, who, as a group, are more likely to have medical issues that require provider intervention than the general population.

263. When I was a jail medical director, we conducted the health assessment as soon as possible, usually within one to three days in the larger facilities and within seven days in the small facilities.

264. Other jails comparable in size to the San Diego Jail do the health assessment at booking. One example is the Salt Lake County jail in Salt Lake City, Utah.

265. However, the Sheriff's Department has chosen not to take the "public health approach" outlined by Dr. Venters and instead to defer a full health assessments for 14 days. This is not a best medical practice. I cannot imagine a reasonable medical basis for the Sheriff's Department's decision to wait for 14 days (or longer) before doing a health assessment. In my opinion, that decision more likely than not was not made for cost-saving reasons.

266. Unfortunately, the Sheriff's Department has failed to adequately meet even this minimal 14-day standard. The NCCHC Technical Assistance Report emphasized the importance of the timeliness of a full health assessment, stating that it "will typically be completed during the intake process and will *always* be completed within 14 days." This sentence is repeated verbatim in the County's contract with NaphCare, NAPHCARE000567, and Dr. Montgomery confirmed it is a "great standard" that "provides great care for [] patients." Montgomery II Tr. at 146:2-3.

267. The Sheriff's Department has failed to implement this standard properly. Although it is the Jail's "goal" to try to complete the health assessment within 14 days of booking, this is not set forth in any written policies and procedures. Montgomery II Tr. at 145:15-146:9; Rognlien-Hood Tr. at 26:12-28:21. Further, health care staff frequently fail to perform a health assessment within 14

days after a patient is booked in the Jail, and, of course, many patients are released before they receive a full health assessment. Ms. Rognlien-Hood testified that when she became the Director of Nursing, she made it a priority to try to get the health assessments done within 14 days. This emphasis began, per her testimony, in March of 2023. Rognlien-Hood Tr. at 27:4-8 Dr. Montgomery confirmed that it "remains to be seen" how frequently the Sheriff's Department is able to timely complete the health assessments. Montgomery II Tr. at 146:4-9. Ms. Rognlien-Hood and Dr. Montgomery could not provide clear estimates of how frequently the health assessments in fact are completed within 14 days, but suggested the compliance rate could be as low as 75 – 80 percent. (Rognlien-Hood Tr. at 100:4-10; Montgomery II Tr. at 146:10-25).

268. This means many patients are being missed. My review showed cases where health assessments were completed after the 14-day mark, for example: [redacted] was booked [redacted] 2023, and staff did not complete her initial health assessment until [redacted] 2023. SD_781311. [redacted] was booked on [redacted] 2023, and staff did not complete his initial health assessment until [redacted] 2023. SD_759408. [redacted] was booked on [redacted] 2021, and staff did not complete his *initial* health assessment until [redacted] 2023, more than two years later. SD_776280.

269. As with many aspects of the deficient health care in the Jail, understaffing appears to be a significant reason for the failure to complete health assessments within fourteen days. Ms. Rognlien-Hood communicated to her supervisors on February 22, 2023 that "[m]eeting this standard [for 14-day health assessments] will … just take the manpower," including sworn staff "be[ing] efficient." Email from Serina Rognlien-Hood to Carl Darnell et al., February 22, 2023, SD_375921-23. The Jail has been developing a "workflow" to meet this standard since at least 2022 and still routinely fails to meet it. SD_375922.

270. There are several problems with this multi-step intake process. First,

even under the Sheriff's Department's "goal" program of completing a health assessment within 14-days—which is not currently happening—at no point is every incarcerated person examined by a practitioner as part of the intake process. Rather, at each step of the assessment described above, the examination is conducted by an RN. Almost all practitioner involvement in intake is done electronically through STATCare.

271. The NCCHC Technical Assistance Report recommended that nurses complete the initial Health Assessment on all patients "soon after booking" as part of the Second Stage Nursing evaluation. SD_060170-71. Dr. Venters similarly recommended that all patients with a significant medical history (in other words, all patients currently referred for a second stage evaluation) be seen in person by a medical practitioner. SD_215371-72. I agree with this recommendation, but that is not what the Jail does as a matter of policy or practice. According to the County's contract with NaphCare, patients are to be evaluated based on medical information obtained during the receiving screening as to the medical necessity of conducting a health assessment by a provider. Contract No. 566117, § 2.3.2.4, NAPHCARE000567-68. In the approximately 80 charts I reviewed, I did not see a single instance of a medical practitioner doing an in-person examination of a patient during intake. I also identified several patients who should have been seen face-to-face by a medical practitioner based on their medical problems and complaints, but were not seen. One example is Raymond Dix (22737506), who was admitted to the Jail on September 6, 2022. Mr. Dix had a medical history that included congestive heart failure, chronic atrial fibrillation, hypertension, COPD and others. He died in custody on September 13, 2022. He never had a full Health Assessment done. He was never examined by a medical practitioner. A second example is [redacted] ([redacted] who was booked on [redacted] 2023. Despite a history of type 2 diabetes and being inappropriately placed on insulin, Mr. [redacted] was never examined by a medical practitioner.

272. Rather, as explained, the only involvement of medical practitioners during the intake process in the vast majority of cases is electronic, relying on STATCare practitioners working elsewhere in the country. Experts from the NCCHC, Dr. Venters, and now I, agree that this intake system is sub-optimal.

273. Medical practitioners who actually see and talk to incoming patients with medical problems would be able to assess problems and prescribe appropriate treatment and formulate a treatment plan with a degree of competency and thoroughness that is lacking in the current system. Nurses do not have the training or expertise to provide comprehensive care in this context, and the STATCare practitioners elsewhere in the country cannot act with the required degree of competence since they never talk to their patients or examine them. They rely instead on drop-down menus in TechCare that often are not a good fit for the individual patient under consideration. It is no wonder that so many mistakes are made that would not be made if on-site practitioners talked to and personally examined their patients just as is done everywhere in medical practice outside of the Jail.

274. Second, although the second stage nurse evaluation is the *de facto* final step in the intake process (given that the 14-day health assessment is not occurring as planned, nor is it described in any policy), I did not identify anything in the Jail's policies and procedures setting forth how the second stage evaluations should be done. These are treated like a Nurse Sick Call clinic visit. But a second stage evaluation is not a nurse sick call clinic, nor do the nurses treat it as such. For example, they do not typically fill out a Standardized Nursing Procedure Form. Instead, the Second Stage Evaluation is an opportunity to take more time to delve more deeply into a patient's medical history, by doing a more detailed history and conducting a physical examination. The fact that a patient can go through this entire process and never have a physical examination done, no matter how significant their medical problems are, is a significant lapse. Dr. Venters gives an example of how a patient with asthma should have an examination of the lungs and a peak flow test

done as part of the booking process. SD_215361. This is not done now as part of the Jail booking process.

275. A Second Stage Nursing Evaluation should not be documented on a SOAP note. Many patients referred for a Second Stage Evaluation have multiple medical issues that need to be evaluated. A SOAP note is designed to document a response to one problem or complaint. The Second Stage Evaluation should be guided by both a formal Policy and Procedure in the Sheriff's Department's MSD Operations Manual and a specific form that guides the evaluation process. Neither exist at present.

276. Third, in my review of presentations from CQI meetings, I did not identify any CQI data on Second Stage Evaluations. This suggests to me that there is no significant training for or supervision over this important process. Supervision is critical because Second Stage Evaluations, which are done on patients with significant health problems, are performed by nurses, not medical practitioners. Since the Sheriff's Department chose to ignore Dr. Venters' advice to have these patients seen face-to-face by a practitioner, practitioners should supervise the process and CQI should closely follow the functionality of the Second Stage program, but neither occurs now. It is important to note here that although STATCare practitioners sometimes participate in the Second Stage Evaluations, they do NOT supervise this process.

277. The failure to timely complete these initial health assessments poses a significant risk of harm to incarcerated individuals and falls below the standard of care. For example, the Sheriff's Department's substandard care at intake has resulted in deaths of incarcerated people and high costs for San Diego taxpayers. As just one example, in May 2024, the family of Ronnie Sandoval was awarded $1.8 million from a federal jury that faulted Sheriff's Department's nursing staff for failing to prevent Mr. Sandoval from a fatal overdose in February 2014. The jury found that Mr. Sandoval was sweating profusely through an hours long booking

process, but the Jail's nurses did not properly respond to his condition. Jeff McDonald, *Jury Awards $1.8 Million to Family of Man Who Died in San Diego County Jail 10 Years Ago*, SAN DIEGO UNION-TRIBUNE, May 3, 2024.

278. The practice of delaying a full Health Assessment to 14 days or longer carries with it substantial risks of harm to incarcerated patients. It is inevitable that the cursory history and minimal physical exam done at the Receiving Screening will miss substantial medical problems, both acute and chronic. Some patients are then referred for a Second Stage Evaluation, but this is unstandardized and sporadic. At its best, the Second Stage Evaluation will also miss or underestimate the presence of medical problems that a thorough Health Evaluation would find. Dr. Venters' description of how asthma should be handled during the booking process is a great example. SD_215361.

279. Medical problems missed by a substandard booking process and a delayed full health assessment will inevitably get worse and only be realized later when the patient's health deteriorates.

280. Delaying a complete health assessment for 14 days would never happen in any outside medical institution. Patients newly admitted to a hospital, a nursing home, or a psychiatric hospital do not have to wait 14 days (and longer) for a full health assessment. It is not hard to speculate on what would happen to their mortality and morbidity statistics if these institutions did delay a full health assessment for two weeks or longer!

281. The only advantage to delaying the full health assessment for 14 days is that the Sheriff's Department then must do fewer of them—*i.e.*, because "at least half of all people admitted to jail leav[e] without" an assessment since they are booked and released after fewer than 14 days—and therefore the Sheriff's Department saves the time and money required to do a Health Assessment on these patients. *See* Venters' Report, SD_215372. However, delaying the health assessments saves little time or manpower in reality because the Sheriff's

Department already does an abbreviated health evaluation during the receiving screen and the second stage evaluation. To add the few extra questions and exam required to complete a full health assessment would require less incremental resources than the Sheriff's Department now expends on tracking and transporting patients 14 days after intake, as well as the cost of "catching up" programs when the County falls behind, and patients are missed. There are also high medical costs of missing potential diagnoses and treatments of short-term detainees.

282. Moreover, many individuals return to the Jail repeatedly. From a medical perspective, not doing a full health assessment on individuals incarcerated for even short periods of time is a missed opportunity to find and treat medical problems before the patient returns to the Jail later with worse medical problems. In the long run, this missed opportunity will create more difficulty for the Sheriff's Department when they must play catch-up later. Even if not re-incarcerated, these individuals are members of the San Diego community and may place demands on community resources like emergency rooms and clinics if their health concerns are not addressed sooner rather than later.

283. In summary, the Sheriff's Department's does not currently have a functioning system that ensures all incarcerated people receive a health assessment within fourteen days. And, even if the medical intake system were functioning as the Sheriff's Department claims it should—*i.e.*, with an assessment conducted by an RN within fourteen days, that system would still fall below the standard of care and place incarcerated people at risk. The Sheriff's "goal" for the system is insufficient because the ideal time for an incoming patient to receive a full face-to-face medical assessment by nurses and medical practitioners is during the booking process, not later. The NCCHC Technical Report and Homer Venters both emphasized this.

284. This is important: In my opinion and based on a reasonable degree of certainty, if the Sheriff's Department instituted a health assessment at booking utilizing nurses and medical practitioners as the NCCHC and Dr. Venters

recommended, the mortality and morbidity at the Jail would decrease. The systemic inadequacy of health assessments is, in my opinion, one Root Cause of the Jail's high Mortality and Morbidity problem.

III. The Sheriff's Department Fails to Continue Medically Necessary Medications and Treatments for Incarcerated People Upon Their Arrival at the Jail or Transfer Between Jail Facilities, Placing Them at Substantial Risk of Serious Harm

285. "Continuity of medical care" means that an incarcerated patient's prescribed medications and treatments are continued without interruption at each stage of that person's incarceration. In particular, continuity of care requires that, when a patient is booked into the jail, the medications and treatments they had been receiving in the community should be continued.[32]

286. Continuity of prescribed medications can be of critical importance to a person's health. Missing doses of essential medications can harm fragile patients. As Dr. Venters stressed in his report, "[a]ccess to appropriate medications in a clinically appropriate timeframe" helps "reduc[e] mortality and morbidity in jail settings," and it is therefore a best practice to "provide several tools for ensuring continuity of medications in jail," "start[ing] with … health staff who screen patients before entry to the jail." SD_215374.

287. Plaintiffs have alleged in their Third Amended Complaint that the Sheriff's Department fails to provide continuity of medical care to people after they are booked into the Jail. Dkt. 231 ¶ 58. As explained in more detail below, I agree.

A. Continuing Medical Necessary Medications After Booking

288. The basic principle of continuity of prescribed medications is this: All medications that patients were receiving before their arrest and incarceration should be continued at a minimum until they are seen face-to-face by a medical

[32] These principles also apply when a patient returns from the hospital to the jail and when a patient is discharged from the jail, so that they can receive medication and therapy in the community. Those issues are discussed later in this Report.

practitioner. These medications "bridge" the gap between a patient's arrival and the first time they see a medical provider face-to-face and so are often called "bridge medications." Once a medical practitioner sees the patient face-to-face, the prescribed medications can be changed as per the practitioner's medical judgment. NaphCare's policy manual for San Diego acknowledges this principle: "Patients entering the facility on prescription medication continue to receive the medication in a timely fashion as prescribed, or acceptable alternative medications are provided as medically indicated unless contraindicated by their medical condition." NAPHCARE000843. But, as explained in more detail below, that does not appear to happen in practice.

289. The biggest problem many jails have during the process of continuing medications is verifying what are (and are not) current prescriptions, because they must contact outside pharmacies to request faxed copies of active prescriptions.

290. The Jail does not have this problem due to the availability of Surescripts. Nurses at the Jail can instantly verify current prescriptions within the state of California by accessing this database. The Jail also has the advantage of having an in-house pharmacy at its intake facilities so that most verified medications can be dispensed immediately.

291. In its contract with NaphCare, the Sheriff's Department laid out a standard for continuing medication of a newly booked incarcerated person: "Validated medications need to be restarted within 12 hours unless the use of specialized pharmacies is required. Any delay in starting medications should be due to the validation process, not identifying/routing the request to a provider." Contract No, 566117, § 2.3.30.8, SD_125280-125281. Since the Jail has Surescripts and an in-house pharmacy, the 12-hour standard is generous. For the vast majority of patients and medications, it should take less than 12 hours to access a currently prescribed medication list, send this list to the in-house pharmacy, and have the medications filled and dispensed.

292. In practice, based on my review of records, NaphCare mandates two additional steps between the verification of outside medications via Surescripts and the filling of those prescriptions by the in-house pharmacy: First, the prescriptions are sent to a STATCare practitioner for approval. Second, if the patient has been taking medications not on the NaphCare formulary, these must be approved via the NaphCare non-formulary process before they are filled.

293. These steps are not required by the NaphCare contract (which states only that this "validation" process must not delay the process of med continuity over 12 hours). *Id*. This extra step of requiring the review and approval of a STATCare practitioner and the non-formulary approval are also not mentioned in either the Sheriff's Department MSD Operations Manual or in NaphCare's Health Policies and Procedures for San Diego.

294. However, these steps can be a problem if used inappropriately to enforce the NaphCare formulary and therefore deny people needed medications that fall outside the formulary. A "formulary" is a list of medications that are preauthorized to be prescribed. Formulary medications tend to be inexpensive. "Non-formulary" medications require authorization before they can be prescribed. Non-formulary medications tend to be expensive. The process of seeking authorization for a non-formulary medication is similar to the Utilization Management process for seeking permission for an offsite consultation, discussed later in this Report. In order for a patient to receive a non-formulary medication, the prescribing practitioner, including STATCare practitioners, must fill out a non-formulary medication authorization form and send it in for approval or denial. The person who approves or denies authorization for non-formulary drugs can be a pharmacist, a physician, a midlevel practitioner, or even an RN. The practitioner asking for approval for a non-formulary drug typically does not know who is making the yes-or-no decision. The prescribing practitioner and the person approving or denying the request generally do not collaborate. Evidently, this

approval process for non-formulary medications is enforced even for medications the patient was taking prior to being booked. In my experience, the number one reason for a formulary in most medical systems is to save money. Non-formulary drugs are usually expensive drugs.

295. Even if non-formulary meds are eventually approved, the verification process can take days during which time the patients are not receiving these medications. This delay can and does harm patients.

296. The Sheriff's Department, through its contract with NaphCare, requires NaphCare to "maintain[] and enforc[e]" a drug formulary, which shall "allow[] medical practitioners and psychiatrists to follow generally accepted clinical practice patterns in their medical management of incarcerated individual patients." *Id.* at §§2.3.30.32, 2.3.30.35, SD_125283. The contract also requires that NaphCare "typically approve[] non-formulary orders." *Id.* at § 2.3.30.35, SD_125283. Finally, under the contract, "[r]ecords of non-formulary requests and responses shall be maintained," *id.* at § 2.3.30.34, SD_125283, and reported in "Standard Management Reports," *id.* at § 2.3.29.3, SD_125278.

297. While there are legitimate reasons to substitute less expensive drugs for more expensive drugs if the two drugs are therapeutically equivalent, jail drug formularies should not prohibit the use of any legitimate medication simply based on its cost. Miraculous new medications that represent a huge improvement in medical care are always expensive. A good example are the new antiviral agents used to treat hepatitis C. They are miraculous—curing hepatitis C in greater than 95% of patients with minimal side effects in just a few weeks. However, they are expensive. Antivirals used to treat Hepatitis C are not included in the NaphCare 2023 formulary. *See* NAPHCARE037047. Expense cannot be a reason to deny incarcerated patients medically indicated medications.

298. Documents I reviewed reveal that, in practice (and likely because of this formulary "extra step") the Sheriff's Department is not continuing incarcerated

people's medications in a timely manner and not continuing legitimately prescribed medications.

299. The Sheriff's Department knows this is a problem. In fact, the Sheriff's Department mentioned this very practice in the Corrective Action Notice ("CAN") sent to NaphCare, dated April 28, 2023, which stated that NaphCare had "failed to restart medications for patients reassigned from the California Department of State Hospitals." NAPHCARE034831. However, as of the December 8, 2023 CAN response, NaphCare had still not provided any specific information regarding medications for patients reassigned from the California Department of State Hospitals. SD_1572354. As of the March 4, 2024 CAN response, the most recent one I have seen, there is a general statement that "Naphcare has appeared to resolve pharmacy and discharge medication issues," but no details about the Department of State Hospitals patient issue. SD_1572610.

300. The documents I reviewed include examples of incarcerated patients who were harmed by the Jail's failure to continue their medications after booking. One example is Raymond Dix, who, as discussed in detail above, was booked on September 6, 2022 and died on September 13, 2022. Mr. Dix had a medical history that included congestive heart failure, chronic atrial fibrillation, hypertension, chronic lung disease (COPD), and others. SD_055186. Mr. Dix was taking multiple medications, and Surescripts confirmed that he was compliant in the community taking his medications. SD_055188. When the STATCare practitioner reviewed Mr. Dix's medication list, two were determined to be non-formulary and were not ordered: Farxiga and Anoro Ellipta. SD_055186. Farxiga is a drug used to treat both Type 2 Diabetes and congestive heart failure. Anoro Ellipta contains two bronchodilators used to treat COPD. Requests for authorization of these non-formulary medications were sent in. *Id.* Mr. Dix received one dose of Farxiga seven days after he was booked; he never received the Anoro Ellipta prescription during his incarceration. SD_002836-002838. An autopsy showed that Mr. Dix

died on September 13, 2022 of "[a]therosclerotic and hypertensive cardiovascular disease," SD_050219, also called a heart attack.

301. As explained above, not receiving those medications for six days may have contributed to Mr. Dix's death. I also note that arbitrarily discontinuing those medications simply because they were non-formulary violated NaphCare's contractual obligations: "the formulary shall allow medical practitioners and psychiatrists to follow generally accepted clinical practice patterns in their medical management of incarcerated individual patients," and "[c]ontractor typically approves non-formulary orders." Contract No. 566117, § 2.3.30.35, SD_125283.

302. Another patient who experienced this problem is [redacted] ([redacted]), who was booked on [redacted] 2023. Mr. [redacted] reported during his receiving screening that he was a diabetic. SD_791079. Surescripts showed an active prescription for Mounjaro, a medication used to treat Type 2 Diabetes. SD_791379. Nh Ngoc Da, Corp PA, did a remote STATCare review of a "Nurse Alert" which stated "Surescripts pt was taking Mounjaro (a GLP-1 diabetic medication) injections for DM, please advise." SD_791100. PA Ngoc Da responded: "[T]h[i]s med [i]s nonformu[l]ary. w[ill] order [i]nsu[li]n s[li]d[i]ng sca[l]e." *Id.* Insulin is not a direct substitute for Mounjaro. It is a totally different medication with a different mechanism of action and different indications for prescription. There is no indication that Mr. [redacted] had ever been on insulin before. *See id.* PA Ngoc Da ordered this without knowing a history or any labs, such as an A1C. *Id.* Nobody told Mr. [redacted] why his Mounjaro prescription had been discontinued or why insulin had been ordered. *See id.* According to a note from NP Chr[i]st[i]ne Su[lli]van on [redacted] 2023, Mr. [redacted] had been on Mounjaro weekly, but it was "NA [not available] wh[il]e [i]ncarcerated." SD_791102. He, rightly, complained. *E.g.*, SD_791631, SD_791635 (Sick Call Requests). On [redacted] 2023, as a result of his request to speak with a doctor about his diabetes, Mr. [redacted] was seen by Frederick Wycoco NP. SD_791116. NP Wycoco

wrote, "He [i]s ask[i]ng for mounjaro…. He sa[i]d he does not want [i]nsu[li]n …. W[ill] order g[li]p[i]z[i]de 5mg qd …. Mounjaro [i]s not formu[l]ary." *Id.* Glipizide is also a totally different medication with a different mechanism of action, different indications for prescription and also not appropriate as a direct substitution for Mounjaro. In my opinion, Mr. [redacted] case was mismanaged to the point of medical malpractice. I discuss Mr. [redacted] case and the standard of care of diabetes in more detail in another section of this report. Suffice it to say here that discontinuing a legitimate outside prescription without seeing the patient and without a medical indication violates continuity of care and is in violation of NaphCare's contract. Further, in my opinion, substituting sliding scale insulin for Mounjaro constituted medical malpractice.

303. Another example is [redacted] ([redacted]), a diabetic who had been prescribed the long-acting insulin Lantus before coming to jail. Ms. [redacted] was booked on [redacted]2024. On the day of her booking, 2024, a STATCare Intake Assessment and Orders form was completed for her by NP Juancho Trinidad. SD_790711. This form explicitly prohibits the continuation of long-acting insulins, such as Lantus, with the following language: "**All long-acting insulins will be substituted with Novolin N BID at an equivalent dose unless there is documented evidence that the patient cannot or should not be transitioned**." SD_790712 (emphasis in original). Accordingly, NP Trinidad discontinued Ms. [redacted] Lantus prescription and instead ordered short acting insulin dosed according to a sliding scale. *Id.* In my opinion, this mandate to substitute any long-acting insulin for Novolin N BID contravenes the term of NaphCare's contract, which states that NaphCare must "typically approve[] non-formulary orders." Contract No. 566117, § 2.3.30.35, SD_125283. NaphCare's contract also states that any substitution of a formulary medication for a non-formulary medication shall "follow generally accepted clinical practice patterns in their medical management of incarcerated individual patients." *Id.* The wholesale discontinuation of long-acting

insulins by substituting short acting insulin on a sliding scale is not a "generally accepted clinical practice pattern." *See Diabetes Management in Detention Facilities: A Statement of the American Diabetes Association*, 47 DIABETES CARE 544-555 (2024).

B. Continuing Medically Necessary Treatment After Booking

304. Besides medications, many newly booked patients have prescribed medical therapies and treatments scheduled in the community, which also should be honored during incarceration as part of continuity of care. Examples include dialysis, cancer chemotherapy, infusion therapy for autoimmune disease, previously scheduled surgeries (even if they are elective), physical and occupational therapy, and other previously scheduled follow-up appointments and consultations.

305. All of these medical obligations should be honored by the jail medical services. One of the duties of the RNs who do the receiving screening is to find out about these medical obligations. Patients who have pending medical appointments and therapies should then be quickly referred to a medical practitioner and to scheduling to arrange for patient transportation to these appointments. The care plan to continue these off-site obligations should also be discussed with the patient so she/he understands what is happening.

306. While I understand that there are security requirements surrounding these offsite visits, security concerns do not negate the Jail's obligations to continuity of medical care.

307. Unfortunately, this Jail abrogates its responsibility for this type of continuity of care.

308. As one example, retired FBI Agent [redacted] contacted the Sheriff's Department in [redacted] 2021 about his incarcerated son, [redacted], who "suffer[ed] from diabetes induced retinopathy" and required "medically prescribed weekly laser treatments," which if missed would "certainly result in vison loss." SD_118455. According to [redacted] father, from his [redacted] 2021 booking at the Jail

to [redacted] 2021 (between seven and eight weeks), [redacted] had "already missed eight required appointments with his retina specialist since the beginning of the current incarceration." *Id.* "Thus far, [redacted] has not had any laser surgeries since his incarceration. Would you consider this to be an appropriate standard of care?" SD_118456. As Mr. [redacted] implies, this conduct falls well below the standard of care.

309. Another example of the Jail's failure to provide continuity of care for medical treatments is the case of [redacted] ([redacted]). In the fall of 2022, Mr. [redacted] had been diagnosed with a malignant carcinoid tumor of his right lung. Medical Records of [redacted] as of [redacted] 2023, p. 109 of 595. He was scheduled to have surgery to have the cancer removed on [redacted] 2023. *Id.* at p. 407. Mr. [redacted] was booked into the San Diego Jail on [redacted] 2022. *Id.* at p. 11. [redacted] 2022, Mr. [redacted] wife and brother both called the jail to inform them that Mr. [redacted] had cancer and "is scheduled for an important surgery at Kaiser in January." *Id.* at p. 551. The same day ([redacted] 2022) Mr. [redacted] medical records from Kaiser were received by the Jail, with the diagnosis of "malignant carcinoid tumor of the right lung" printed in bold font on the first page. *Id.* at p. 109. A TechCare task was entered for a medical practitioner to review these records. *Id.* at p. 533. On [redacted] 2022, Mr. [redacted] was seen by Nurse Practitioner Nicholas Kahl, who wrote:

> h/o lung cancer (pt unsure of which type) and due have surgery at Kaiser today ([redacted]) but was booked on [redacted]. Need to f/u on ROI and reestablish cancer care as he will be incarcerated for a year.

Id. at p. 552. NP Kahl obviously did not review the medical records that had already been received. Those records, and the report from Mr. [redacted] wife already recorded in Mr. [redacted] medical record, should have been enough for NP Kahl to see that the surgery was not that day but was instead scheduled the next

month. In any case, NP Kahl's plan was "ROI for Kaiser sent, waiting for records to arrive for review." *Id.* On [redacted] 2022, Dr. Joseph Molina wrote: "[K]aiser records reviewed. [R]eferral placed for surgery reevaluation." *Id.* at p. 555. Dr. Molina wrote no summary of the medical records in the medical record. *Id.* He did not comment on the already scheduled surgical date of [redacted] 2023. *Id.* On [redacted] 2023, Mr. [redacted] was again seen by Dr. Molina. *Id.* at p. 557. Dr. Molina noted that "R lung confirmed via biopsy (Kaiser records scanned for reference)" and that Mr. [redacted] was supposed to have surgery in [redacted] 2023. *Id.* However, Dr. Molina wrote that the referral he had requested two weeks earlier was still "pending authorization." *Id.* at p. 558. On [redacted] 2023, the Jail received a "COURT ORDER for Defendant to be seen by Jail MD regarding medical condition." *Id.* at p. 559. As a result of this court order, Mr. [redacted] was seen on [redacted] 2023 by Nurse Practitioner Frederick Wycoco. *Id.* NP Wycoco wrote a reasonably good summary of Mr. [redacted] Kaiser medical records, in which he noted that Mr. [redacted] had had a complete work up and had been scheduled for surgery to remove the tumor on that very day, [redacted] 2023. *Id.* at pp. 559-561. Mr. [redacted] was admitted to the MOB [redacted] 2023, *Id.* at p. 459. NP Wycoco noted that all of the records, including "surgeon consult, and PFT" (pulmonary function testing) results had been "sent to Naphcare for review for thoracic surgeon." *Id.* at p. 561. NP Wycoco also asked NaphCare Utilization Management (who is responsible for offsite referrals, described in more detail later in this Report) to "expedite" the review. *Id.*[33]

[33] NAPHCARE026024 is a spreadsheet of NaphCare Utilization Management requests. Mr. [redacted]r is listed 201 times on this spreadsheet (from line 18,062 to line 18,263). According to this spreadsheet, the NaphCare UM program first received the request for Mr. [redacted] to see a cardiothoracic surgeon on [redacted] 2023 and that the request was approved a day later, on [redacted] 2023 (see lines 18,098–18,105). This is not credible based on the medical record, which, as described above, show that the Jail was on notice of Mr. [redacted]'s need for surgery as of [redacted] 2022, and that Dr. Molina requested a referral on [redacted] 2022.

310. On [redacted] 2023, Mr. [redacted] was seen again by court order: "COURT Order- Defense request to be released from Custody to have surgery without objection is denied. Defendant is to be evaluated by jail medical regarding condition with conditions before next hearing." *Id.* at pp. 570-571. At this meeting, NP Wycoco informed Mr. [redacted] that "he has a pending scheduling appt with surgery (requested expedited thoracic surgery since [redacted]/2023 for this medically necessary surgery)." *Id.* at p. 571. On [redacted] 2023, NP Wycoco responded to a Court Order to "review records form Kaiser per Court Order scanned on [redacted] 23." *Id.* at p. 576. NP Wycoco noted he had already reviewed those records on [redacted] 2023 and "pt already referred to specialists." *Id.* On [redacted] 2023, NP Wycoco recorded that "UCSD is requesting referral for pulmonology." *Id.* NP Wycoco submitted an inquiry about the referral to "case management." *Id.* p. 576. On [redacted] 2023, Mr. [redacted] was seen by Dr. Molina again by court order. *Id.* at pp. 576-577. Mr. [redacted] was "wondering when he will see the surgeon regarding his tumor." *Id.* at p. 577. Dr. Molina again documented that "specialist evaluation upcoming … I notified patient I have little to no control regarding specialist follow ups." *Id.* In the end, Mr. [redacted] finally had the surgery to remove his cancer on [redacted] 2023. Medical Records of [redacted] [redacted] as of [redacted] 2023, p. 814 of 2164. By then, the tumor had grown considerably and Mr. [redacted] had a documented weight loss of 39 pounds. *Id.* at pp. 819, 1442. The surgery finally occurred only after the direct intervention by the Chair of the San Diego County Supervisors, Nora Vargas, in [redacted] 2023, SD_652956-652959, and after the San Diego Union Tribune published an article about Mr. [redacted] case on July 23, 2023.[34]

311. In my opinion, the delay of this critical surgery was entirely

[34] Jeff McDonald, *"'I'm in a little disbelief': Diagnose with a tumor just before going to jail, La Mesa man fights for long-delayed surgery,"* SAN DIEGO UNION-TRIBUNE (July 23, 2023).

unnecessary, likely subjected Mr. [redacted] to unnecessary pain, and placed him at a great risk of harm—given that his tumor had grown considerably over the six months he waited and that he had lost nearly 40 pounds. Of course, the larger the tumor is, the harder it is to remove surgically and the greater the likelihood of complications. The surgery would have been less difficult to perform and would have had less likelihood of complications had it been done when originally scheduled.

312. What should have been done in Mr. [redacted] case is clear. Mr. [redacted] arrived at the Jail a month before his scheduled surgery. That is plenty of time to arrange for continuity of that essential care. Soon after Mr. [redacted] arrived at the Jail, someone from the Sheriff's Department (perhaps the Jail Medical Director or Dr. Molina) should have called Dr. [redacted] surgeon directly to coordinate care. Mr. [redacted] should have had his surgery, as scheduled, on [redacted]2023. If the surgery had to be rescheduled because of security concerns, it should have been shortly thereafter and with the knowledge and approval of his surgeon. No Corporate Utilization Management system was needed. In fact, given that Mr. [redacted] was a Kaiser (HMO) patient, his surgery had surely already been vetted by the outside UM program associated with his care.

313. In summary, the Jail fails to continue medically necessary medication and treatment for people after they are booked into the Jail, in violation of the standard of care. This places incarcerated people at risk of harm, including death, (such as Raymond Dix) and unnecessary pain and suffering (such as [redacted]).

IV. The Sheriff's Department Does Not Provide Incarcerated People with a Reliable and Timely Way to Alert Health Care Staff of Their Medical Needs, Placing Them at Substantial Risk of Serious Harm

314. It is my opinion that the Sheriff's Department lacks adequate policies and practices to reliably and timely respond to incarcerated people who alert health care staff of medical needs, which is a necessary component of any correctional

medical system. Absent such a functioning system, the Jail's medical system inherently falls below the accepted standard of care.

315. To meet standards of care in a jail system like this one, incarcerated people must be able to communicate their medical needs to health care staff—including routine, urgent, and emergent medical issues—and be assured that those needs will be addressed in a timely manner. Due to the size of the Jail population, and therefore the expected volume of medical requests, the Sheriff's Department must have robust, functioning systems for (a) collecting and triaging incarcerated person medical requests; (b) conducting timely in-person nursing evaluations of people requesting medical care; (c) reviewing and responding to grievances incarcerated people submit about their medical care; (d) identifying and responding to medical emergencies in the Jail; and (e) identifying and communicating with people with mental illness who may be unable to advocate for their own medical care.

316. The Sheriff's Department's own policies and procedures regarding "Access to Care" require that incarcerated people "have access to care for their serious medical … needs." MSD Operations Manual, A.1.1. According to that policy: "*Access to care* means that, in a timely manner, a patient is seen by a qualified health care professional, is rendered a clinical judgment, and receives care that is ordered." *Id*. These procedures further provide examples of "unreasonable barrier[s]" to care, including "[b]eing [an] understaffed or poorly organized system whereby care cannot be provided in a timely manner" and "[h]aving a utilization review process that inappropriately delays or denies specialty care." *Id*.

317. Based on my review of Jail policies and procedures, my review of charts and other documents, and my conversations with incarcerated patients, it appears that the Jail has four ways for patients to alert health care staff of their medical needs: (i) emergency buttons or intercoms; (ii) sick calls; (iii) grievances; and (iv) face-to-face interactions with health care or custody staff.

318. In policy and practice, it is apparent to me that these do not function to respond to the needs of people incarcerated in the Jail. My review of documents and my interviews with Jail staff and incarcerated patients during my inspection of the Jail showed many substantial problems with the Jail's system for requesting medical care. This places incarcerated people at risk of serious harm. Clearly, if an incarcerated patient is unable to effectively notify staff of a medical problem, that problem will not be addressed, or will be addressed belatedly, and the patient could suffer harm as a result.

A. The Sheriff's Department Lacks an Effective Process for Submission, Tracking, and Scheduling of Sick Calls

319. Incarcerated people must be able to request medical care via requests that are processed, tracked, and scheduled for appointments in an organized and effective manner.

320. In the community, people have multiple ways to seek medical attention for themselves or others. If they think they have an emergency, they can call for an ambulance or go directly to a hospital emergency room. If they have an urgent medical condition, they can go to an urgent care clinic or a walk-in clinic at a doctor's office that does not require an appointment. If they have a non-urgent medical condition, they can make an appointment with a medical practitioner.[35]

321. Jails should provide incarcerated patients with the same opportunities. Since incarcerated patients cannot go themselves to a hospital, call an ambulance, or make an appointment at an outside doctor's office, the standard of care requires that jails provide incarcerated patients the following functional mechanisms to alert staff

[35] People in the community may also be scheduled for regular check-ups even if they are feeling well, especially if they have chronic medical conditions such as diabetes or are elderly. Many screening lab tests and x-rays are done at such check-ups. People in the Jail with chronic medical problems should also receive scheduled check-ups where routine monitoring labs, x-rays, and examinations are performed and medication is renewed—even if the patient feels well. I discuss the standard of care for chronic care appointments and the Jail's failure to meet that standard later in this Report.

based on the urgency of their medical needs:

322. First, when incarcerated patients have a medical emergency, such as a seizure, a severe fall, a stroke or a heart attack, they must have a way to immediately notify staff of this emergency. This is usually accommodated by having an emergency call button in each patient's cell or housing unit. (I discuss the Jail's emergency response system in more detail in a later subsection).

323. Second, when incarcerated patients have acute medical issues, such as rashes, vomiting, headache, etc., they must be able to notify medical staff of their symptoms and the urgency of their medical need. Jails commonly ask patients to fill out a medical request form when they have non-emergency medical symptoms or issues. Since written medical requests include both urgent and nonurgent issues, these must be triaged by medical staff in a timely manner and urgent complaints evaluated in a timely manner (usually within 24 hours).[36] Jail policies and procedures must take into account the fact that many incarcerated patients have difficulty or are unable to communicate their medical needs in writing, *e.g.*, those with developmental or mental health disabilities or those who do not speak English or Spanish, to communicate their medical needs. This should include the ability to verbally request medical care from custody or medical staff, who will then enter the request into the medical system and initiate the 24 hour face-to-face evaluation.

324. Third, custody and other jail staff, including mental health staff, must be able to submit requests for medical care on behalf of patients they are concerned about. These should be entered into the system as if the patient had made the request themselves, and should initiate a 24 hour face-to-face evaluation just like a patient-generated medical request. This is particularly important, for example, for

[36] Many jails now allow incarcerated people to submit such requests electronically, *e.g.*, through a tablet, which may be preferable because medical requests written on paper can be easily lost or misplaced and it is harder to document when such a written request has been triaged or when the patient was seen for this particular complaint by a medical practitioner. Electronic submission of these requests automatically keeps track of all requests and when the requests were attended to.

developmentally disabled patients, patients with dementia, and severely mentally ill patients. These patients, by nature of their illness, may have impaired reasoning, diminished insight into their medical condition, and/or paranoia that leaves them less able to communicate their medical needs. Jails are likely to have many such patients, they must therefore have systems in place to check on those individuals.

325. Fourth, family members, attorneys, and other interested parties also must be able to initiate medical evaluations of incarcerated people. These requests must be considered as equivalent of the patient herself submitting the request and so also immediately trigger the 24 hour face-to-face evaluation.

326. The San Diego County Sheriff's Department policies provide a minimal description regarding the medical request process. Medical Services Division Operations Manual section MSD.S.3 first provides general guidance that "[a]ny patient with a medical, dental, mental health or developmental disability may be identified by self, deputy, medical staff, family, attorney or advocate referral." In terms of how a request is made, it states that: "Patients shall request routine sick call by completing one (1) Sick Call Request Form" which are then placed by the patient into a "locked medical (red) box." MSD.S.3 Procedure Part III. These forms are to be gathered "daily by designated health staff" and reviewed; each patient is to be seen face-to-face by an RN within 24 hours "of receiving requests." *Id.*

327. Section MSD.S.3 further states that, "[i]n the event a RN refers a patient to sick call, there will be documentation in the electronic medical record substantiating the reasons for the referral." *Id.* However, there is no guidance regarding how to document referrals by security staff, clergy, family, LVNs, and any number of other people who may want to make such a referral.

328. Regarding non-written requests for medical care, the MSD Operations Manual explains that "[p]atients with an urgent medical complaint may be referred to health staff at any time." *Id.* at Part IV. However, there is no guidance regarding

how patients who have difficulty in writing, *e.g.*, those with cognitive disabilities and those with mental health issues, can submit non-urgent requests for medical care.

329. Detention Services Policy M.15 (for custody staff) is similar, it explains that "[s]ick call requests are deposited by the incarcerated person into the secure medical mailbox," and that "health staff is responsible for collecting the sick call request … each night." Notably, Policy M.15 does not include a 24-hour face-to-face requirement.

330. Based on my interviews with Sheriff's Department staff during my inspection of the Jail, I understand that, in practice, the Sheriff's Department still requires incarcerated people to submit all in writing. Patients who report medical problems are told to fill out a medical request form. The incarcerated person must fill out the medical request form (Form J-212) and place it in a box located in the housing unit. Of course, not all of them do so—perhaps because they struggle with writing or have a mental health issue—meaning that opportunities to treat medical problems are then lost.

331. Once submitted, the requests are picked up by a medical staff member (usually an LVN) and taken to the medical offices. The requests are then reviewed by a registered nurse, who time stamps them and sorts and triages them, to the extent possible. A nurse I interviewed during my inspection reported that sometimes she was not able to complete her triage of all requests the same day because there are so many. The stack of that day's medical requests is then transferred to the RN responsible for doing a Face-to-Face assessment with each patient within 24 hours. After seeing the patient, this nurse makes a follow-up appointment for sick call, if the RN deems it necessary.

332. This process has several problems and inefficiencies that make it inadequate to provide incarcerated people with care that meets medical standards.

333. First, many incarcerated people have difficulty with a system requiring

written requests. This includes those who do not speak English or Spanish, those with cognitive disabilities, mentally ill patients, and many others. I was unable to find this issue addressed (at all) in either the MSD Operations Manual or NaphCare's Policies and Procedures. Similarly, submission of a physical written request form can be daunting for patients who are only allowed out of their cells for a small amount of time daily.

334. Documents I reviewed suggest that some staff refuse to accept requests for medical care unless they are written. For example, in July 2022, a member of Sheriff's Department staff named Alejandra Carbajal reported to the head of mental health, Melissa Quiroz, that she had "seen [nursing staff] with [her] own eyes, give a [sick call] to an [incarcerated person] [complaining of] an annal [sic] infection willing to show the nurse on the spot … and the nurse just continued to hand [her] the [sick call] slip." SD_194081. Because of this practice, Ms. Carbajal believed that nursing staff was "doing [the] bare minimum for inmates." *Id.* I tend to agree with Ms. Carbajal in this regard. In my opinion, the limitation of requiring a physical, written request is a major oversight, which could result in some incarcerated people being unable to request medical care.

335. Second, the MSD Operations Manual does not explain how medical care referrals from custody staff or from others outside the Jail, *e.g.*, family members or attorneys, should be documented and processed. For example, if a family member calls and states that a particular patient has an unmet health care problem, how is this documented in the medical record? Who takes this information and enters it into the system as an official medical request that will trigger a face-to-face evaluation? The MSD Operations Manual is silent on this, and without a policy on how a family concern turns into a formal request for medical care, family member concerns can and are ignored, resulting in their frustration in trying to get health care for their oved ones. This also can result in harm to the patient, who does not receive the necessary health care that the family is trying to arrange.

336. According to patients I interviewed during my inspection of the Jail, incarcerated people sometimes attempt to inform the nurses who pass out medication about an urgent medical problem. However, those patients report that, rather than promptly contacting the sick call nurses or physicians on duty, medication pass nurses often dismiss the person's request and instruct them to fill out a sick call request, which delays their access to care. Similarly, I was told that when incarcerated people inform custody staff about a medical problem, custody staff again often dismiss the person's request and instruct them to fill out a sick call request rather than notifying medical immediately about an urgent problem.

337. Third, the medical request process is not standardized across the various Jail facilities. As an example, during my tour of the Jail, I learned that some facilities keep a copy of the medical requests in a binder whereas others do not. This discrepancy in practices makes it difficult to track systemwide trends through CQI; medical requests that are kept organized are amenable to CQI review, while unorganized medical requests are not. This lack of standardization across facilities would be remedied if the policies were more explicit. Similarly, it appeared to me that there was confusion about when precisely in the triage process the medical request form was scanned and placed within the patient's chart. Again, this lack of clarity may lead to errors, including the possibility of some sick call requests falling through the cracks. For example, if a request is scanned into the chart too early, does that mean the appointment has already been completed? If different staff have different expectations for when a request form is supposed to be scanned, this can lead to confusion.

338. Fourth, according to the interviews I conducted during my tour of the Jail, some nurses doing triage eliminated sick call requests that they felt were redundant. In other words, if the nurse believed that a patient had already submitted a request on a particular issue, they would simply eliminate that request. This, again, creates a risk of health care needs slipping through the cracks, for example, if

the issue was not exactly the same as the prior request. Also, repeated written requests often indicate the urgency of the problem. The patient may be indicating, via repeated requests, that this is an urgent matter that should be dealt with promptly.

339. Fifth, according to my interviews, sometimes, nurses responded to the requests in writing at the bottom of the J-212 medical request form, returned the form to the patient, and that was the end of the matter. This results in no clinical encounter with the patient, which is what the patient asked for, and is outside of normal process of recording patient interactions in SOAP notes in the electronic medical record.

340. Finally, as noted above, my interviews of Jail staff indicated that it was common for there to be so many sick call requests that it was not possible to triage them in a single day, leading to backlogs. As of her deposition, Ms. Rognlien-Hood testified that there was a backlog of 300 medical requests. Rognlien-Hood Tr. at 196:16-23.

341. In summary, the Jail system for patients to request medical care works as intended only some of the time. Other times, the request is lost in the paper shuffle of hundreds of requests a day, is never acted on, is not entered into the system, etc. Many of the incarcerated patients I interviewed expressed frustration with the inefficiency of this system. And, depending on what complaint "falls through the cracks," this system certainly can cause medical harm.

B. Even When Medical Requests Received and Processed, They Are Often Not Timely or Adequately Addressed

342. Once a request for medical care is received by the Jail, the person complaining of a medical problem should be seen face-to-face, so that health care staff can decide whether the patient has a medical issue that is urgent (for example, bladder or sinus infections or a painful rash like shingles) or not-urgent (for example, longstanding musculoskeletal pain or a non-painful skin lesion).

343. At this face-to-face meeting, as in any medical encounter, vital signs should be taken. They give vital information needed to properly triage "urgent" from "non-urgent" requests. As an example, a patient complaining of a headache with a very high blood pressure of 190/120 should be triaged as urgent. Without the blood pressure, a complaint of a headache may be triaged non-urgent. Similarly, a patient complaining of back pain with a very high heart rate of 130 should be triaged as urgent. Without the heart rate, a complaint of back pain may be triaged as non-urgent. Vital signs take literally about a minute to perform, during which time the nurse could be conversing with the patient.

344. In response to the State Audit's February 2022 conclusion that the "San Diego County Sheriff's Department … has failed to adequately prevent and respond to deaths of individuals in its custody," the Sheriff's Department announced that it was implementing a process of "doing face-to-face assessments (of patients) within 24-hours of receipt of a request for medical services at the (jail) facilities." SD_184484; Rognlien-Hood Tr. 87:6-10, 87:24-88:4. Similarly, NaphCare recommended that when patients submit sick calls complaining of clinical symptoms, nursing staff see them face-to-face within 24 hours to triage the request. Rognlien-Hood Tr. 87:6-10, 87:24-88:4.

345. The MSD Operations Manual requires that, as part of the triage process, patients who submitted sick calls should be seen face-to-face by an RN within 24 hours of the request being received. MSD.S.3.

346. However, in actual practice, the Jail gives the nurses 24 hours from the time of receipt to triage medical requests and another 24 hours to do the face-to-face evaluation from the time the request was triaged. This timeline is laid out in a September 2023 CQI report conducted at Central Jail in which 10 charts were reviewed for the "following key indicators:" "1. The sick call slip is initialed and dated with the date that it was received. 2. Sick call is triaged within 24 hours of receipt. 3. A Face-to-Face assessment is conducted within 24 hours of triage. 4. A

referral is made for sick calls that require further evaluation." SD_729828. The compliance for the face-to-face assessment in this study was 10%. The overall compliance 50%.

347. Neither the MSD Operations Manual nor NaphCare's Policies and Procedures define how face-to-face evaluations should be conducted, *e.g.*, whether vital signs should be taken.

348. It should be noted that as of 2017 the NCCHC requirement was "that a qualified health professional has a face-to-face encounter with the patient within 48 hours of receiving requests with a clinical symptom." DUNSMORE0260639.[37] Thus, the Sheriff's Department set an ambitious standard for itself with its 24-hour face-to-face requirement in its policies, but in actual practice, according to the CQI indicator above, is trying to achieve a 48 hour standard.

349. However, the Sheriff's Department has not been able to meet either the 24-hour standard or 48-hour standard for face-to-face assessments. Rognlien-Hood Tr. 87:11-14, 88:8-10, 90:15-92:18. Ms. Rognlien-Hood testified: "Q. And does the 24 hour face to face for clinical symptoms always happen as a matter of practice? A. No." *Id.* at 89:8-10.

350. This testimony is confirmed by documents I reviewed. A QA/QI report from July 2023 stated that at George Bailey, with regard to the "[t]imeliness of 24 face to face," the Sheriff's Department was "averaging 45-50% of the threshold of 90%." SD_114412. Timeliness of sick call responses at Central Jail was no better, with the Sheriff's Department reporting that "[c]ompliance indicators have slowly been declining since implementation. Overall compliance has fallen from 76% to 50%." SD_114467. The Sheriff's Department was well-aware of the lack of timely sick call responses, stating in that July 2023 QA/QI presentation that its corrective action plan would include "continu[ing] to work on triaging sick call slips" and

[37] As of 2018, the NCCHC updated this guidance so that a 24 hour face-to-face is required.

"[a]nswer[ing] in a timely manner." SD_114467. Nevertheless, based on Ms. Rognlien-Hood's testimony, it appears that the delays persisted.

351. At least part of the problem appears to be the lack of sufficient nursing staff to complete these face-to-face assessments. Ms. Rognlien-Hood wrote in 2023 that "24-hour face to face is hard to accomplish due to the sheer volume and manpower needed to accomplish this both on the medical and sworn side." SD_375922.

352. After being seen by the nurse, incarcerated patients must then wait even more to be seen by a medical practitioner. The average wait to see a medical practitioner is around 15 days according to Sheriff's Department data from July 2023. SD_114495. Notably, this is over twice as long as the NCCHC reported in 2017. And, of course, half of all incarcerated people who need to see a practitioner wait *longer* than 15 days, and sometimes much longer. Patients I interviewed commonly told me about waiting for weeks to be seen for serious medical concerns. When they put in a second or third request raising their medical concerns again and asking why the process is taking so long, they report that those requests are often ignored by nurses. This was confirmed by a nurse assigned face-to-face duty at Central Jail, with whom I spoke during the inspection. She stated that repetitious medical requests were ignored, in an attempt to make the face-to-face task list more manageable. In my review of patient charts, I found many examples of requests for medical care that were not triaged by a nurse for many days or, in some cases, weeks. As one example of this, [redacted] submitted a grievance on [redacted] 2022 that stated: "I [have] been requesting some kind of treatment for the fungi I have on my feet for more than 6 weeks and haven't gotten any response back." SD_817006. Of course, a delay of well over a month to treat an infection can certainly allow that infection to fester and worsen and even potentially spread. Delay always increases the likelihood of some medical conditions getting worse and patients suffering as a result.

353. NaphCare has exacerbated the Sheriff's Department's failures to respond to sick call. According to a February 22, 2023 email and attachment from Ms. Rognlien-Hood, NaphCare's training regarding 24 hour face-to-faces created "confusion." SD_375922. Specifically, when training Sheriff's Department staff, NaphCare's Vice President of Nursing "stressed … that vitals must be done for all medical concerns during the face to face," but NaphCare's Chief Medical Officer separately wrote that this was not necessarily the case, although he "would not [] give us direction on when to do them and not do them." *Id*. This is poor training.

354. In summary, the Jail set a standard for itself of having an RN see each patient within 24 hours of the receipt of a request for medical care. At some point, they began to allow 24 hours for triage of medical requests and another 24 hours for a face-to-face encounter. Either way, the Jail has not been able to meet its own standard. The Jail has attempted to cover this inadequacy with various questionable measures, such as not taking vital signs, but, in the end, the program does not work, leaving patients at risk of harm.

C. Grievances Are Often Ignored or Not Answered Satisfactorily

355. Unlike patients in the community, incarcerated patients are unable to choose a medical care provider on their own. Incarcerated patients similarly are unable to switch medical providers if they feel that their medical needs are not being met. Their only alternative is to make a formal complaint in the form of a grievance. The grievance process is an opportunity for the patient to point out what they perceive as deficiencies in their medical care and an opportunity for the jail medical staff to improve medical care by learning about problems that may have fallen through the cracks or been unaddressed due to deficiencies within the medical system.

356. For that reason, grievances are an essential part of medical care for the incarcerated. As the NCCHC Technical Assistance Report stated: "The goal [of the grievance program] is to solve patient complaints … as soon as they become

known." DUNSMORE0260627. Grievances about medical care should, like simple medical requests, also usually be addressed with a face-to-face evaluation. In fact, in my opinion, a face-to-face discussion of medical grievances is essential to a satisfactory resolution.

357. The MSD Operations Manual has a lengthy section on "Grievance Procedures," which emphasizes that grievances should be responded to in writing within seven days. MSD.G.1. Under that policy: "The staff member delivering the response to the inmate will have the inmate sign and date one copy of the response." If the patient is not satisfied with the response, "the staff will be directed in writing by the patient through successive levels of command until resolution is obtained, or the Medical Administrator reviews the grievance." Each of these levels must be completed within ten days. "The decision of the administrator is final."

358. The next section of the Grievance Procedures discusses how patient grievances may be administratively relabeled as "Personnel Complaints." The Detention Services Bureau (custody-side) grievance policy, No. N.1, is similar, though it also lists further ways a grievance can be administratively relabeled, for example, as a "request." Importantly, if a grievance is relabeled as a "request," "[n]o entry in JIMS is required."

359. The Sheriff's Department's grievance forms also contain a box in the response area that states, "This is not a grievance." Other than discussing the difference between a medical grievance and a personnel complaint or request, the Sheriff's Department's policies does not provide guidance for the frequent practice of relabeling a grievance as "not a grievance." For example, Policy N.1 states that a grievance can address "Medical/Mental Health care," but does not explain in what circumstance a grievance about medical care should be relabeled as a request. Since there is no written guidance on when to do this, it is left to the reviewing RNs judgment (or whim) as to when to do this.

360. In practice, I understand that, in the Jail, grievances are often ignored or

not answered satisfactorily. During my inspection of the Jail, I interviewed many patients who told me that they have received no response to medical grievances they submitted. No response, of course, violates the MSD Operations Manual, which includes detailed instructions and timelines for grievances.

361. Further, the Sheriff's Department's CQI reports provide little meaningful information about grievances other than listing the ostensible number of grievances per quarter. *See, e.g.*, MSD QA/QI Meeting, July 18, 2023, SD_114475. CQI data on grievances should contain: (a) the average length of time before a response is issued to the patient; (b) how many grievances were answered late; (c) what percentage escalated to each level up to the Medical Administrator; and (d) what the resolution was for each grievance. But none of this information is contained in the Sheriff's Department CQI reports on grievances. *See id.*

362. There are several problems with the grievance system in both policy and practice. First, the Sheriff's Department Operations Manual Section MSD.G.1 requires no face-to-face interaction with the patient who wrote the grievance. Written grievances contain only a short summary of what the patient thinks the problem is. Seeing the patient in person allows the patient to voice their concerns in more detail. It also allows the person responding to explain medical issues that perhaps the patient does not understand.

363. Second, grievances should never be arbitrarily relabeled as something else except by the patients themselves. This also makes grievance statistics unreliable since it is not known how many were arbitrarily relabeled as not a grievance. Relabeling grievances is also potentially a mechanism to manipulate statistics to make them appear more favorable than they really are. Not allowing grievances to be relabeled removes this bias. In the Jail, however, patients often receive responses with the "this is not a grievance" box checked. Ms. Rognlien-Hood admitted that this happens in her deposition. Rognlien-Hood Tr. 206:12-24. While most grievances were not included in the patient records sent to me, several

were included and marked as "This is not a grievance." As one example, [redacted] wrote a grievance attempting to contest the discontinuation of his suboxone medication on [redacted] 2022. SD_820924. In response, the Jail checked the boxes for "This submission is not a grievance" and "It is an inmate request … (No entry in JIMS …)." *Id.*

364. This practice appears to artificially deflate the number of grievances received the Jail. As an example, the "TechCare Monthly Report" for Central Jail for the months of January, February and March, 2023, says that a total of six (6) medical grievances were filed over those three months out of an average daily population of 750. NAPHCARE031601. In my experience, this is not credible and is more likely the result of arbitrarily relabeling grievances as something else.

365. Third, the Jail's failure to analyze grievances substantively during the CQI process means that the Jail does not know how many of the grievances were justified and pointed out true deficiencies in medical care or Jail medical processes. The grievance process should be viewed as an opportunity for improvement, not as a nuisance to be swept under the rug. It should allow patients to point out problems of medical care that they see from their end.

366. Finally, during my tour of Central Jail, a nursing supervisor there told me that patient grievances are taken directly to the nursing supervisors. The nurses and the practitioners are not informed of them even if they are named. In my opinion, this is wrong.

367. In summary, the Jail grievance system does not work as it should. Some grievances are ignored, in violation of policy. Many grievances are arbitrarily relabeled as "not a grievance." Grievances are not tracked in a meaningful manner by the CQI process.

D. The Sheriff's Department Lacks an Effective Alert System for Medical Emergencies

368. Outside of jail, people who have a medical emergency can either call an

ambulance (which usually responds in minutes) or go themselves to a hospital emergency department. Incarcerated patients cannot do either. Jails must have some other system that allows incarcerated patients to get emergency medical care. This involves two steps: (1) ensuring that incarcerated people can effectively notify security staff that they are experiencing a medical emergency, and (2) ensuring that the jail security and medical staff will respond in order to get emergency care to the patient.

369. Incarcerated people must have a reliable way to alert security and medical staff when they experience medical emergencies, so that staff can respond immediately. Failure to provide an emergency alert mechanism—and to ensure that staff respond immediately—can lead to preventable in-custody deaths. As explained above, the February 2022 State Audit identified cases in which where deputies did realize that a person was unresponsive or otherwise in distress and therefore "did not perform or delayed lifesaving measures" like CPR. SD_174824-25.

370. I understand that Plaintiffs' other expert(s) will opine in greater detail about emergency buttons and intercoms. However, because this issue is critical to the provision of medical care in the Jail, I also address it here, with a focus on the medical perspective, in particular, the MSD Operations Manual regarding emergency medical communications from patients using the intercom in their cells.

371. Most correctional facilities I am aware of have emergency buttons and intercom in the cells and housing units, which incarcerated people can use to alert staff of medical emergencies. Jail policies should also explain—for various types of medical emergencies—exactly what response should occur, by whom, and within what time frame. Such common medical emergencies include: "I think I'm having a stroke!"; "I can't wake my cell mate up!"; "My cell mate fell and hit her head. It looks bad."; "I can't breathe!"; and "My cell mate is having a seizure!"

372. Yet, the MSD Operations Manual does not contain any guidance

regarding emergency medical communications from patients using the intercom in their cells. The Operations Manual does contain MSD.M.1 "Medical Emergencies." Although MSD.M.1 contains much information about what security and medical staff should do when notified of an emergency, it does not address how incarcerated people notify staff of an emergency and nothing about the need for functional emergency call buttons.

373. In practice, the "emergency" buttons and intercoms in the cells at the Jail also frequently do not work. During my inspection of the Jail, three different patients demonstrated this fact to me by pushing the buttons in their cells with no effect. I observed many other emergency buttons to be always fully depressed and so clearly not in working order. This is a serious issue in that a patient experiencing an emergency medical condition cannot alert security or medical personnel, nor can their cell or dorm mates.

374. For example, the July 2022 death of Abdiel Sarabia, who, as noted above, appears to have been dead for some time before his body was discovered in the Jail, suggests that the Sheriff's Department is unable to identify people experiencing a medical emergency. It is probable that Mr. Sarabia and many others knew that they were having a medical emergency for some time before they died but were unable to notify staff because of non-functioning emergency buttons.

375. Documents I reviewed suggest that the Sheriff's Department fails to train staff properly regarding physician responses to emergencies. In an email dated February 22, 2023, then Director of Nursing Rognlien-Hood, reported that "ER training has confused the staff" because NaphCare stated in one training that STATCare should be used for emergent issues, and stated in another training that on-site providers should be used." SD_375921. Ms. Rognlien-Hood claimed the later procedure, if followed, would burden on-site providers." *Id.* Confusion about who should respond to an on-site emergency (seizures, trauma, unconsciousness) can certainly harm incarcerated patients if an essential medical provider fails to

show up, thinking "STATCare has it!" Examples include patients needing life-saving airway placement or patients needing life-saving medications administered immediately.

E. The Sheriff's Department Lacks a Working System for Ensuring that People with Mental Illness or Other Communication Difficulties Receive Medical Care.

376. The problems described above are even more significant for incarcerated people with mental illness. Mentally ill patients get the same medical problems as anyone else. Mentally ill patients have heart attacks. Mentally ill patients get cancer. Mentally ill patients get infections.

377. Mental illness and medical problems interact in important ways. First, because of difficulty with thought processes, paranoia, and other aspects of mental health disability, mentally ill patients sometimes lack insight into their own medical needs and also do not communicate well when they are having medical symptoms, even severe symptoms. More effort is often necessary to make medical diagnoses in the mentally ill.

378. A second way that mental illness can affect medical problems occurs because psychiatric medications frequently have side effects that manifest as significant medical problems. For example, haloperidone frequently causes disabling muscle stiffness; risperidone is notorious for occasionally causing gynecomastia (breast growth in men); olanzapine increases the risk for diabetes. All incarcerated mentally ill patients should be followed by the medical team because mental health professionals do not have the training or experience to recognize significant medical side effects from psychiatric medications.

379. Third, mental illness itself can lead to medical problems. Severely mentally ill patients may become sick from not eating or from eating inappropriate things. Mentally ill patients may harm themselves and cause injury. Mentally ill patients can develop skin lesions from lack of self-care. These problems need to be recognized and treated by the medical team.

380. Finally, medical problems can mimic mental illness and vice versa. For example, infections can cause a disordered mental state that can be confused with psychosis. Sometimes it can be difficult to determine whether an incoherent patient is acutely psychotic or rather is delirious from an infection, meth intoxication, or substance withdrawal. For all these reasons, it is impossible to totally separate medical issues from mental health issues.

381. The medical standard of care requires that medical personnel and mental health personnel at a jail communicate with each other, to ensure that mentally ill patients do not have their other—*i.e.*, physical—medical problems neglected. Specifically, **jails must have a clear plan for the addressing the healthcare needs incarcerated patients who are not fully able to communicate those needs on a formal medical request.** A system to ensure medical care for patients such as these has three components.

382. First, such patients must be identified. This can be done by placing these patients on a "Chronic Care" or "Special Needs" list such as those used to identify other patients with chronic health needs (*e.g.*, diabetics or those with physical disabilities).

383. Second, jails must have a policy or guideline in place that details what special care will be provided to these patients. These guidelines must include "wellness checks" by both medical and mental health professionals. Such patients should not be required to write their requests for medical care. Referrals to the medical clinic can be made verbally, by any staff member who is concerned about the patient, and by family members.

384. In fact, such patients must receive extra scrutiny and care at every stage of incarceration. Since they sometimes cannot or will not give medical information at intake, information may need to be gathered from other sources, such as old records, outside providers, or family. Since such patients sometimes do not care for themselves properly, custodial and medical staff need to be vigilant that these

patients bathe, eat, and sleep properly. Since such patients often do not communicate well that they are having medical symptoms, medical staff must frequently check on them and specifically ask about their well-being.

385. As a rule, patients who are unable or unwilling to advocate for themselves must receive **more** frequent medical checkups, not **fewer**.

386. It is clear that this Jail does not provide sufficient medical checkups for people with mental illness and communication challenges. One needs to look no further than the deaths of Lonnie Rupard and Roselee Bartolacci, described above, as evidence of this. The Forensic Pathologist who performed the autopsy on Lonnie Rupard opined that he died due to medical neglect and ruled the death a homicide. Ms. Bartolacci's case was strikingly similar to Mr. Rupard's. Both patients had significant mental illness that impacted their ability to request and accept medical care.

V. The Sheriff's Department Improperly Documents "Refusals" of Medical Care, Resulting in the Denial of Care to Incarcerated People, and Placing Them at Substantial Risk of Serious Harm

387. It is my opinion that the Sheriff's Department does not appropriately document refusals of medical care by incarcerated people. In fact, based on my review of documents in this case, it is my opinion that Sheriff's Department staff frequently record that a patient has "refused" to attend a medical appointment, even though the patient was never informed or offered the opportunity to attend the appointment in the first place. This practice has the effect of denying medical care to incarcerated people and therefore places them at a risk of serious harm.

388. In general, Jail patients have the right to refuse medical care. However, such refusals must be appropriately documented. As the NCCHC Technical Assistance Report explains: "[t]he standard practice is that all refusals need to be made with a health staff in attendance to counsel the patient as to the possible health outcomes of a refusal of care. A deputy can be the second witness signature when the inmate refuses to sign the refusal form." DUNSMORE 0260650.

389. Of course, it should go without saying that staff should not sign a form indicating that an incarcerated patient has refused a medical appointment unless and until the patient has been informed about their appointment, has been counseled on the possible risks of refusing care, and has affirmatively stated that they do not want to receive that care.

390. The State Audit identified the Sheriff's Department policies on refusals as a potential factor in the extraordinarily high death rate at the Jail: "we identified several instances in which sworn staff were the only witnesses when incarcerated individuals refused to sign the refusals. Because follow-up care is important, it is critical that the desire to refuse care be shared with health staff who are in a better position to ask appropriate questions, explain the adverse consequences to health that may occur as a result of the refusal, and assess whether an individual has critical health needs that should be addressed." SD_174820-21. The Audit recommended that the Sheriff's Department "[r]evise its policy to require that a member of its health staff witness and sign the refusal form when an individual declines to accept necessary health care." SD_174851.

391. When the Sheriff's Department responded one year later, their Progress Report: Update on State Jail Audit stated that they were complying with the Auditor's recommendation about refusals: "In the event a patient refuses prescribed medication, the nurse will counsel them on the potential impact and try to convince them to take the prescribed medication." SD_184485. In the case of refusals of a medical appointment, "[t]he patient will be counseled by medical staff, which may include a provider or nurse, regarding the potential effects on their health of missing the appointment and try to convince them to attend." *Id*.

392. However, after reviewing medical records and hundreds of medication refusal forms, I can state confidently that the Sheriff's Department does not meet this standard in either policy or practice.

393. MSD Operations Manual Policy D.1.1 states that a patient who refuses

either medication or treatment is required to "sign a refusal form … including the medication/dose or treatment and witness signature." However, "[i]f Patient refuses to sign Refusal form, two (2) witnesses, i.e. licensed nursing personnel and Deputy shall sign the Refusal form …." *Id.* And, "[a]fter three (3) consecutive refusals of all other medication(s)/treatments, patients are counseled by licensed nursing personnel and scheduled for provider chart check to determine if medication/treatment will continue to be offered." *Id.* I note that this policy differs from what the Sheriff's Department stated that they were doing in their Update to the Audit.

394. On its face, this procedure falls below the standard of care because it does not require health care staff to be present until a patient has refused care three consecutive times. Instead, the policy would allow for any two witnesses—including two deputies—to witness the patient's refusal. Allowing a refusal to be documented without a healthcare staff member present is problematic because it means that the incarcerated patient does not receive an appropriate advisal of the risks of refusal before refusing. By requiring the patient to refuse three times before receiving any counsel about the risk of refusals, incarcerated people may end up refusing without full awareness of the benefits of the medication, and, as a result, be delayed in receiving necessary medical care.

395. Notably, there is a separate policy governing the refusal of offsite and specialty clinic appointments, which *is* adequate. Under MSD Operations Manual Policy MSD.R.5, a patient who refuses an offsite or specialty clinic appoint is provided a "risk and benefit counseling … by nursing staff as soon as possible following notification of patient's refusal." And, the refusing patient's physician is instructed to "discuss" with the patient "the reason for the off-site referral and … include the benefit to them versus the medical risk of not going to the appointment." *Id.*

396. If patients are not properly counseled regarding refusals of offsite care,

it can compromise medical care in several ways. The Jail's health care staff should make referrals for offsite care only when clinically-indicated, and the failure to ensure the patient receives this care can and will have a detrimental effect on patient health. Further, in my experience, cancelling appointments can strain the Jail's relationship with offsite specialists, who usually must make special arrangements for such visits and cannot see other patients in the time set aside for the patient who refuses. It is in the best interest of current and future patients in the Jail that refusals are kept to a minimum.

397. However, as explained in more detail below, this policy does not appear to be followed. My review of documents indicates that, even if the Sheriff's Department's policies for refusals were appropriate, in practice, the Sheriff's Department does not appropriately document refusals.

398. After reviewing hundreds of medication refusal forms, I can state confidently that custody staff alone are involved in almost all patient refusals of medications, lab draws, clinic visits, and off-site visits. Nurses are rarely present for these interactions. Rather, custody staff state that they have spoken to the patient, the patient refused care, and also has refused to sign the refusal form. Then, a nurse and the custody officer (or two custody officers) sign the refusal form, even though the nurse did not personally witness the refusal.

399. As just one example of many, the medication refusal form for a patient named [redacted] ([redacted]), dated [redacted]2023, and signed by custody and nursing staff, simply states that a medication was "'refused' per deputy." In other words, this notation indicates that the supposed patient refusal was communicated only to the deputy, and the nurse who signed the refusal form was told *by the deputy* that Ms. [redacted] had refused the appointment. *See* SD_781379.

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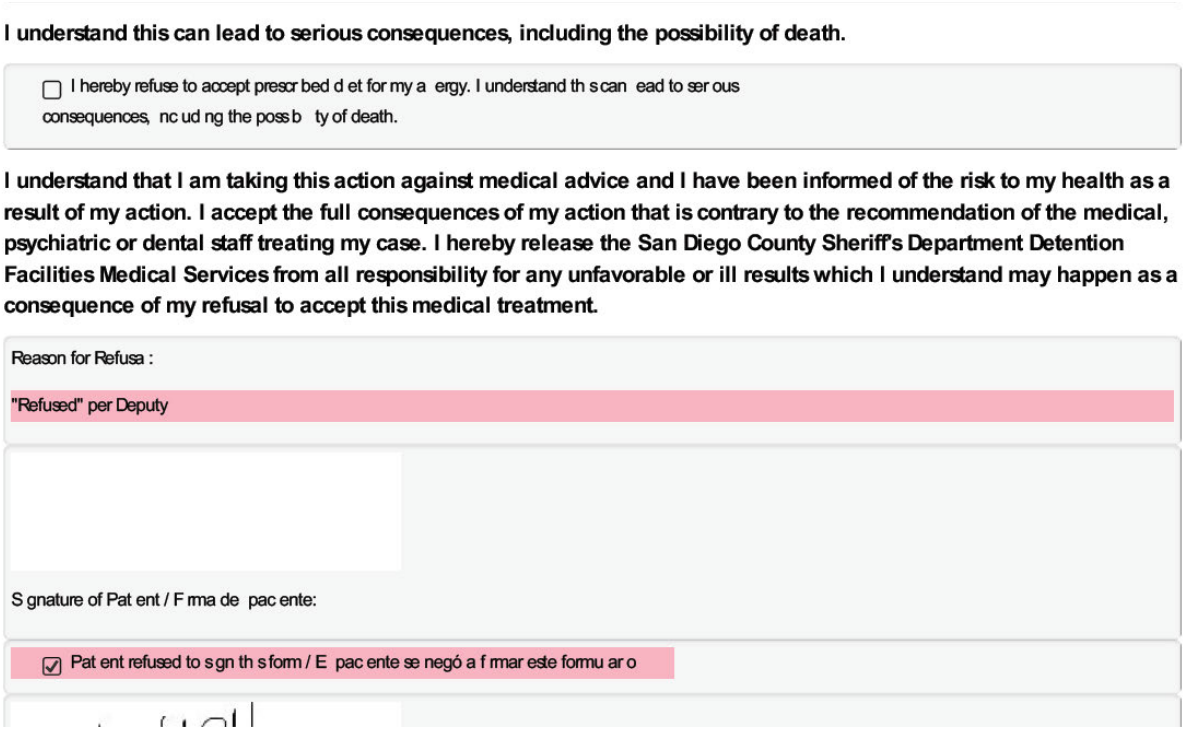

I understand this can lead to serious consequences, including the possibility of death.

☐ I hereby refuse to accept prescr bed d et for my a ergy. I understand th s can ead to ser ous consequences, nc ud ng the poss b ty of death.

I understand that I am taking this action against medical advice and I have been informed of the risk to my health as a result of my action. I accept the full consequences of my action that is contrary to the recommendation of the medical, psychiatric or dental staff treating my case. I hereby release the San Diego County Sheriff's Department Detention Facilities Medical Services from all responsibility for any unfavorable or ill results which I understand may happen as a consequence of my refusal to accept this medical treatment.

Reason for Refusa :

"Refused" per Deputy

S gnature of Pat ent / F rma de pac ente:

☑ Pat ent refused to s gn th s form / E pac ente se negó a f rmar este formu ar o

400. Most of the refusal forms I reviewed looked like this—with the "per deputy" notation indicating that a deputy had stated that the patient refused. In my experience, this is problematic. Deputies are busy and sometimes infer that patients are refusing their medications when in fact, they are not.

401. A second example involves a patient named [redacted] ([redacted]). On [redacted] 2022, Ms. [redacted] was seen at her cell by Dr. Rana Ram in response to complaints of dizziness for the prior two weeks. Dr. Ram ordered labs. SD_748165. Later that day, a nurse made the following note: "Patient call for blood draw. Per deputy #0474 patient refused." SD_748165. On [redacted] 2022, Ms. [redacted] was seen at her cell by Dr. David Christensen to "re-evaluate dizziness/fatigue." Dr. Christensen ordered an EKG in addition to the labs. SD_748164. Ms. [redacted] then reportedly refused to go to medical for the EKG three times. The first time, a nursing note stated: "Called Pt at the housing but refused to come to Medical Clinic. Refusal form signed by the Pt. herself without any reason." SD_748164. The second time, a nursing note stated, "Pt was called for EKG, declined and also declined to sign refusal form witnessed/signed by

Dep. #4122 & Dep.#0395." The third time, a nursing note stated: "Called housing deputy to bring pa. to medical for EKG. Per deputy, pt. refused. Refusal witnessed by deputy 3454. Refused 3X already." SD_748163. Later that day, a Nurse Practitioner wrote, "pt may refuse recommended medical treatment," and discontinued the lab and EKG orders. SD_748163. In violation of the Sheriff's Department's policies and procedures, no medical personnel witnessed any of these refusals or counseled the patient. This has the potential to adversely affect medical care because the labs and EKG ordered were important in elucidating the cause of Ms. [redacted] symptoms. Dizziness and fatigue can be symptoms of serious medical pathology, including (to give just two examples), heart problems and cancer. Moreover, the notes makes little sense. Why would Ms. [redacted] refuse lab tests and a simple EKG test three times without providing a reason? Medical personnel should see patients like Ms. [redacted] to assess her condition and the reason for any refusal.

402. A third example involves [redacted] ([redacted] whose case is discussed in more detail in the section on diabetic care. As explained there, Mr. [redacted]—who is not supposed to receive insulin—was nonetheless prescribed insulin and refused it for months. Health care staff did not provide him with counseling despite his many months' worth of refusals:

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Patient: [redacted] [redacted] Class: 3
DOB: [redacted] Sex: M Race: B
Housing [redacted] Court Date: Type:
Status: ACTIVE Booking Date: [redacted] Proj. Rel: [redacted]

NovoLIN R Injection 100 UNIT/ML Solution [redacted] 2023 3:00:00 PM - [redacted] 2023 2:59:00 PM Mo ina, Joseph MD
Inject 1 unit(s) twice a day for diabetics subcutaneous y for 30 day(s). Dispense 60 so ution. 2 Refi (s). *Insu in S iding Sca e Standard.
Profi e On y
A ergies:

A erg es:
No Known Drug A ergy, No Known Food A ergy

	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Jan	Feb	Feb	Feb	Feb	Feb	Feb	Feb	Feb	Feb	Feb
Hours	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
0330		R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
1500	R	R	R	R	R	R	R	R	R	R	R		R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R

See SD_815346.

403. A string of refusals like this can adversely impact health care in the Jail simply by occupying time, both from health care and custody staff, who are supposed to fill out a refusal form after each refusal. Further, insulin is an important medication. If insulin is essential to this patient's health, health care staff must follow clinical standards of care, and visit with the patient often to see why he is refusing and to assess how he is doing medically despite the refusals. If insulin is not essential to this patient's medical care (as was the case here), then a medical practitioner should have discontinued it and documented this appropriately.

404. Another example involves a patient named [redacted] ([redacted]). A refusal form showed that he refused a blood pressure check on [redacted] 2022. SD_816935. The reason for refusal states "refused to come take am med and to sign refusal with no given reason." *See* SD_816936. There is no evidence Mr. [redacted] knew he was refusing a blood pressure check and not just his morning medication. Many other allegedly refused blood pressure checks in Mr. [redacted] records were documented "per deputy." On [redacted] 2023, a deputy "entered the module to inform patient … [and] returned and reported patient refused BP check." SD_816292. The same reason for refusal was written on [redacted] 2024 and

[redacted] 2024. *See* SD_816282, SD_816278. In all, at least 90 of Mr. [redacted] refusals of blood pressure checks and medication were "per deputy."

405. Another example involves a patient named [redacted] ([redacted]). He allegedly refused medication "per deputy" on at least ten occasions. For example, he allegedly refused to take his Lexapro on [redacted] 2023, and the reason for refusal simply states "'Refused' per Deputy … assisting med. pass." SD_759457. He allegedly refused Lexapro again on [redacted] 2023, and the reason for refusal was "Per deputy 4338 patient refused medication." SD_759462. On [redacted] 2023 he allegedly refused to take Lexapro and "refused to see nurse per deputy." *See* SD_759471. No actual reason for Mr. [redacted] alleged refusals was written.

406. Still another example is the tragic death of 32-year-old Michael Wilson at the Jail. According to documents I received regarding *Estate of Michael Wilson v. County of San Diego*, Case No. 3:20-cv-0457 (RDR-BMD), Mr. Wilson died in custody February 14, 2019 due to acute congestive heart failure, causing fluid to accumulate in his body. Mr. Wilson was on four medications for his heart condition and was admitted to the Jail with a Court Order that medical staff pay special attention to his medical needs. Mr. Wilson also had a history of bipolar schizophrenia. Dr. Freedland in his deposition stated that the patient declined an examination. Given the patient's serious health conditions including his mental illness, more should have been done to examine the patient and ensure he received life-saving heart medications.

407. In addition, the testimony of multiple named plaintiffs in this case suggests that at least some of the refusals documented in patients' medical records are inaccurate. For example, named Plaintiff Ernest Archuleta, in response to a question about the medication refusals in his medical records, stated: "[I]f you weren't your cell and [medical staff] pass by, they would call that a refusal… I don't remember ever signing anything to refuse my meds." Archuleta Tr. at 187:16-20;

see also id. at 188:9-22 ("I wouldn't refuse [my medication]."). Similarly, named Plaintiff Michael Taylor, when asked about a grievance response that purportedly said he had "refused to go to an optometrist appointment," responded: "I would never have denied to go to an optometrist appointment." Taylor Tr. at 210:10-16; *see also id.* at 252:15-253:3 (Q: "Did you refuse visual acuity assessments during housing rounds?" … A: "No … I would have never refused. … I would have never refused an optometrist or any kind of vision anything.").

408. Documents produced by the Sheriff's Department about offsite medical appointments are similarly concerning in regards to refusals. A spreadsheet reflecting offsite appointments between June 1, 2023 and November 29, 2023 listed 432 completed appointments and 95 "refused" appointments. *See* NAPHCARE026024.

409. In my experience, that almost 20 percent of all patients scheduled for offsite medical appointments would refuse to go is astounding—and not credible. In my 25-year career practicing medicine in jails, I cannot recall any patients who refused to go to an offsite appointment—zero. Something is thus deeply wrong with the Sheriff's Department statistics.

410. The Sheriff's Department's policies and procedures require that each of these patients who refuse offsite transport to be counseled face-to-face by a physician. The Sheriff's Department said that they were doing counselling in such cases in their Progress Report: Update on State Audit. SD_184485. However, I see no documentation in the medical records I reviewed that such face-to-face physician counseling occurred for most of these refusals. I also did not review any evidence showing that the extremely high rate of refusals of offsite care was formally investigated by the Sheriff's Department.

411. Refusals of medical care are particularly concerning when the incarcerated patient is someone with mental illness or an intellectual or developmental disability. As explained above, mental illness can lead to people

lacking insight into their medical condition and also being unable to communicate their medical needs. Critically, because of paranoia and difficulty with communication, mentally ill patients sometimes refuse appropriate and even essential medical care. When mentally ill patients do refuse necessary medical care, serious efforts should be made to:

a. Find out why the patient is refusing. Sometimes, the reason for the refusal is simple to deal with (for example, a patient who does not want to take a medication in the morning because it makes him sleepy, but will take it willingly in the evening).

b. Determine whether the mentally ill patient is competent to make the refusal.

c. Plan for follow up. Mentally ill patients are often ambivalent, which means that if they refuse necessary medical care today, they may not refuse tomorrow.

412. The MSD Operations Manual does not adequately address the special needs of patients with cognitive disabilities or mental health problems that might impact their ability to withhold consent. The NaphCare Policy and Procedure Manual does mention this issue in general terms in D-02 Medication Services—Refusal or Non-adherence: "Patient refusal of medication and treatment requires additional intervention and education by treating staff and take into account the medical and mental health status of the individual patient." This implies rather than states the truth that patients with cognitive or mental health disabilities need *more* care and attention, not *less*.

413. In practice, the Jail does not ensure that patients with these kind of mental health or developmental disabilities are in fact receiving care. This failure has led to preventable deaths, including the death of Roselee Bartolacci as described above. An additional example is Teresita Tuazon, a type 2 diabetic who was booked on September 4, 2021. SD_337258. Ms. Tuazon also had severe mental illness,

which led her at times to severe self-neglect, requiring admission into the Psychiatric Stabilization Unit. *See* CLERB Report, SD_050607. She died on September 28, 2021 from "complications of Diabetes Mellitus." *See* Autopsy report, SD_055072. A contributing factor to her death was the fact that she had refused to take her prescribed insulin or other diabetic medications for three days prior to her death and six of the last ten days.

Patient:TUAZON, TERESITA M #:400257958 (21134134) Class:4
DOB[redacted]960 (Age=62) Sex:F Race:F
Housing:---- Court Date: Type:
Status:NOT ACTIVE Booking Date:9/4/2021 4:49:31 PM PDT Release:9/28/2021 8:10:00 PM

Lantus Subcutaneous 100 UNIT/ML Solution 9/11/2021 9:00:00 PM - 10/10/2021 11:59:59 PM Ram, Rana DO
Inject 10 unit(s) beneath the skin DIABETIC BEDTIME for 30 day(s). Dispense 300 solution. 0 Refill(s) *ATE Profile Only
Allergies:

Allergies
Penicillin

	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Sep	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct	Oct
Hours	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4	5	6	7	8	9	10
2100	X	X	X	X	X	X	X	R	X	R	X	X	R	X	R	R	R													

Not Administered - Refused - Doreen Marasigan RN - 9/27/2021 9:00:00 PM
Not Administered - Refused - Shannon Keene RN - 9/26/2021 9:00:00 PM
Not Administered - Refused - Ana Adraneda RN - 9/25/2021 9:00:00 PM
Administered - Ana Adraneda RN - 9/24/2021 9:00:00 PM
Not Administered - Refused - Espergene Manalo LVN - 9/23/2021 10:56:37 PM
Administered - Grace Leonor RN - 9/22/2021 10:27:28 PM
Administered - Julie Baliwan RN - 9/21/2021 8:26:44 PM
Not Administered - Refused - Julie Baliwan RN - 9/20/2021 9:00:00 PM
Administered - Johana Guansing RN - 9/19/2021 7:59:36 PM
Not Administered - Refused - Hazel Camama RN - 9/18/2021 9:50:58 PM

See CLERB Report SD_050607.

414. From my review of her medical records, Ms. Tuazon received no extra attention, care, or counselling because of these refusals. This was a preventable death.

415. In conclusion, how the Sheriff's Department deals with refusals of medical care in actual practice (1) violates their own Policies and Procedures, (2) is different than what was promised in the 2023 Progress Report: Update on State Audit, and (3) violates the medical standard of care. The Sheriff's Department's poor performance on patient refusals has led to patient harm and even deaths. In my opinion, the Sheriff's Department's flawed response to patient refusals of medical

care is one of the root causes of the exceptionally high death rate the Jail has.

VI. The Sheriff's Department Routinely Attempts to Provide Medical Care Without Examining Patients or By Asking Medical Staff to Operate Outside Their Scope of Practice, Placing Incarcerated People at Substantial Risk of Serious Harm

416. It is a basic principle of medicine that, before providing treatment, a physician must examine her patient. In particular, a medical practitioner must conduct a physical examination of the patient including the area of complaint, checking the patient's vital signs, and, if appropriate, ordering lab tests and imaging studies.

417. Without the physical examination or checking the vital signs, the practitioner is missing essential information needed to be accurate and provide appropriate treatment and is, essentially, "flying blind." Inevitably, a practitioner who omits the patient's medical evaluation will make critical mistakes. As an example, when a patient complains of shortness of breath, it makes a difference whether the practitioner finds wheezing or stridor (airway obstruction) or rales (fluid in the lungs) or if there is little air movement at all. Each finding requires a different medical response. Without an exam, practitioners can harm patients by assuming the wrong cause of a symptom and prescribing the wrong treatment.

418. Based on that examination, labs, and patient history, the medical practitioner will make a diagnosis and care plan.

419. Critically, the term "medical practitioner" means a physician, nurse practitioner ("NP"), or physician assistant ("PA"). PAs, while practitioners, still must be supervised by a physician licensed in the relevant state and must conduct only those tasks formally delegated by the supervising physician.

420. Other medical staff, including registered nurses ("RNs"), licensed vocational nurses ("LVNs"), and medical assistants are not "practitioners." Although they assist practitioners by gathering data (like histories, vital signs, etc.), they cannot make diagnoses, prescribe medication, or make ongoing treatment

plans. Those activities are beyond their scope of practice.

421. There are two special instances in the community where a practitioner will not see or examine a patient in person during the medical encounter. The first is when practitioners are on-call. The second is during a telehealth visit. Both are worth discussing in more detail.

422. In the community, hospitals, nursing homes, and other residential medical centers may not have medical practitioners on site 24/7. When a practitioner is not on site, there may be one on-call, whereby they receive phone calls from nurses whenever patients experience medical problems that cannot wait until the practitioner returns to the facility in the morning. Calls to an on-call practitioner are typically made via a telephone, and the case is discussed. In these instances, nurses should have a specific policy to rely on that states what information to have available for the practitioner. The nurse then asks the necessary questions, and the practitioner answers the questions. This exchange must then be documented in the medical record. In almost all cases, the practitioner will then see the patient face-to-face when they are next in the facility again.

423. Telehealth is another example of remote medical practice. In telemedicine, the patient and the practitioner interact with each other via video conferencing, telephone, or other electronic method. In a telehealth visit, practitioners must meet the same standard of care that they would if they were seeing the patient face-to-face in their office. Generally, that means that an appropriate prior examination would have occurred by a practitioner (even if not the one meeting the patient via telehealth). And, critically, during a telehealth appointment, the patient and provider are able to communicate *directly* about the patient's symptoms and concerns. In other words, unlike the on-call practitioner example, there is no nurse acting as an intermediary. All practitioners of telehealth should possess the necessary licenses required to practice medicine in the patient's state. This includes the appropriate medical license and a DEA license if the

practitioner prescribes controlled substances, like narcotics or benzodiazepines.

424. In contrast to on-call and telehealth practices, which require a patient examination, is the inappropriate practice of internet prescribing. This is when a person who wants a certain medication (for example, Viagra) fills out a form online which is then sent to a medical practitioner who writes the prescription. The practitioner has never seen the patient, nor is there a direct conversation between the patient and practitioner. The only interaction has been the electronic form that the patient filled out. The patient does not even know who the practitioner authorizing the prescription is. In this instance, there has been no "appropriate prior examination."

425. Nurses are often involved in both on-call practitioner and telehealth encounters. It may be tempting for the remote practitioner to allow the nurse who is physically present with the patient more latitude than he should have. As an example, a nurse could contact the practitioner in a telehealth encounter and say, "this patient has a UTI and should get a prescription for the antibiotic Bactrim." A practitioner who simply says "OK" and writes the Bactrim prescription engages in the practice of "delegation." The practitioner has inappropriately delegated to the nurse her authority to diagnose and prescribe. This would be, in effect, the nurse again acting outside the scope of practice.

426. Based on my review of documents, it is my opinion that the Sheriff's Office fails to uphold each of these principles. Medical care at the Jail is routinely provided without sufficient examinations by practitioners located off-site who cannot examine the patients themselves, or by nurses or other professionals acting outside of the scope of their practice. The PAs who routinely conduct remote care at the Jail via STATCare are not adequately supervised by a Jail physician. Each of these practices places incarcerated people at a substantial risk of harm, and in fact has harmed many.

A. The Jail Misuses STATCare, Employing Midlevel Practitioners in Remote Locations to Cover for, Supplement, and Replace On-Site Medical Practitioners.

427. "STATCare" is a NaphCare program in which nurses at the Jail communicate with and receive orders from a mid-level medical practitioner employed by NaphCare. STATCare practitioners consist of NPs and PAs, but as far as I can tell, no physicians. *See* Barkley Tr. at 56:16-25. STATCare practitioners never physically practice at the Jail (in contrast to an on-call physician at a hospital, for example, who practices in person during the week, but is on-call over the weekend). Indeed, STATCare providers are usually not even physically present in California—they reside elsewhere in the country, *e.g.*, Nevada and Alabama. STATCare practitioners respond to medical questions from nurses at NaphCare facilities all over the country, not just the Jail. In effect, STATCare attempts to fill the role of an on-call medical provider without ever appearing in person.

428. The NaphCare Health Care Policy & Procedure Manual—Full San Diego Policy Manual (*With Site Addendums*) June 1, 2022, hardly mentions STATCare. *See* NAPHCARE001541. The MSD Operations Manual mentions STATCare only in relation to the treatment of patients experiencing alcohol withdrawal. *See* § MSD.A.3. Neither manual defines the appropriate (or inappropriate) use of STATCare practitioners, leaving unanswered questions like: When should Jail nurses call them? When should they instead talk to practitioners physically present at the Jail? As a general matter, the P&P manuals do not say. The absence of guidance in the P&P manuals is surprising given the ubiquitousness of STATCare in the medical records. STATCare practitioners were involved in every medical chart I reviewed, usually multiple times.

429. While nurses on the ground at the Jail can talk to a STATCare provider by phone, I understand that, in practice, nurses typically rely on instant messaging or email-like communications with STATCare providers via NaphCare's electronic medical record system, TechCare. Ms. Rognlien-Hood described STATCare

interactions as basically "a messenger system." Rognlien-Hood Tr. at 62:10-12.

430. Ms. Rognlien-Hood described STATCare's duties as including: (1) ordering medications at intake for newly booked patients, and (2) addressing urgent medical concerns, like an infection, that need to be started on antibiotics immediately. Rognlien-Hood Tr. at 233:13-34:2. These are two typical functions for any on-call medical provider.

431. In practice, STATCare is actually used for many other medical indications, as well, not typically handled by on-call practitioners. These include:

a. Reviewing patient medical records from a hospital visit. Medical Record of Rosalee Bartolacci, May 10, 2023 SD_711881, 711885.

b. Chronic care management of a patient with chronic hepatitis C and cirrhosis who had been booked six months earlier. Incident Review, Death of Robert Vogelman, SD_055946.

c. Determining if patients have type 1 or type 2 diabetes. Montgomery II Tr. at 233:3-8. (In fact, it is often difficult to determine whether patients have type 1 or type 2 diabetes and a remote midlevel clinician certainly does not have that ability.)

d. Acting as gatekeepers to face-to-face evaluations with on-site medical practitioners. Montgomery II Tr. at 148:9-49:25, 230:14-32:5.

e. Evaluating patients for HIV and sexually transmitted diseases Medical Record of [redacted] for Booking [redacted] 2024, at p. 489.

f. Evaluating complaints of hernia and ordering a truss. Medical Record of [redacted] for Booking [redacted] 2022, at p. 151.

g. Evaluating a complaint of hemorrhoids and ordering hemorrhoid medication. Medical Record of [redacted] 2023, SD_791105.

h. Deciding whether patients can be admitted to the MOB or housed elsewhere. Medical Record of [redacted], [redacted] 2022, SD_746366.

i. Interpreting EKGs. SD_754746, SD_754764. (EKG interpretation is tricky even for a Board-certified emergency physician. I do not know what training, if any, STATCare midlevels have had on the subject or how good they are at this skill.)

432. Each of the above decisions made by a remote STATCare practitioner is a medical evaluation, which instead should have been done by an on-site practitioner. It may be the case that this overreliance on STATCare is due to the absence of P&P to guide appropriate use of STATCare. However, documents I reviewed suggest that the Sheriff's Department has a policy of pushing nurses to use STATCare instead of turning to onsite practitioners. A February 3, 2023 email and attachment from Sheriff's Department staff member Travis Anderson to Ms. Rognlien-Hood contains an "audit" of the medical doctor sick call waiting list, focused on identifying examples that, according to policy, "should have" gone to STATCare instead. SD_320376-320382. For example, [redacted] ([redacted]), who had recently returned from the emergency room for a rash, was seen by a nurse who noted: "Rash getting larger and with some clear discharge. Moved to L eye and pt had vision changes to blurry." SD_320377. According to the auditor, who appears to have made notes in highlighted in yellow, "StatCare should have been notified and not a MDSC." *Id.* An examination of the face and eye of the patient is critical in a case such as this. STATCare cannot do such an examination.

433. STATCare evaluations of Jail patients are necessarily limited compared to what an on-site practitioner could do. Because they are remote, STATCare providers plainly cannot conduct a physical examination prior to providing treatment. Nor do they ever speak or communicate directly with the patient, unlike in a telehealth visit. STATCare providers have access to whatever Jail medical records are present in TechCare, but little else. Yet, the Sheriff's Department's nurses use STATCare rather than calling the local on-call medical practitioner

employed by CHP. In fact, the nurses contact the remote STATCare practitioners even when there are medical practitioners present at the Jail. Rognlien-Hood Tr. at 62:6-63:3, 76:17-77:19.

434. Troublingly, not all of the STATCare practitioners who have provided care to patients at the Jail had appropriate California and DEA licenses. This became an issue (of course) when this was discovered by the Sheriff's Department administration at which time NaphCare was instructed to get appropriate licensure for STATCare practitioners. A May 26, 2023 email from Dr. Montgomery to Christopher Miedico states: "It is worth noting that SDSD initiated the conversation regarding staffing, and inquired about the licensure and registry of NaphCare employees. We are relieved that NaphCare has followed through to ensure that their employees are now registered with the State." SD_227522. Based on Dr. Montgomery's email, it appears that there is ineffective Sheriff's Department oversight of STATCare practitioners to ensure that they are correctly licensed; this is left to NaphCare to do.

435. Dr. Montgomery's email from May 2023 also mentions the fact that Sheriff's Department administrators were unsure about who actually supervises STATCare practitioners: "there is some discussion about who would actually be serving as their [STATCare's] supervisor." *Id.* It appears that there is no Sheriff's Department oversight of the STATCare practitioners or STATCare activities. Each STATCare practitioner has a supervising physician within the NaphCare corporate structure. *See* NAPHCARE034704. For example, STATCare NP Juancho Trinidad's supervising physician is Dr. Elliott Wade, the NaphCare regional medical director for Western States. *Id.* The STATCare program is supervised overall by NP Martha Burgess, the NaphCare Senior Vice President of Clinical Operations. Freedland Tr. at 183:15-23. Similarly, Dr. Freedland testified that CHP's new contract with the county provides no oversight of the STATCare practitioners, even by the CHP Medical Director at the Jail. *Id.* at 178:5-7.

436. Similarly, neither the Sheriff's Department nor CHP appear to have oversight of the medical policies and procedures that guide STATCare practitioners. Instead of providing guidance regarding how to address various medical conditions, they allow STATCare practitioners to rely on drop-down menus to see medical options for the various medical conditions, such as hypertension and diabetes. I discuss the guidelines in these drop down menus in more detail later, but suffice it to say here that they are questionable medically and certainly not in concordance with the medical practice of the CHP practitioners.

437. STATCare activities are also not tracked in any meaningful way by the Sheriff's Department CQI monitoring. For example, how often were STATCare practitioners called about chronic care issues? How many labs did they order? How many times did STATCare review medical records of patients sent off site? Does anyone evaluate the accuracy of their EKG interpretation? Based on my review of CQI documents, these metrics (or any other STATCare metric) are not monitored and evaluated as part of the Sheriff's Department CQI program.

438. Unless they need someone who can perform the normal functions of an on-call practitioner, *i.e.*, to be available when there is no practitioner present at the Jail, it makes little sense for a nurse to contact a STATCare midlevel practitioner who lives in, say, Alabama, about an acutely ill patient at the Jail, rather than call a practitioner (who may be a physician) who is physically present at the Jail. There is no way that a STATCare midlevel practitioner contacted electronically can be as effective as an on-site practitioner, because plainly a remote practitioner is completely unable to conduct a physical examination of the patient and must rely solely on the information transmitted via TechCare versus seeing and hearing the patient.

439. Given these challenges, remote practitioners inevitably will make mistakes. Indeed, the problem of remote STATCare practitioners making medical mistakes comes up over and again in my review of medical charts. A particularly

bad example is the deficient care that STATCare provided to [redacted]. Mr. [redacted] is a type 2 diabetic, who, after a second stage nursing evaluation, was referred to Juancho Trinidad, a STATCare Nurse Practitioner based in Las Vegas. *See* SD_815566. On [redacted] 2022, NP Trinidad reviewed this message from the onsite nursing evaluation: "NIDDM, BS 293, asymptomatic, reports last dose of metformin last night." *Id.*, SD_815587-89. Without any other history, labs, and certainly without examining Mr. [redacted] NP Trinidad ordered "Insulin Sliding scale (Regular) TID x 15 days." SD_815587-89. NP Trinidad also ordered "Provider chart review for glucose readings in 5 days." *Id.* There was no referral for an in-person evaluation by a site-based medical provider. *See id.* As discussed further in the section on diabetic care, the STATCare provider incorrectly prescribed insulin to this type 2 diabetic. The treatment provided to Mr. [redacted] was incompetent, inappropriate on many levels—including that his medication was changed without any labs, examination, or discussion with MR. [redacted] and potentially life-threatening.

440. Because STATCare practitioners are not accountable to the Jail's medical director, gross medical mistakes such as those that occurred with Mr. [redacted] are not noticed, not addressed, and not corrected. STATCare practitioners who make such mistakes will continue to make them in the absence of oversight and corrective action.

441. In my opinion, the Sheriff's Department has likely embraced the use of STATCare rather than onsite practitioners as a way to save on costs and to reduce the work-load of onsite practitioners, who are overworked due to understaffing. However, this practice has seriously compromised patient care. Although the Sheriff's Department has signed a new contract to expand the numbers of practitioners available onsite, there is no indication that the Sheriff's Department will cease its inappropriate use of STATCare. As a result, there is no guarantee that the Sheriff's Department will end this dangerous practice.

B. Jail Medical Practitioners Provide Care to Incarcerated Patients Without Proper Examination.

442. Even when patients are treated by on-site practitioners at the Jail, my review of the records indicates that there is no guarantee that on-site practitioners will see or examine the patient before providing treatment. This practice falls below the standard of care.

443. For example, my review of the records indicates that cell-side clinical encounters commonly omitted vital signs. Examples abound in the records I reviewed. Here are just a few: NP Sonia Megert's [redacted]2024 evaluation of [redacted] SD_814760-61; MD Joseph Molina's [redacted] 2023 evaluation of [redacted] SD_816437; MD Joseph Molina's [redacted]2022 evaluation of [redacted] SD_798727; and NP Teresa Hurley's [redacted]2023 evaluation of [redacted] SD_813216-17.

444. The practice of omitting vital signs during patient evaluations is so ubiquitous that one can pick any almost any patient chart, search for "MD note," "NP note," or "RN note," and the vital sign section of the encounter notes will often be blank. This is poor medical practice that does not occur during patient encounters in the community. Vital signs are called "vital" for a reason. Vital sign abnormalities are often the earliest signs of a gravely ill patient. Not taking vital signs does not save very much time, either. It takes only around 60 second to obtain a set of vital signs during which time one can continue to converse with the patient.

445. My review of the records indicates that practitioners also often fail to obtain a full patient history and fail to perform an adequate physical exam, for example of an abdomen or heart. Such practices may save time, but fall below the standard of care and could lead to serious risks of harm. Inevitably, the missing information can be critical to making a correct diagnosis and therefore providing correct treatments. If the condition is life threatening, this omission could lead to an avoidable death.

446. One example is [redacted] ([redacted]). Mr. [redacted] complained of having a hernia and requested that he be referred to a surgeon for repair. He was seen at his cell on [redacted] 2023 by a NP who did not conduct an examination of the hernia but nevertheless informed Mr. [redacted] that "as long as it is reduc[e]able, it is not emergent even if it will not remain reduced." SD_787868-69. Later the same day, Mr. [redacted] submitted a medical request stating "I would like a second opinion about my hernia from a Doctor, not a Nurse. Thank You." SD_788163. He was seen at his cell on [redacted] 2023 by NP Stacy Thompson. SD_787871. NP Thompson also did not perform a physical examination of the hernia (writing "GU deferred due to location") but approved a truss for Mr. [redacted] *Id.*

447. There is no indication in the records I have that any medical practitioner ever examined Mr. [redacted] hernia. This is concerning because, as explained in more detail below, hernias should generally be treated with surgery and can cause debilitating pain if left untreated for too long. For a practitioner to provide "treatment" for a hernia without examining it is below the standard of care.

C. Registered Nurses Operate Outside Their Scope of Practice at the Jail

448. In my review of the records, I found numerous examples of registered nurses performing outside the scope if their practice, *e.g.*, ordering labs or making diagnoses. This is below the standard of care and may even be against the law.

449. One example is patient [redacted] ([redacted] Ms. [redacted] was a [redacted]-year-old woman with documented heart disease. SD_754291. On [redacted] 2023, Ms. [redacted] was seen by RN Maria Germono for complaints of chest pain. SD_754076-80. RN Germono filled out a "Chest Pain (Non-Acute)" form, which documented that Ms. [redacted] had the cardiac risk factors of age and hypertension and was hypertensive at that moment. *Id.* RN Germono documented that Ms. [redacted] had moderate left sided chest pain with nausea/vomiting. *Id.* RN

Germono performed an EKG. RN Germono sent the EKG to STATCare practitioner Nh Ngoc Da PA, who wrote "EKG similar to [redacted]23 EKG," but did not document that the EKG was, in fact, not normal or in what ways it was not normal. SD_75746. PA Da did not interact with RN Germono in any other way about this case; he only commented on the EKG. RN Germono diagnosed "acid reflux" and "anxiety." SD_754079. RN Germono did not immediately refer Ms. [redacted] to an on-site medical practitioner. RN Doreen Marasigan similarly did a chest pain evaluation of Ms. [redacted] including an EKG with STATCare interpretation, on [redacted] 2023. SD_754099-103. This could have been a catastrophic outcome. Here is a patient with known heart disease complaining of chest pain. Almost all such patients should go to the ER for a cardiac work up. The RNs collectively misjudged Ms. [redacted] risk for a bad outcome, did work-ups outside of their scope of practice that they were not competent to do, made inappropriate diagnoses, and provided inadequate follow-up.

450. A second similar example is [redacted] ([redacted]) who was seen by RN Ju_e H_aro (letters missing in medical record) on [redacted] 2021 for complaints of chest pain and shortness of breath. SD_785880-81. The RN documented normal vital signs, normal heart sounds, and normal chest sounds. *Id.* The RN did an EKG which she interpreted as "normal; sinus rhythm." *Id.* The RN diagnosed "muscular strain" and gave Mr. [redacted] ibuprofen for discomfort. *Id.* She did not refer Mr. [redacted] to be seen by a medical practitioner and, as far as I could determine in his medical record, Mr. [redacted] was never evaluated by a medical practitioner for this complaint. The RN should have immediately referred this case to a practitioner. In this case, RN H_aro did a physical examination of the heart and lungs, ordered a, EKG diagnostic test, interpreted that test, made a diagnosis, and prescribed a treatment. Ordering and interpreting diagnostics tests and making diagnoses are outside the scope of nurse's practice and therefore did not meet the medical standard of care.

451. In summary, the regular practices of the medical staff at the Jail include practices that do not conform to the medical standard of care and, over time, can and do lead to patient harm. These include (1) using STATCare midlevel practitioners in roles that they are not suited to, since they are remote and cannot interact with patients; (2) allowing STATCare practitioners to practice separately from the rest of the Jail medical practitioners, utilizing different leadership, oversight and protocols; (3) failing to ensure that on-site jail practitioners take vital signs and perform complete examinations of patients; and (4) allowing nurses to practice above and outside of their scope of practice. It is my opinion that these practices place incarcerated people at a substantial risk of serious harm.

VII. The Sheriff's Department Lacks Sufficient Contracts with Hospitals and Offsite Providers and Lacks Proper Referral Processes to Provide Adequate Medical Care to Incarcerated People, Placing Them at Substantial Risk of Serious Harm

452. It is my opinion that the Sheriff's Department's entire system for providing incarcerated people with adequate offsite health care falls below medical standards. Specifically, the Sheriff's Department also does not ensure that its contractors apply appropriate utilization management ("UM") processes to secure care for all patients who need it. In addition, the Sheriff's Department fails to maintain sufficient contracts with community medical providers to allow Jail medical providers to refer incarcerated people with chronic and emergent medical needs to those community providers when the Jail medical units are full or do not have the resources to provide necessary treatment.

453. Offsite medical treatment is essential to the healthcare of a large number of incarcerated patients with complex medical needs that cannot be met with onsite medical services. The list of examples is large but broadly falls into four categories.

454. **Surgery.** Many incarcerated medical patients need surgical care. Incarcerated patients suffer from the same diseases and ailments requiring surgery

as patients in the outside community, ranging from complex brain surgeries to simpler, but still necessary, hernia repairs, appendectomies, and orthopedic procedures. Surgeons must often be consulted to determine the proper role of surgery in a particular patient's care. Surgeons must be allowed to follow up after surgery in a manner that they deem proper.

455. **Medical specialties.** Many patients have complex medical problems that require the expertise of medical specialists such as oncologists, neurologists, cardiologists, rheumatologists, and many others. General practice physicians and midlevel NPs and PAs simply do not have the training or practice expertise to be able to, say, prescribe cancer chemotherapy or therapy for a myriad of other complicated medical patients.[38] Just as is done in outside medicine, referrals to the specialist are essential to optimal medical care. When the advice of a specialist is sought, it is important that that advice be followed.

456. **Diagnostics**. The list of diagnostic procedures that must be done off-site includes MRIs, cardiac stress tests, PET scans, and many others.

457. **Medical therapies.** Physical and occupational therapy are excellent examples of the type of medical therapy that is often not available within a correctional facility but is necessary to the medical well-being of a patient. Other examples include providing cancer chemotherapy, radiation therapy, and rheumatological infusion therapy that must be done off-site.

458. Before an incarcerated patient can be seen for any one of the above outside appointments at the Jail, their request must be approved through NaphCare's UM process. UM arose in the context of Health Maintenance Organizations ("HMOs") and health insurance companies (I term this "Corporate UM"). The

[38] Note that the category of prescribing specialty care is distinct from the actual giving of specialty treatments. For example, a patient with cancer may need to go to both an oncologist, who will prescribe the best chemotherapy, and to separate appointments for the chemotherapy infusions. Those are two distinct, but equally important, outside referrals.

purpose of Corporate UM is to control medical costs. UM does this by requiring pre-approval from the HMO or insurance company before they will pay for certain expensive medical procedures or medications. HMOs and insurance companies approve or deny medical requests based on a set of evidence-based guidelines.[39] HMOs and insurers most commonly use nurses to evaluate incoming medical requests, who compare the requests to the company's guidelines, then either approve or deny each request.

459. Corporate UM has been criticized on the following grounds.

a. HMOs and insurance companies have a financial incentive to deny requests. The UM department of an HMO or a medical insurance company is a substantial part of the corporate structure with hundreds of employees and the requisite offices, computers, technology, etc., meaning that it is very expensive to administer. It only makes sense to pay all of this money if the Corporate UM program can deny or inhibit enough medical requests to make the endeavor worthwhile.

b. In many cases, Corporate UM creates barriers to good medical care rather than encouraging good medical care.

c. The UM process of submitting a request and waiting for a reply is time-consuming. Filling out the requisite paperwork to request permission for a medical claim takes a great amount of time from the medical practitioner and her staff. Waiting for a reply can take literally weeks. This process imposes a large financial burden on the medical practices submitting these claims.

d. Denials are often perceived as nonsensical. And, once again, it takes a great deal of time to submit a request to reconsider.

e. The process is bureaucratic and opaque. When a request is

[39] The most used sets of guidelines are propriety products called Interqual and the Milliman Care Guidelines. Because they are propriety, they are not easily available for outside review.

denied, it is often hard for the requesting practitioner to know why.

460. Correctional facilities, such as the Jail, do not belong to an HMO and do not use traditional health insurance companies to pay for health care for their incarcerated populations. Nevertheless, many companies that provide medical services to correctional facilities (like NaphCare) have adopted the system of Corporate UM. The ostensible reason is to control medical costs. They often hire nurses with experience in Corporate UM to set up correctional UM programs modelled after a typical HMO.

461. There are problems with this, though, because Corporate UM is designed for a system and patients who are quite different from incarcerated patients. One important difference is that a patient in the free world with an HMO—unlike an incarcerated patient—has the opportunity to seek the medical care they need outside the HMO. If the HMO denies, say an MRI or a particular medication, the patient has the right to get the MRI or the medication anyway and pay for it personally. An incarcerated patient has no such option; if a jail's UM process denies a patient a procedure or a medication, then the patient simply will not get that care.

462. Another important difference is the scale of operation. HMOs and health insurance companies may have millions of members and tens of thousands of medical practitioners. Communications in such a large system must be written and formal. For example, if a primary care practitioner (one of tens of thousands in the program) wants to order an MRI for one of her patients, she must submit paperwork to the patient's insurance company explaining the need for the procedure. Days or weeks later, someone—most likely a nurse—will review the request (along with thousands of other requests that arrived at the same time) and either approve or deny payment for the procedure based on the HMO's pre-established guidelines. Critically, the medical practitioner and the UM reviewer do not know each other. They are unable to discuss the request or collaborate in any way. If the practitioner

does not understand the reason behind a denial, she is unable to ask the UM nurse for clarification. In fact, she will never know which of the many UM nurses employed by the insurance company handled her request. In the end, Corporate UM processes are impersonal, anonymous, and bureaucratic. The entire process can take days or weeks. It is expensive on both ends. The practitioner submitting the request must bear the cost of the time and salaries of her and her employees to write out, submit and keep track of these UM requests. The HMO or insurance company, on their end, has to pay the salaries of all of their reviewers plus the necessary technology.

463. In contrast, the Jail only has approximately 4,000 patients, (relatively) few medical practitioners, and only one Medical Director. In such a small setting, it makes little sense to use the bureaucratic, anonymous, opaque and expensive Corporate UM model. Instead, the UM process in a jail should be local and collaborative, with the goal of ensuring that patients receive appropriate medical treatment in a timely manner. A primary care practitioner at the Jail who wants to order an MRI for one of her patients should not have to fill out a formal request form and send it to Alabama to be approved or denied by an anonymous reviewer. Instead, requests for an MRI or anything else should be reviewed by a supervising physician at the Jail who the ordering practitioner knows, such as the Jail's medical director or a physician assigned to UM duty. The ordering practitioner and the reviewer at the Jail should be able to talk the case over. If the UM reviewer at the Jail thinks an MRI is not warranted, she should discuss the case with the ordering practitioner, explain why, and jointly create a reasonable care plan for that patient. In other words, the UM process at a correctional facility should be a collaboration between colleagues to ensure that appropriate medical care is provided.

464. The Sheriff's Department has instead chosen to use the bureaucratic method of Corporate UM by sending requests for medical care to NaphCare's Corporate UM Department. In my opinion, this is time consuming, wasteful of

resources, and expensive, and it results in inappropriate denials of medical care that harms patients. MSD Operations Manual No. MSD.R.2 spells out how the UM process works in the Jail:

a. Site practitioners must complete an "Off-Site/Consult Request" form.

b. The requests are then reviewed for approval or denial by the Managed Care Group "and a disposition for appropriateness will be determined by a physician reviewer utilizing evidence-based criteria." (Although the Operations Manual specifies that these reviews are done by a physician, my understanding is that, like other corporate UM systems, nurses do the majority of the UM work, only referring to a mid-level practitioners to authorize a denial. Physicians are not a regular part of the NaphCare UM Team, but may be consulted for "particular patients." Nix I Tr. at 223:5-24.

c. And, whether the referral is approved or not "will be communicated to the referring provider."

465. This is a Corporate UM model. It is anonymous, opaque, bureaucratic, time consuming, expensive, wasteful, and unnecessary. As Ms. Rognlien-Hood described it: "[W]e're at the mercy of whoever NaphCare has contracted with to get" outside appointments. Rognlien-Hood Tr. at 36:4-5.

466. Based on my experience with similar programs, I anticipate that, as with any Corporate UM program, NaphCare's program is resource intensive and therefore expensive. It only makes financial sense for NaphCare to run such a program if they deny more medical treatments than the cost of running the program. From the perspective of the Sheriff's Department, the cost of nurses and practitioners submitting these forms and keeping track of hundreds of replies is also time consuming and expensive.

467. The MSD Operations Manual's explanation of the UM process is not entirely consistent with the County's contract with NaphCare, which envisions a

"discuss[ion]" of non-emergent service requests among the NaphCare onsite medical director, designated site staff, the Chief Medical Officer or designee, and a "dedicated utilization nurse," as well as "progress notes documented in TechCare." County Contract No. 566117, § 2.3.16.5. The MSD Operations Manual does not provide for any such "discuss[ion]," and I have seen no evidence of those meetings in progress notes of the charts I reviewed.

468. In my opinion, by utilizing a method of Corporate UM administered by NaphCare, the Sheriff's Department's policy for referring patients to offsite providers is inadequate to treat the needs of patients and therefore places incarcerated people at risk of serious harm.

469. This UM structure violates other directives of MSD Operations Manual, in particular, No. A.1.1 ("Access to Care"), which prohibits "[h]aving a utilization review process that inappropriately delays or denies specialty care" and "[p]ermitting unreasonable delays before patients are seen by prescribing providers or outside consultants to obtain necessary diagnostic work or treatment for their serious health needs."

470. In practice, the NaphCare UM program denies requests for offsite care at an unacceptably high rate—so much so that the County began raising concerns about the denial rate as early as late 2022. Rognlien-Hood Tr. at 158:6-22. For example, Ms. Rognlien-Hood testified that people who need physical or occupational therapy were frequently denied outside appointments and directed instead "to do certain exercises." *Id.* at 160:4-13. However, she explained, it was often not possible for the patient to complete those exercises while they were incarcerated, both due to limitations in the facility and the lack of anyone "to teach [the patient] these exercises." *Id.* This practice—denying an outside appointment but failing to provide a feasible alternative plan—is not commensurate with the standard of care.

471. Even when outside referrals are approved by NaphCare, the inefficient

UM system creates delays in patients receiving care. Rognlien-Hood Tr. at 115:20-116:12. As Ms. Rognlien-Hood testified, prior to contracting with NaphCare, if an outside referral was recommended, "it happened. It got approved." *Id.* at 115:15-16. In contrast, the system now includes "a lot of steps that [Ms. Rognlien-Hood] think[s] are unnecessary"; describing these many steps, Ms. Rognlien-Hood stated that there is a lot of "approved, authorized, pending scheduling." *Id.* at 115:16-19. As Ms. Rognlien-Hood stated in a February 22, 2023 email: "Case management ha[s] been a disaster," "due to the process change to get appointments approved." Email and attachment from S. Rognlien-Hood to C. Darnell et al., February 22, 2023, SD_375922.

472. This concern was echoed by Physician Connie Orem, who I interviewed while touring the Las Colinas facility. When I asked Dr. Orem, "if you could make one change to improve healthcare [at the Jail], what would it be?" She replied, "more funding" so that the Jail could pay for therapy she would like to provide to patients. In her experience, "referrals take forever or are not approved."

473. An example of a bureaucratic problem that resulted in delayed care is the case of [redacted]. During Mr. [redacted] 2023 receiving screening, a nurse noted that Mr. [redacted] had a "deform[i]ty at upper [l]eft side of mouth, teeth po[i]nt[i]ng [i]nward" following an assault. SD_873245. On [redacted] a nurse noted that Mr. [redacted] was in pain and having difficulty chewing and swallowing due to the injury. SD_873259-60 (Progress Note). According to the email correspondence between the Sheriff's Department and NaphCare, an expedited referral to an oral surgeon was submitted, which indicates that the request was "approved" by "Corp UM" on [redacted] 2023, and "authorized" on [redacted], 2023, with an "appointment pending." Email from E. Arroyo to OMS Scheduler et al., [redacted] 2023, SD_351217. The reason for the expedited referral is stated as: "infection and loss of jaw use." *Id.* However, the emails show that no progress was made on this request for weeks, with repeated emails from the Sheriff's Department

to NaphCare asking for update. SD_351210-16. As the Supervising Detention's Nurse stated in a [redacted] 2023 email: "This patient has been waiting for surgery since [redacted] and seeing as it is now [redacted] we have been waiting several months for this patient to receive his care. I really don't want this to come back to us as a delay in care." Email from B. Rafail to E. Arroyo et al., [redacted] 2023, SD_351209. Mr. [redacted] finally received surgery for his facial injury on [redacted] 2023. SD_873962. I agree with Supervising Nurse Ms. Rafail that this constitutes an unacceptable delay in medical care.

474. Another example is patient [redacted] ([redacted]). Before Ms. [redacted] was incarcerated on [redacted] 2023, she had had a complete evaluation of spinal stenosis in her neck by a neurosurgeon. She had received spinal injections for pain and was scheduled to discuss surgical options. Ms. [redacted] informed the jail that she needed a neck fusion on [redacted] 2023: "I was told by my lawyer to request an operation that is necessary. My neck needs fusing." SD_755507. "I'm in chronic pain." A request to have Ms. [redacted] see a neurosurgeon, sent on [redacted] 2023, was denied. SD_755889. Dr. David Christensen resubmitted a request for a neurosurgical consult on [redacted] 2023. SD_755893. Ms. [redacted] had a repeat MRI of her neck done on [redacted] 2023, and a CT on [redacted] 2023. SD_755667. Yet another neurosurgical consult was submitted on [redacted] 2023. SD_755916. Ms. [redacted] was scheduled for neurosurgery in [redacted] of 2024. SD_755917, but was released from the Jail before then. In my opinion, this delay of medical care was unnecessary and unacceptable. What should have been done: when Jail medical personnel learned on [redacted] 2023 that Ms. [redacted] had been seeing a neurosurgeon and was at the stage of having surgery, someone from the Jail (the Medical Director or Dr. Christensen, perhaps) should have called her outside neurosurgeon to coordinate care and facilitate whatever medical care had already been scheduled. Starting over with a new neurosurgical consult (denied the first time) and a new work up just served to delay a necessary surgery by nine months,

and subjected Ms. [redacted] to unnecessary pain.

475. In addition to the delays in patient care from the UM system, it is apparent from the documents that I reviewed that, since NaphCare began its operations in the Jail and assumed responsibility for outside referrals, the Jail has suffered a loss of medical contracts and strained relationships with outside medical specialty groups and hospitals. That strain on relationships with outside providers poses a serious risk of harm to incarcerated people. As Ms. Rognlien-Hood testified, the Sheriff's Department used to "have a good rapport with our local hospitals, and then NaphCare did things a little different …." Rognlien-Hood Tr. at 116:15-17. Those "hiccups"—as Ms. Rognlien-Hood put it—may harm patients, because "community partners [may] get frustrated and not see our patients." *Id.* at 117:4-7.

476. Indeed, that is exactly what happened when NaphCare took over. In its Corrective Action Notice ("CAN") to NaphCare, the Sheriff's Department explained: "As of April 17, 2023, there are $9.3 million dollars of unpaid bills due to hospitals. Of the total outstanding claims, $4.6 million dollars are past due the 30-day threshold. ***Due to lack of payment, some community providers do not want to see or accept our patients***, which include, but not limited to: Podiatry (Oxford), Alvarado, Vibra, Kindred." SD_1572586 (emphasis added).

477. In a May 26, 2023 email, Dr. Montgomery indicated that he had yet to receive confirmation that the issue was resolved: "We need documentation from the community facilities/hospitals showing claims/bills paid." Email & Attachment from J. Montgomery to C. Miedico et al., May 26, 2023, SD_227523; *see also* SD_227524 ("Need some proof regarding resolution with hospitals").
Dr. Montgomery also noted that NaphCare's failures were particularly problematic for high risk patients, for whom NaphCare had no plan "for risk mitigation/housing." SD_227526. He explained that NaphCare had completely failed to address "long term care sites" and would "do everything possible to avoid placing patients in a LTAC." *Id.*

478. Documents from late October 2023 suggest that the relationships with outside providers had not been fully repaired nearly six months later, despite assertions that the contracts had been fully paid, *see* Rognlien-Hood Tr. at 150:9-10. For example, in email correspondence about an incarcerated person at Kindred—one of the providers referenced in the original CAN as having hesitations about treating Jail patients—the Sheriff's Department Medical Services Administrator, Christopher Miedico, referenced the possibility of a "contractual dispute" between NaphCare and Kindred. Email from C. Miedico to J. Montgomery et al., October 31, 2023, SD_335430. Moreover, Dr. Montgomery expressed concern that the patient may have been delayed in receiving a PEG tube, which, according to Dr. Montgomery, "was a needed procedure a week ago." *Id.*; *see also* SD_335431 ("This has gone on too long."); SD_335434 ("This most recent email seemed to indicate some issue regarding PEG tube placement… which should have been handled several days ago.").

479. PEG tubes are feeding tubes that are surgically implanted so that the tube comes out of the abdomen. They are used to feed patients who, for many possible reasons, cannot swallow or use their esophagus. PEG tubes must receive regular maintenance to make sure that they remain clean and do not get clogged up with feeding liquids. They must be replaced periodically. Not performing appropriate care and not replacing PEG tubes when necessary can certainly harm patients who are dependent on their PEG tube for nutrition.

480. Nor had these relationships been repaired by late November 2023. Email correspondence about another patient's referral to a gastroenterology clinic reveals substantial confusion about where the patient could be evaluated. Although the referral was submitted on November 15, 2023, NaphCare and Sheriff's Department staff were still attempting to figure out whether an appointment could be scheduled as of November 29, 2023. Email from D. Williams to M. Farrier et al., November 29, 2023, SD_350248-350254. Although the appointment was

apparently scheduled for Alvarado Hospital, the appointment had to be canceled because the hospital did "not have a contract with NaphCare," which apparently was a "surprise[]" to those scheduling the appointment. Email from B. Nelson to MSD Managed Care Group, November 29, 2023, SD_350243. NaphCare then responded to state that this was "a misunderstanding," and they were "in contact with the hospital" to correct it. SD_350241. Despite multiple emails on November 30, the day the appointment was supposed to be scheduled, NaphCare and the Jail were unable to make the appointment happen. SD_350232-350238. Sheriff's Department staff instead discussed bringing the patient to the emergency department instead, but again confusion reigned. SD_350226-350227 ("This is not what we were told. Maybe we should just hold off …"). In her deposition, Ms. Rognlien-Hood explained that the patient was brought to the emergency room to see a different doctor, but that doctor "would not admit her," so the patient had to be returned to the Jail. Rognlien-Hood Tr. at 148:20-149:4. The patient ultimately did not receive treatment until either January or February of 2024—over a month later. *Id.* at 149:5-8 (treatment was within 45 day of Ms. Rognlien-Hood's February 14, 2024 deposition). As Ms. Rognlien-Hood put it: "This is a mess!!!!!!" Email from S. Rognlien-Hood to M. Farrier, November 29, 2023, SD_349895.

481. It is also worth noting that the Sheriff's Department's CQI program (discussed in more detail later in this Report) does not contain adequate information about the progression and health of the off-site referral process. When a CQI program considers specialty consultations and off site medical care, the CQI reports should contain analysis and information about gaps in current contracted off-site specialists; the UM process, including the average time taken to get UM approval and the percentage not approved, broken down by specialty; the average wait times for appointments with each particular specialist; and problems encountered in making and keeping these appointments, such as the reason for all missed or rescheduled appointments.

482. However, none of this information is contained in the Sheriff's Department CQI reports that I reviewed. Instead, these reports give only bland statistics of how many off-site appointments were completed in a given month, and occasionally how many were cancelled due to refusals, discharges, etc. These CQI statistics are gravely limited and suggest to me that the Sheriff's Department does not itself have a clear picture of the health of its offsite referral process and how it can be improved.

483. To be sure, the off-site referral process is one of the more challenging aspects of carceral medical care, but it can also be of critical importance to patient health. That is why CQI analysis is essential. Without proper CQI, there is no opportunity to find and fix problems before they impact patient care and patients are harmed.

484. In summary, the system of off-site referrals at the Jail is broken. The UM process is wasteful and inefficient. The essential relationships between the County and community health providers has been strained. The Jail does not appropriately evaluate these problems in its CQI program. And, as a result of these many systemic failures, incarcerated people's medical care is delayed and denied, placing them at risk of serious harm.

VIII. The Sheriff's Department Fails to Provide Adequate Diagnostic and Chronic Care to Incarcerated People and Provides Inadequate Treatment for Several Common Medical Conditions, Placing Them at Substantial Risk of Serious Harm

485. In their Third Amended Complaint, Plaintiffs allege that the Sheriff's Department fails to order medically necessary diagnostic care in a timely manner, resulting in an unreasonable risk of harm to incarcerated people. Dkt. 231 at ¶ 104. Based on my review of the documents and as described in more detail below, I agree. It is also my opinion that the Sheriff's Department does not have an adequate system for chronic care and provides inadequate care—including but not limited to diagnostic and chronic care—for several of the medical conditions that are most

common among the incarcerated population.

A. Diagnostic Care

486. Diagnostic care refers to those laboratory tests and imaging studies that must be done to accurately diagnose and assess patient medical conditions. Examples of commonly ordered laboratory tests are complete blood counts, urinalyses, and comprehensive metabolic panels that include tests to measure electrolytes (such as potassium and sodium), kidney function, liver function, and nutritional status. Examples of commonly ordered imaging studies are chest x-rays, extremity x-rays, computerized tomography (CT) scans, and electrocardiograms (EKG).

487. Diagnostic tests are needed to accurately diagnose many acute medical complaints, such as infections and heart problems. Diagnostic tests are also needed for chronic care, such as routine chronic care labs to check the status of diabetes or the progression of kidney disease. Diagnostic tests are critical to patient health. They are often essential to making timely, accurate diagnoses and to monitoring the progression of chronic diseases.

488. The appropriate process of using diagnostic tests in the medical process includes several steps, all of which should be documented in the medical record. First, diagnostic tests must be ordered by a *medical practitioner*; this responsibility should not be delegated to nurses. Second, the test must be completed, *e.g.*, blood in drawn, x-rays are run, etc. Third, the test result must be interpreted by a medical practitioner (preferably by the practitioner who ordered the test); again, this responsibility should not be delegated to a nurse. Fourth, the practitioner must determine what changes, if any, will be made in the patient's overall care plan based on the diagnostic test results. Finally, the patient must be informed of the test results and the changes in care, if any.

489. Each of these steps is important. If necessary diagnostic tests are not ordered, findings and diagnoses will be missed and patients will be harmed. If

diagnostic tests are ordered but not reviewed—or reviewed but the significance of the labs are not noticed—again, findings and diagnoses will be missed and patients will be harmed.

490. The policies and procedures of the Jail should address the proper way to order, interpret, and document the results of diagnostic tests. The MSD Operations Manual is silent on this subject except for addressing patient refusals of lab tests. *See* MSD Operations Manual No. MSD.R.5.VII (2022). NaphCare's Policy and Procedures address this by stating that "[d]iagnostic tests will be reviewed by the clinician in a timely manner," without defining "timely," NaphCare P&P, E-9.8; "[t]reatment plans are to be modified as clinically indicated by diagnostic tests," *id.*, E-9.9; at that the tests and plans will be "discussed with the patient," *id.*, E-9.9. NAPHCARE 031275. NaphCare's P&P Manual does not discuss minimal standards for documentation.

491. The NCCHC Technical Assistance Report found the Jail deficient in reviewing diagnostic studies, recording them in the chart, and communicating results with the patients. DUNSMORE 0260641 (discussing lack of compliance with NCCHC standard J-E-12).

492. My review of patient records also shows that critical study results are not reviewed. One example is [redacted] ([redacted]). Mr. [redacted] asked to be tested for sexually transmitted diseases. RN Jamee Barrera wrote that the "STD labs completed" on [redacted] 2022. SD_782038. On [redacted] 2022, the lab results returned, showing that Mr. [redacted] had tested positive for syphilis. SD_782079. But there is no indication that a medical practitioner ever reviewed the positive syphilis test. *Id.* Mr. [redacted] was released from the Jail on [redacted] 2022, SD_1575334, without this positive test being addressed or communicated to him. Mr. [redacted] was rebooked into the Jail ten months later, in [redacted] of 2023. *Id.* On [redacted] 2023, NP Frederick Wycoco finally addressed the positive syphilis screen. SD_782042. RN Maria Ugaban had noted the day prior that Mr. [redacted]

syphilis test was positive on [redacted] 2022 "but syphilis was not addressed at that time because pt was released." *Id.* Had Mr. [redacted] not returned to the Jail, that positive test would never have been noted and dealt with; in the interim, Mr. [redacted] could have suffered negative health effects and spread the disease to others.

493. Another example is Abdiel Sarabia (21118298), a patient who died on July 22, 2022 of "Hypertensive cardiovascular disease," with hypothyroidism as a contributing factor. Autopsy Report, SD_001362. On October 16, 2021, blood labs were drawn on Mr. Sarabia which showed a markedly elevated level of triglycerides at 932 (normal is less than 150), elevated cholesterol test of non-HDL cholesterol at 157 (therapeutic goal of less than 100) and an elevated Thyroid Stimulating Hormone indicating the possibility of hypothyroidism. SD_011633-34. Mr. Sarabia had other abnormal labs, too, such as elevated liver tests indicating liver damage. *Id.* No one reviewed these labs at the time.

494. *Four months later*, on February 1, 2022, a psychiatric nurse practitioner noted the elevated triglyceride and TSH levels and referred Mr. Sarabia to medical. SD_011546-47. Once notified, Joseph Molina, MD, reviewed the labs on February 8, 2022 and ordered fenofibrate, a medication for high triglyceride levels. However, Dr. Molina still did not address the abnormal thyroid test, the other lipid abnormalities, or the elevated liver enzymes. He did not discuss the results with Mr. Sarabia in person. SD_011551. Mr. Sarabia's abnormal thyroid levels—which the autopsy determined were a contributing factor in his death—were never addressed over the several months Mr. Sarabia was incarcerated.

495. [redacted] ([redacted]) blood test results dated [redacted] 2023 showed an extremely low platelet levels among other lab abnormalities associated with chronic hepatitis C infection. SD_814796. I can find no note that anyone reviewed those labs or noted his particularly low platelet level.

496. The fact that lab reviews are not documented properly and discussed

with patients was corroborated by a CQI review, which reported, "This quality improvement study focuses on provider follow-up after ordering of labs, diagnostic studies or specialty consults/referrals to identify whether results are being reviewed by providers and discussed with patients. In May [2023], SBDF achieved 28% overall compliance. In June, compliance was 16%." CQI Review PowerPoint, July 18, 2023, SD_114489. This is an abysmally low compliance rate.

497. The Sheriff's Department's failure to review diagnostic testing places incarcerated people at risk of serious harm, because it allows their medical conditions to worsen. The consequences of this can include death, as it was for Mr. Sarabia.

B. Chronic Care

498. Inside and outside the correctional setting, people have conditions that require regular medical visits, even if they are not experiencing any acute or urgent symptoms caused by the underlying medical condition. One example is diabetes. People with diabetes should be evaluated by a medical professional at regular intervals for a check-up in order to confirm that their condition is being managed appropriately. These chronic care appointments are distinct from any urgent medical care a person might need if they begin to experience acute symptoms from their underlying condition.

499. The medical standard of care for the frequency of chronic care appointments and what should happen at those appointments (*i.e.*, what labs should be checked) are set forth by well-recognized medical guidelines issued by medical specialist societies.[40]

500. Even though a chronic care appointment does not necessarily treat an urgent or acute problem, it is nonetheless important to a patient's health, and failing

[40] As one example, *see* Daniel L. Larber et al., *Diabetes Management in Detention Facilities: A Statement of the American Diabetes Association*, 47 DIABETES CARE 544 (2024).

to provide such appointments can place a patient at a serious risk of harm. These clinics have the specific goal of monitoring a patient's condition over time. Often, even though a patient feels well, their condition has deteriorated in a way that should be addressed with a new medical treatment plan. For example, consider a hypothetical patient with type 2 diabetes. Although she feels well, she may be suffering from diabetic retinal disease, which is asymptomatic at first, but could lead to blindness, if untreated. Absent a chronic care appointment, she would miss a referral to an ophthalmologist for treatment.

501. The Jail has a long history of failing to provide appropriate chronic care for its patients. The NCCHC Technical Assistance Report listed numerous criticisms of aspects of chronic care. The NCCHC noted that the Jail lacked chronic care guidelines for several chronic diseases, including seizures, diabetes, asthma, and many others. DUNSMORE 0260643 (discussing lack of compliance with NCCHC standard J-G-01). They stated that "[c]hronic disease services must be developed," and patients with chronic diseases "monitored according to [a] protocol" developed based on accepted national standards. *Id.*

502. Perhaps in response to negative assessment, the 2022 contract that the Sheriff's Department negotiated with NaphCare devoted an entire section of the Statement of Work to a "Chronic Care Program" that required NaphCare to establish chronic care protocols and chronic care clinics. Contract No. 56117, § 2.3.11, NAPHCARE000580-81. These chronic care clinics must comply "with standards established for the care and treatment of chronic illnesses." *Id.* § 2.3.11.6. These clinics were to be scheduled for each patient with a chronic disease, at a minimum, within "approximately one month" of admission. *Id.* § 2.3.11.10. In addition, TechCare lists several of recommendations for chronic care at the end of its Health Assessment form. *See* NAPHCARE034787-88.

503. However, in practice, NaphCare has not met this obligation of their contract as far as I can tell. The Jail's provision of chronic care falls below the

standard of care. Testifying on behalf of the Sheriff's Department, Dr. Montgomery explained that as of the date of his deposition, there is no separate chronic care clinic. Montgomery II Tr. at 119:15-18. Instead, the Jail was "using an acute care setting to manage chronic appointment types." *Id.* at 119:19-20. According to Dr. Montgomery, this practice of "using chronic appointments in an acute-care setting would certainly be less efficient and could potentially reduce the speed or effect a delay in getting a patient aligned with the community." *Id.* at 121:20-22. It is my impression that some chronic care appointments are occurring, but many of the charts I reviewed show patients are not scheduled appropriately for chronic care.

504. Dr. Montgomery also testified that one of the goals of the Sheriff's Department's new contract with CHP was to "create a separate chronic care clinic," which in turn would "allow for a longer time frame for the patient/physician encounter to accommodate all chronic-care needs and requests." Montgomery II Tr. at 119:22-120:8. However, this is not expressly laid out in the new CHP contract, which merely states, under the definition of "Clinic": "Provisions are made for both scheduled appointments for addressing chronic care issues and same-day appointments for acute issues." Contract No. 571418, Agreement With Correctional Healthcare Partners Inc § 5.5.8, SD_1579719. For his part, Dr. Freedland stated in his deposition that he was "aware" of the NCCHC requirement for chronic care clinics but was unable (or unwilling) to state which national standards he would follow in developing chronic care guidelines. Freedland Tr. at 171:9-15.

505. From this testimony, and the relative lack of chronic care appointments in the charts I reviewed, it is my opinion that the chronic care system at the Jail remains inadequate, putting incarcerated people at risk of harm.

C. Inadequate Treatment of Common Medical Conditions

506. My review of documents also revealed inadequacies in treatment of multiple conditions that are common in the incarcerated population: hepatitis C, type 2 diabetes, hernias, latent tuberculosis, sexually transmitted infections, and

asthma.

1. Hepatitis C ("HCV")

507. HCV is a virus that infects liver cells. HCV is an infectious disease spread blood-to-blood, most commonly by sharing needles between persons injecting heroin, meth, or other drugs of abuse. Up to 85% of people infected by HCV develop chronic infections. These people never clear the virus from their blood and so are infectious to other people for the remainder of their lives or until they are treated and cured. Over time, HCV causes liver disease (termed fibrosis) and the death of liver cells (termed cirrhosis); it can ultimately lead to liver cancer (hepatocellular carcinoma), the need for liver transplant, or death.

508. Although most patients with chronic HCV infection are asymptomatic until their liver disease has progressed to a moderate-severe stage, those patients remain infections and can transmit the virus to other individuals in the community. Diagnosis of chronic HCV infection is made through simple lab tests.

509. Chronic HCV can be treated with antiviral drugs, which will totally eradicate HCV in over 95% of patients, essentially curing them of the disease (although the liver damage they have already sustained may not be entirely reversible). HCV antiviral drugs are remarkable in that they are easy to administer as pills taken once a day for 8-12 weeks, and they cause very few side effects. There is no need for lab monitoring during therapy. There is no need for consultations with infectious disease specialists or liver specialists in most patients.

510. The standard of care for HCV in correctional facilities includes the following key points.[41] First, jails should implement opt-out testing for HCV,

[41] The standard of care for patients suffering from chronic HCV infection can be found in several places, including standard medical textbooks (such as the online textbook Uptodate) and guidelines published by specialty organizations. Probably the most cited and respected of these guidelines is *HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C* published jointly by the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA). This guideline contains a section that specifically addresses care for incarcerated patients: *HCV Testing and*

meaning that incarcerated people are automatically tested for HCV unless they choose not to be. The opposite is "opt-in" testing, in which people must request a test. Second, all people who test positive for HCV and are expected to be in the Jail for at least 10 weeks should receive the (essentially curative) antiviral treatment noted above. Ideally, even people who may be released sooner than 10 weeks should receive antiviral treatment and, if necessary, be connected to a community healthcare provider who can continue the treatment after release. In any case, treatment should not be dependent on the patient's level of liver damage. Finally, people with HCV should receive counseling about the infection and be provided linkage to follow-up community healthcare for evaluation of liver disease and treatment upon release.

511. However, my review of patient charts and my interviews of incarcerated patients during my jail tour show that the Jail is not following this guidance.

512. The Jail does not do opt-out testing for HCV infection, despite having a large percentage of patients with risk factors for HCV infection. The Jail instead does only opt-in HCV testing. Opt-in testing is dependent on patients knowing that they might have Hepatitis C and that they have the right to request the test. However, the Jail does not adequately inform incarcerated patients that HCV testing is available to anyone who wants it. Of course, patients who do not know about HCV testing will not request it. Choosing to test patients for HCV infection only when they request testing and failing to inform patients of their right to ask for this test does not make any sense from a medical perspective. It only makes sense as a way of minimizing the number of HCV cases found in order to save money by not having to treat them. By choosing this method of screening, the Jail is missing many patients who have chronic HCV infections that could be cured by treatment.

Treatment in Correctional Settings (Dec. 19, 2023) [hereinafter *HCV Treatment in Corrections*], https://www.hcvguidelines.org/unique-populations/correctional.

Since they were not discovered and not treated, these patients will continue to deteriorate over time and continue to infect others.

513. The Jail also denies treatment to many patients who they know are suffering from HCV, based on the misguided principle that only patients with at least moderate liver damage should receive treatment. I understand that the Jail has a document referred to in medical records as "Physician's Treatment Guide [PTG] for Hepatitis C," also known as "PTG.H.9." *See, e.g.*, Medical Record of [redacted] SD_781828. Although I understand that Plaintiffs' counsel asked for all Jail policies, including those governing medical care, I have not seen PTG.H.9 and am not aware that the Sheriff's Department provided it. In fact, the "PTG" is barely referenced in the MSD Operations Manual, and it appears that at least some portion of section H of the PTG has been "archived" since at least November 2022. *See* Policy MSD.H.14 (noting that PTG.H.3 has been archived). Practitioners in the Jail should not be providing care based on an archived treatment guide.

514. However, in at least some cases, medical practitioners appear to rely on this PTG and, consistent with that guidance, provide treatment for HCV only if patients have at least a moderate to severe degree of liver damage. This was the case, for example, with [redacted], whose treatment was deferred on [redacted] 2023, SD_754905, and [redacted], whose treatment was deferred on [redacted] 2023 and [redacted] 2023, despite his request to resume HCV medications and his statement that he was receiving HCV treatment at another facility, SD_782060-61. As far as I can tell, unless a patient has advanced liver fibrosis, the Sheriff's Department will refuse to provide HCV treatment.

515. This makes no sense medically. Modern antiviral treatment for HCV will cure greater than 95% of patients, does not take very long (8 weeks), has few side effects, and requires minimal monitoring. Treatment also does not usually require consultation with a liver or infectious disease specialist. Treatment is so simple and so effective that the CDC encourages primary care doctors to treat most

HCV patients themselves rather than referring to a specialist. *See, e.g.*, Richard R. Andrews, *Family Physicians Can Manage Adults with Hepatitis C*, 98 AM. FAM. PHYSICIAN 413, 413 (2018).

516. Denying patients with chronic HCV infection a cure until they get sicker (and can infect more people) unquestionably violates the standard of care, which is to treat everybody who will be incarcerated for "sufficient time" (approximately ten weeks or longer). *See HCV Treatment in Corrections*, *supra* at 2. Denying infected patients a cure until their liver is more damaged only makes sense if the goal is to save money by denying necessary medical care.

517. I have also seen no evidence that the Jail meets the other standard of care elements: HCV patients not given counseling while they are in the Jail, nor are they connected to community healthcare providers upon their release. Ideally, the Jail would have identified a specific community partner who has the funding and resources to treat discharged Jail patients with HCV infection, including planning for patients who are uninsured. The Jail could and should work with San Deigo County Health and Human Services to create a plan for HCV patients without insurance who are discharged without treatment. However, I have not seen any evidence that such a community partner has been identified.

518. Examples of patients who were denied medical treatment for chronic HCV infection contrary to the medical standard of care include:

519. [redacted] ([redacted]) was seen on [redacted] 2023 by Nas Rafi MD, who wrote, "pt. requesting hep c treatment. His fib4 is 0.69 indicating low level fibrosis, so no indication for tx [treatment] based on county guidelines." Medical Record of [redacted] from Booking [redacted], at p. 483. Mr. [redacted] was seen again during the same incarceration on [redacted] 2023 by NP Nicolaus Rosete, who wrote, "30 yo [year old] male pmhx [past medical history of] Hep C, reports having diagnosis for 13 years, he is requesting treatment … FIB4 calculation is 0.98. Informed patient he is unlikely to have advanced liver fibrosis based on

score" and denied Mr. [redacted] treatment. *Id.* at pp. 484-85. NP Rosete did not address the fact that Mr. [redacted] Fib-4 score (which measures the degree of liver damage) had worsened from 0.69 to 0.98 in two months. This indicates that Mr. [redacted] had rapidly progressing liver damage due to his HCV infection. Denying him appropriate care meant that his liver would continue to deteriorate and that he would remain infectious to other people.

520. [redacted] ([redacted]) was seen on [redacted] 2023 by NP Frederick Wycoco, who wrote "Fib4 score = 0.51 High likelihood of low stage fibrosis. Per SDSD policy PTG.H9: Defer Hepatitis C treatment at this time." SD_754905.

521. [redacted] ([redacted]) requested treatment for HCV infection and was seen on [redacted] 2023 by NP Ozoma Enworom, who wrote "Informed IP FIB score 0.60 and that per SD Sheriff current guidelines treatment is deferred." SD_782061.

522. [redacted] ([redacted]) submitted a sick call request for treatment for HCV infection on [redacted] 2023. SD_772844. A handwritten response on Section 2 of the Sick Cal form states "Per provider, your level did not meet the criteria for treatment." *Id.*

523. [redacted] ([redacted]) was seen on [redacted] 2022 by David Christensen MD because for HCV infection counseling. Medical Record, SD_800289. Dr. Christensen wrote "I discussed the patient's labs with her. Her FIB4 = 0.37. She does not meet Hep C treatment criteria." *Id.*

524. In essence, the Jail medical providers are telling these patients: "We have a medication that could cure you of your deadly HCV infection quickly and easily. But we have decided that we will not give it to you until more of your liver is diseased and you are sicker." It is important to keep in mind that each of these patients is infectious and can transmit this deadly disease to others. In the end, the Sheriff's Department is deliberately withholding treatment for patients with a

serious medical illness that could be quickly and easily cured.

525. This policy of denying treatment to patients who the Jail knows have a serious progressive disease contrary to the medical standard of care, apparently because they are not sick enough, places these patients at a risk of serious harm.

2. Type 2 Diabetes

526. The Jail fails to provide patients with type 2 diabetes with care consistent with national standards.

527. Type 2 diabetes is a progressive disease in which patients develop resistance to the effects of the hormone insulin that they produce. In contrast to type 1 diabetes, in which patients produce no insulin and must be given insulin to survive, patients with type 2 diabetes initially have plenty of insulin—their insulin levels may indeed be abnormally high. Their problem is insulin resistance, meaning that their insulin does not work as effectively as it should. The result of insulin resistance is abnormally high blood sugars. Over time, the elevated blood sugar causes many serious health problems, including kidney failure, heart disease, neuropathy (nerve damage), retinal disease, and many more.

528. The treatment of type 2 diabetes differs considerably from that of type 1 diabetes. Insulin is usually not used to treat type 2 diabetics early in their disease for two reasons: (1) patients with type 2 diabetes have plenty of their own insulin (their insulin levels may even be high), and (2) they are insulin resistant, meaning that giving them more insulin has little effect. After about 20 years of having this disease, type 2 diabetics' insulin levels tend to fall below normal levels and, at that time, insulin therapy should begin. Before that, there are many other medications that can be used effectively to treat type 2 diabetes. An appropriate diet is also important in the management of type 2 diabetes.

529. The standard of care for type 2 diabetes in correctional facilities

includes the following key elements.[42] First, type 2 diabetics should have a complete medical history taken, as well as a comprehensive intake physical examination, including a retinal exam, cardiac exam, peripheral pulses, foot exam, and neurological exam. They should also have a number of labs taken as part of intake, including but not limited to a Hemoglobin AIC blood test ("A1C"), which is the most important diagnostic test to follow the progress and status of type 2 diabetes. Second, as noted above, insulin is not the primary medication required for many adults with type 2 diabetes. Insulin should generally be used only for people with an AIC of over 10%. And, when insulin is necessary, so-called "sliding scale" insulin is expressly discouraged. Finally, patients with type 2 diabetes should receive dietary and lifestyle counselling.

530. My review of patient charts and my interviews of incarcerated patients during my inspection show that the Jail is not following this guidance and is, instead, providing poor medical care to diabetic patients. In particular: the Jail does not conduct recommended physical exams or labs in a timely manner; discontinues long-acting insulins as a matter of course and instead prescribes sliding scale insulin; changes patients' medications without consulting them; and provides minimal, if any, diabetic counselling to type 2 diabetic patients.

531. One particularly troubling fact is that the Jail's formulary does not include (and therefore essentially prohibits the use of—see discussion of formularies earlier in this Report) some legitimate diabetic drugs and encourages irresponsible substitutions. In particular, the Jail requires STATCare practitioners to irresponsibly

[42] The standard of medical care for patients suffering from Type 2 DM can be found in several places, including standard medical textbooks (such as the online textbook Uptodate), and guidelines published by specialty organizations. Probably the most cited and respected of these guidelines for DM is the American Diabetes Association, *Standards of Care in Diabetes* (2023) [hereinafter *ADA Standards of Care*], https://diabetesjournals.org/care/issue/46/Supplement_1. The American Diabetes Association recently released guidelines specific to management of diabetes in correctional settings. Larber, *Diabetes Management in Detention Facilities*, *supra.*

discontinue long-acting insulins on newly admitted patients taking them. The STATCare Intake and Order Form contains this statement: "***All long-acting insulins will be substituted with Novolin N BID at an equivalent dose unless there is documented evidence that the patient cannot or should not be transitioned**." *E.g.*, SD_790712. Novolin N (a short acting insulin) is given exclusively via a sliding scale. The STATCare Intake and Order Form allows STATCare practitioners only one way to prescribe it: "Insulin Sliding Scale (Standard) BID x 30 days."

532. All of this deviates so severely from the guidelines of the American Diabetic Association, that, in my opinion, it constitutes medical malpractice.

533. The records I reviewed suggest that the Sheriff's Department has good reason to know that this guidance for treatment of diabetes is inadequate and dangerous. In September 2021, two people with type 2 diabetes died in the Jail: John Wright, died September 16, 2021, Autopsy Report, SD_001427; and Teresita Tuazon, died September 28, 2021, Autopsy Report, SD_055905. Both Mr. Wright and Ms. Tuazon died of type 2 diabetes complications that take days to develop, meaning Jail staff should have noticed their abnormal blood sugar levels over that period and intervened to save their lives.

534. Those two preventable diabetic deaths within two weeks of each other no doubt led Dr. Montgomery to, on December 3, 2021, issue "Medical Directive: #7 – Internal Transition of Care for the Management of All Patients with Diabetes." SD_169026-27. This Medical Directive required: "All identified diabetic patients will be scheduled for an in-person assessment by a qualified healthcare practitioner (Physician/clinician) within 72 hours." *Id.* "Nursing staff will request dietary consultation in Techcare and order a STAT basic chemistry panel and HgA1c to have test results available at the medical encounter." *Id.* "Medical clinicians are expected to initiate a treatment plan, to include considerations for medications, periodicity of glucose checks, and provision for continued evaluation/additional

encounters for chronic care follow up." *Id.* And, a "sliding scale is used for initial stabilization, but the sliding scale is not designed or intended for ongoing clinical management." *Id.*

535. In my opinion, each of these is excellent clinical practice that conforms to the medical standard of care as set forth by the American Diabetic Association.

536. However, nine months later, on August 16, 2022, Dr. Montgomery issued Medical Directive 7A, which **rescinded** Medical Directive 7. SD_375927. Medical Directive 7A basically put diabetic management in the hands of the STATCare practitioners, leading the Jail to its current, inadequate treatment as described above.

537. With the stroke of a pen, in-person evaluations with on-site practitioners were out and remote diabetic management by STATCare was in. Sliding scales were again permitted for "ongoing clinical management." Treatment plans for diabetics were optional. And (per the STATCare mandates noted above) all long-acting insulins were to be discontinued at booking. Further, the NaphCare guidance cited in Directive 7A contains no information about proper management of Type 2 Diabetes. All of this was a departure from the American Diabetic Association Guidelines and failed to meet the standard of care.

538. In his deposition, Dr. Montgomery stated that the "reason" he rescinded the excellent provisions in Medical Directive 7 "was due to NaphCare's arrival" and the "introduction of StatCare," which is no excuse for abandoning the appropriate standard of care. Montgomery II Tr. at 229:16-21.

539. The following cases exemplify the Jail's mismanagement of type 2 diabetes:

540. [redacted] ([redacted]) is a type 2 diabetic. At his [redacted] 2022 booking, RN Elizabeth Miller noted that Mr. [redacted] had non-insulin dependent diabetes mellitus with "BS 293, asymptomatic, reports last dose of metformin was last night." SD_815566. This case was referred to

STATCare NP Juancho Trinidad, who reviewed RN Miller's message and, without any other history, labs, and certainly without examining Mr. [redacted] ordered "Insulin Sliding scale (Regular) TID x 15 days." SD_815587-89. NP Trinidad made no referral for an in-person evaluation by a site medical provider. *Id.* Mr. [redacted] was rightfully confused about why he had been prescribed insulin. On [redacted] 2022, Mr. [redacted] wrote "I've never had insulin injection before." SD_815922. He was seen by RN Grace Ceclio, who noted that she "[e]xplained importance of getting insulin, made aware of risk and benefits of refusing insulin. Pt. refused. IP requesting to see a medical provider." SD_815922. On [redacted] 2023, NP Frederick Wycoco reviewed Mr. [redacted] blood sugars in the medical record and noticed that Mr. [redacted] had been refusing his blood glucose checks. NP Wycoco made no attempt to see Mr. [redacted] and did not schedule him to be seen by another medical practitioner. SD_815922. On [redacted] 2023, Mr. [redacted] refused to allow a blood draw for a Hemoglobin A1C. SD_815923-24.

541. Because he had refused his A1C lab test, on [redacted] 2023, Jospeh Molina MD saw Mr. [redacted] at his cell. Dr. Molina wrote, "Patient states he just does not want to take medications. He knows he has diabetes. He doesn't have continuous follow up with a doctor on the outside. He does not know what an A1C is. He was prescribed metformin previously and it was a discharge medication from the hospital." *Id.* Dr. Molina did no vital signs and no physical examination, noting only that Mr. [redacted] appeared to have a "normal affect." Dr. Molina did not explain to Mr. [redacted] why insulin had been prescribed for him. Instead, he noted "I advised patient to take medications—patient understands. Continue offering medications." Mr. [redacted] then simply began refusing insulin. He refused insulin the rest of the time he was at the jail. *See* SD_815924-36. The LVNs had to fill out a refusal form every time, which was a monumental waste of their time. When he was discharged from the jail on [redacted] 2023, he was given

a prescription for needles and for insulin that he had never taken, did not want, and should never have been prescribed in the first place. *See* SD_815605.

542. Mr. [redacted] treatment fell below the standard of care in numerous ways: he was inappropriately prescribed insulin without a medical indication; he was inappropriately prescribed short acting insulin and placed on a sliding scale; he was not seen or examined by the practitioner who put him on insulin; he never received an appropriate physical examination or lab studies; and he was not allowed to have informed consent and input into his own therapy.

543. [redacted] ([redacted]) was booked on [redacted] 2023. SD_791077-84. At his receiving screening, done by RN Wenyon Boyd, he stated that he was a diabetic. *Id.* No blood sugar was checked, and he was not referred for a second stage nursing evaluation. *Id.* The same day, Nh Ngoc Da, Corp PA, did a remote STATCare review of a "Nurse Alert" which stated "Surescripts pt claims taking Mounjaro [a GLP-1 diabetic medication] injection for DM, please advise." SD_791100. PA Ngoc Da responded: "[T]his med is nonformulary. Will order insulin sliding scale." *Id*. There is no indication that Mr. [redacted] had been on insulin before. PA Ngoc Da ordered this without reviewing a medical history or any labs, such as an A1C. *Id.* NP Nicholas Kahl then did a provider chart review on [redacted] 2023. SD_791101. NP Kahl did not see Mr. [redacted] but did order diabetic labs. *Id.* Mr. [redacted] labs showed an A1C of 6.1, which is too low for a diagnosis of diabetes. SD_791179. (A diagnosis of type 2 diabetes cannot be made until the A1C is greater than 6.5. An A1C of 5.7 or below is normal. A1Cs between 5.8 – 6.5 are termed "pre-diabetes," which is usually treated with diet, exercise, and weight loss—not drugs.) NP Stacey Thompson reviewed Mr. [redacted] labs on [redacted] 2023 and wrote "Labs reviewed." SD_791102. NP Thomson did not mention the A1C result. *Id.* On [redacted] 2023, NP Christine Sullivan also reviewed Mr. [redacted] labs: "Reviewed labs done [redacted] 2023 and A1C 6.1 in PRE-DM [pre-diabetes mellitus] range so for now his metformin 1000 mg/day is

fine." SD_791102. NP Sullivan evidently did not notice that Mr. [redacted] had been prescribed insulin on a sliding scale. Mr. [redacted] labs were repeated on [redacted] 2023, and his Hemoglobin A1C was 6.2, still too low to justify a diagnosis of diabetes. SD_791181.

544. On [redacted] 2023, as a result of his request to speak with a doctor about his diabetes, Mr. [redacted] was seen by NP Frederick Wycoco. NP Wycoco wrote, "He is asking for Mounjaro. … He said he does not want insulin. … Will order glipizide 5mg qd. … Mounjaro is not formulary." SD_791117. NP Wycoco evidently did not notice that Mr. [redacted] had been prescribed and was receiving insulin on a sliding scale. Glipizide, in any case, was an inappropriate prescription for a patient with an A1C below 6.5. Mr. [redacted] continued to ask for resumption of his Mounjaro prescription. On [redacted] 2024, Mr. [redacted] was seen by Joseph Molina MD, who wrote "pt is wondering why he can't get mounjaro." SD_791123. "Reviewed labs with patient, reassured pt with order f/u [follow up] A1C glucose checks ordered." *Id.* This A1C was drawn on [redacted] 2024 and was 6.0, well below the threshold of 6.5 for a diagnosis of type 2 diabetes and near normal (5.7 and below). SD_791186. Despite his objections, Mr. [redacted] continued to be offered insulin injections as late as January 2024. SD_791659.

545. Mr. [redacted] treatment was below the standard of care reveals the following failures: his verified prescription for Mounjaro was discontinued because it was not on the Jail formulary; he received no significant diabetic counselling; he had no blood sugar test done at his receiving screening; he was inappropriately prescribed short-acting insulin without a medical indication; he was inappropriately placed on a sliding scale; he never received an appropriate physical examination; and he was not allowed to have informed consent and input into his own therapy.

546. [redacted] ([redacted]) is a type 2 diabetic who reported during her receiving screen on [redacted] 2024 that she was taking Lantus 15 units once a day. SD_790711. That same day, STATCare NP Juancho Trinidad

discontinued the prescription for Lantus and substituted short-acting insulin via a sliding scale, as the STATCare Intake Assessment and Orders required him to do. SD_790712. NP Teresa Hurley reinstated appropriate long-acting insulin orders on [redacted] 2024 after a chart review disclosed that Ms. [redacted] blood sugars were very high. SD_790691. NP Hurley did not examine Ms. [redacted] at this time or schedule her for a chronic care visit. *Id.*

547. Ms. [redacted] treatment was below the standard of care in the following ways: the records I have for Ms. [redacted] indicate that no A1C or other labs were ever ordered or drawn, *see* SD_790687-790695; no practitioner ever did an appropriate physical examination; Ms. [redacted] received no diabetic counselling; her verified Lantus prescription was discontinued; and she was placed inappropriately on a sliding scale of short acting insulin.

548. The Sheriff's Department also does not provide diabetic patients with medically required retinal examinations.[43] As noted above, patients with type 2 diabetes should be given a retinal examination.

549. If annual exams show no evidence of retinopathy and blood glucose levels are at goal, screenings can be done every 1–2 years. However, if any level of diabetic retinopathy is detected, yearly examinations are essential, and more frequent exams are needed if retinopathy progresses or poses a threat to vision.

550. My review of the charts of several diabetic patients shows that none of this is being done. *E.g.*, [redacted] ([redacted]); [redacted] ([redacted]); [redacted] ([redacted]); [redacted] ([redacted]); and [redacted] ([redacted]).

551. In conclusion, the care of type 2 diabetic patients in the Jail does not meet the standard of care set forth by the American Diabetes Association. Diabetics

[43] The standard of eye care for patients with type 2 diabetes is also laid out in the American Diabetic Association Guidelines. *See* Larber, *Diabetes Management in Detention Facilities*, *supra*.

are not evaluated and examined by a health care practitioner at intake or during the health assessment. Prescribing is done, rather, by midlevel practitioners working remotely who are contacted electronically. This failure to meet the standard of care has caused patient harm in the past and will continue to cause patient harm in the future.

3. Hernias

552. The Sheriff's Department routinely fails to diagnose and treat incarcerated patients with inguinal (groin) hernias in compliance with the medical standard of care and recognized published treatment guidelines.

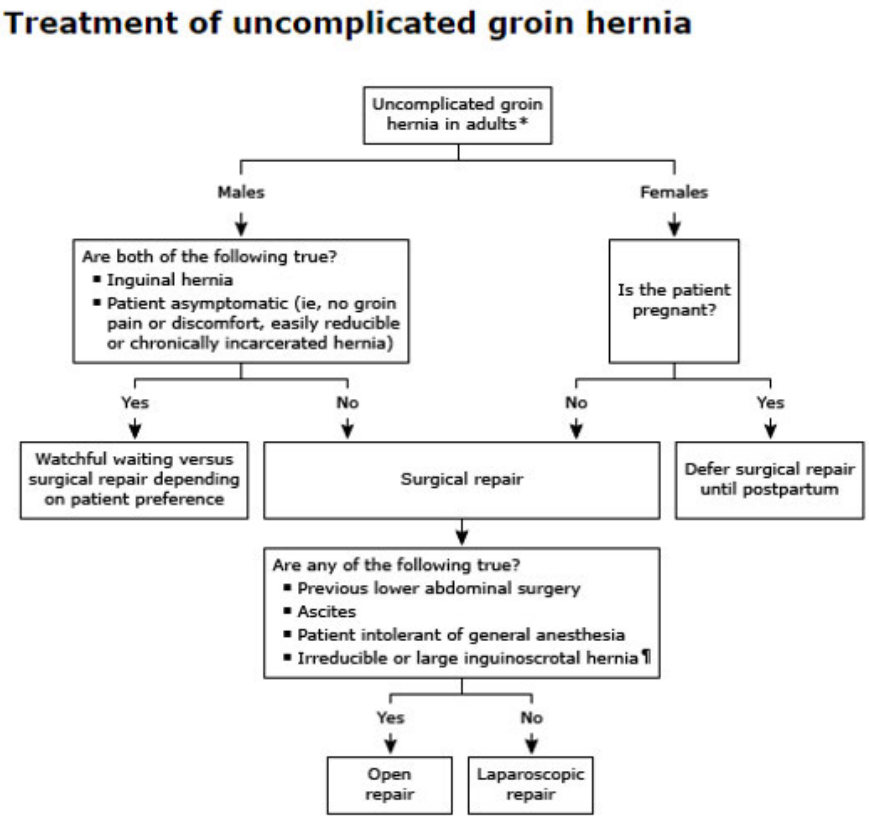
553. Inguinal hernias arise when the muscular wall of the abdomen weakens and allows the underlying abdominal contents to bulge out. When hernias are small, only abdominal fat bulges out of the hernia. However, without treatment, hernias get larger over time. As they get bigger, more abdominal tissue can bulge through the opening, and it becomes harder to push the abdominal contents back into the abdomen (called "reducing" the hernia). Sometimes, abdominal contents cannot be reduced. This is termed "incarceration" of the hernia and is a surgical emergency, because the bulging abdominal contents can be squeezed by the hernia opening so tightly that the tissue dies, causing serious harm to the patient. "Uncomplicated' hernias are small and cause no significant problems for the patient. "Complicated" hernias do cause problems, such as debilitating pain or interference with daily life.

554. The standard of care for hernia patients requires that patients be given the option for surgical treatment of the hernia.[44] Delaying a surgical repair is

[44] The standard of medical care for patients with inguinal and/or umbilical hernias can be found in many places, including standard medical textbooks as well as guidelines published by surgical specialty organizations. I referred to two such references as establishing the medical standard of care for hernias. The first was HerniaSurge Grp.. *International Guidelines for Groin Hernia Management*, 22 HERNIA 1 (2018). The second was the medical textbook UPTODATE. David C. Brooks, *Overview of Treatment for Inguinal and Femoral Hernia in Adults*, *in* UPTODATE (Michael Rosen et al eds), https://www.uptodate.com/contents/overview-of-treatment-for-inguinal-and-femoral-hernia-in-adults.

appropriate *only* if (a) the hernia is asymptomatic or minimally symptomatic *and* the patient, after having been counseled of the risks of delaying surgery, choses to do so; or (b) the patient is pregnant.

555. *Uptodate* provides the following flowchart:



556. Although a truss, or hernia belt, may be helpful in certain situations, their use is generally discouraged, because there is insufficient evidence to prove their efficacy. In addition, inappropriate use of a truss may harm abdominal contents in a hernia sac or complicate subsequent surgical repair.

557. Neither the Sheriff's Department policies and procedures manual nor the NaphCare policy manual contains any guidance regarding the treatment of hernias. *See MSD Operations Manual, supra*; NaphCare Policy & Procedure Manual, September 2022, NAPHCARE 031065-373.

558. In practice, my review of patient charts and my interviews with incarcerated patients during my inspection of the Jail show that the Sheriff's

Department is following none of the guidance outline above. First, based on my review of individual medical records, it is my opinion that the Jail has an unwritten institutional policy to deny surgical treatment of hernias, even in severe cases. Indeed, the records reflect that Sheriff's Department medical staff have told patients that hernias are not repaired by policy on multiple occasions from 2017 to 2023. It is my understanding that surgery for hernias is never approved or even considered unless the patient has a surgical emergency. Even patients with persistent debilitating pain from hernias are refused surgical repair of their hernias. Second, practitioners routinely diagnose and prescribe treatment for hernias without ever examining the hernia. Third, practitioners in the Jail frequently prescribe trusses for patients with hernias without examining them and irrespective of whether the patients find the trusses helpful.

559. In fact, during my inspection of the Jail, I observed two patients with hernias who stated the Jail medical staff refused to repair them. One was [redacted] (DOB [redacted] 1955). Although sitting in a wheelchair, Mr. [redacted] had a basketball sized right inguinal hernia visible beneath his clothes. Mr. [redacted] stated he had submitted multiple requests and grievances but "they're not helping me." The second was [redacted] (DOB [redacted] 1972), who lifted up his shirt to show me a grapefruit-sized umbilical hernia. He said, "They won't repair that." I later learned that Mr. [redacted] was booked on [redacted] 2023, meaning that he had been in the Jail for about seven months when I saw him.

560. The following are examples of patients whose records I reviewed and who were denied appropriate care for their hernias:

561. **Michael Taylor** (17122758), a named plaintiff in this case, informed the Jail medical staff that he has a right sided inguinal hernia when he was booked on April 11, 2017. Medical Record, DUNSMORE 0071323. The next day, medical staff noted, "IP with groin hernia for 1 month. IP looking to have surgery ASAP." DUNSMORE 0071347. He was seen by a medical practitioner, on April 16, 2017

who noted that Mr. Taylor was already scheduled to have the hernia repaired at Scripps Mercy Hospital. DUNSMORE 0071348. However, the medical plan was for Mr. Taylor to "notify medical" if the hernia got worse. *Id.* Mr. Taylor told a nurse that his hernia was "increasing in size and discomfort" on April 18, 2017. DUNSMORE 0071350. The nurse told him "this nurse would schedule pt to see MD." *Id.* However, the MD did not see him, and instead asked to get his outside medical records. *Id.* On May 25, 2017, Mr. Taylor reported that "[m]y hernia has gotten so bad I can no longer poop." DUNSMORE 0071358-59. He was given an "athletic supporter" and a prescription for a laxative. *Id.* Although he continued to complain of hernia pain and associated constipation throughout his period of incarceration, he was never offered surgical repair of his hernia. This violated the standard of care.

562. [redacted] ([redacted]): On [redacted] 2019, Mr. [redacted] reported to a nurse that he was experiencing nausea and had vomited repeatedly and that he had suffered an inguinal hernia a year prior. Medical Record of [redacted] at p. 166 of 1072. The nurse also documented that Mr. [redacted] experienced "10/10 shooting pain when moving and during palpation." *Id.* On [redacted] 2019, Registered Nurse Cesar Felarca completed an ER Referral form, noting that Mr. [redacted] had a "right inguinal hernia with increased swelling and episodes of vomiting x 10 since" the night before and sending him to the hospital. *Id.* at p. 88. Dr. Montgomery was the referring practitioner.

563. At the hospital, the ER doctor was able to reduce the hernia. When Mr. [redacted] returned to the Jail, he reported, "They manually pushed it back in and gave me a shot." *Id.* at p. 170. "They said it had a knot and if I didn't get it pushed in I would have died." (I do not have a copy of the ER report.) On [redacted] 2019, Registered Nurse Shirley Equipado wrote that Mr. [redacted] was "[r]equesting to see the MD to be evaluated re: hernia problem, R groin." *Id.* at pp. 173-74. On [redacted] 2019, Mr. [redacted] again requested to have his hernia evaluated by a

doctor. *Id.* at p. 58. On [redacted] 2020, Mr. [redacted] once again requested to be seen, noting: "Hernia sticking out bad. Hurts. Already went to the hospital here." *Id.* at p. 328.

564. On [redacted] 2020, Mr. [redacted] was finally seen by a doctor in the Jail about his hernia for the first time. Dr. Nas Rafi wrote that Mr. [redacted] was "requesting [an] inguinal hernia repair." *Id.* at pp. 180-81. However, Dr. Rafi did not examine Mr. [redacted] hernia. *Id.* Instead, she wrote "discussed that there is no Indication for hernia repair in the setting of asymptomatic reducible hernia." *Id.* This ignored the fact that Mr. [redacted] had been sent to the hospital for an incarcerated hernia and had complained of hernia pain multiple times in the previous four months, including after his return from the hospital.

565. Mr. [redacted] continued to complain of pain, including in a sick call request form dated [redacted] 2020, in which he stated: "Need a hernia belt / get it checked out." *Id.* at p. 329.

566. On [redacted] 2020, NP Rodalyn Ulep-Brown approved a hernia belt for Mr. [redacted] without seeing or examining him. *Id.* at pp. 184-86. Mr. [redacted] never did receive surgery repair of his hernia while incarcerated.

567. [redacted] **(**[redacted]**):** On [redacted] 2023, Mr. [redacted] was scheduled to be seen by a Sheriff's Department practitioner after he complained that he had a hernia in his right groin for one month, with a pain level of 5 out of 10. Medical Record, SD_787864. Mr. [redacted] was seen that day by NP Lacey Beaston, who made the following notes: "Pt states his main concern is that he wants to get his hernia repaired," and "he states it will no longer stay reduced when he pushes it back in." SD_787869. NP Beaston did not examine Mr. [redacted] hernia but informed him that "as long as it is reducable it is not emergent even if it will not remain reduced." *Id.* She denied Mr. [redacted] request for surgery. *Id.*

568. Mr. [redacted] subsequently wrote: "I would like a second opinion about my hernia from a doctor, not nurse. Thank you." SD_788163. He received no

response to this request.

569. On [redacted] 2023, Mr. [redacted] requested pain medication due to "extreme pain [in his] groin area" from the hernia. SD_787870-71. That day, NP Stacy Thompson wrote that Mr. [redacted] was "requesting a truss for his right inguinal hernia" since no repair had been offered. *Id.* NP Thompson approved this request despite not examining Mr. [redacted] *Id.*

570. On [redacted] 2023, health care staff notified STATCare that Mr. [redacted] was having abdominal pain from his hernia. SD_787843-44. Katherine O'Neal Corp NP, responded, "Determine if family is able to bring truss for support," despite the fact that Mr. [redacted] already had a truss. *Id.* Otherwise, NP O'Neal approved Tylenol and Ibuprofen for Mr. [redacted] *Id.*

571. On [redacted] 2023, RN Pooja Mita saw Mr. [redacted] for "several complaints regarding having a hernia and not receiving his psych meds." SD_787874-95. Mr. [redacted] was upset that his hernia complaints were being ignored. *Id.* RN Mita "re-educated pt regarding importance of wearing truss." *Id.*

572. Mr. [redacted] was never referred for a surgical evaluation of his hernia. *See id.* SD_787945-46 (discharge summary prepared [redacted] 2023).

573. [redacted] **(**[redacted]**)**: Mr. [redacted] complained of bilateral inguinal hernias throughout several incarcerations beginning in 2020 and continuing into 2024. He was seen by a nurse on multiple occasions, but never received adequate treatment for his condition. For example, Mr. [redacted] was seen by RN Andrea Medina on [redacted] 2022, who wrote that Mr. [redacted] reported his "hernia really hurts. I should get surgery on it." Medical Record of [redacted] from Booking [redacted], at pp. 151-52. RN Medina noted a "large left inguinal hernia" and alerted STATCare. *Id.*

574. In response, STATCare NP Juancho Trinidad wrote that Mr. [redacted] had complained of "excruciating pain to left lower [abdomen]; claiming to have a hernia…. No clinical assessment performed on this patient." *Id.* NP Trinidad only

ordered an "IBU, colace, and hernia belt/scrotal support." *Id.* NP Trinidad performed no examination of Mr. [redacted] and did not know if his hernia had any complicating factors. *Id.*

575. On [redacted]2022, NP Nicholas Kahl visited Mr. [redacted] at his cell due to complaints of abdominal pain from a distended abdominal hernia. NP Kahl wrote "bring pt to clinic for exam and to attempt manual reduction of the hernia." *Id.* at p. 153.

576. The next day, Mr. [redacted] was seen at the clinic by NP Emiliza Comejo. *Id.* at pp. 154-55. However, NP Comejo did not examine the hernia and did not attempt any manual reduction. Instead NP Comejo only noted that Mr. [redacted] had "bulging" in his "[l]eft groin." NP Comejo wrote that she "encouraged him to use [a] [t]russ," but Mr. [redacted] reported that this made him more uncomfortable. *Id.* In the end, NP Comejo told Mr. [redacted] to notify medical if he became worse and did nothing else. *Id.*

577. Mr. [redacted] continued to complain of hernia pain. As just one example, he was seen by RN Matthew Duenskie on [redacted]2022 for hernia pain that RN Duenskie incorrectly documented on a "Muskuloskeletal pain/strain" form. Medical Record of [redacted] from Booking [redacted], at p. 61.

578. Mr. [redacted] has continued to have hernia problems throughout 2023 and into 2024, which were treated only with hernia belts.

579. These four examples demonstrate patients who have hernias that met the medical standard for surgical intervention, but were not properly evaluated or treated in the Jail. None of these patients (except Mr. Taylor in 2017) was examined by a medical practitioner. All the patients' requests for surgery were denied. The patients' complaints of pain and disability were ignored. Hernia belts (trusses) were prescribed by practitioners who had never examined the patient. Neither the Sheriff's Department nor NaphCare has any written guidelines or policy for hernia evaluation and treatment—at least, that I have seen. However, there appears to be

an unwritten policy that patients with hernias are not to be referred to a surgeon. This violates the medical standard of care, and incarcerated patients have suffered as a result.

4. Latent Tuberculosis ("LTB")

580. The Jail fails to provide appropriate screening and treatment for people infected with LTB.

581. Tuberculosis is an infection with a more complicated course than most other infections. Patients usually are exposed to tuberculosis by breathing the infectious agent into their lungs. After a brief illness like a chest cold, the tuberculosis organism goes into a latent state. After a period that can last years, the tuberculosis organism reemerges and becomes an active infection. Patients with active tuberculosis are seriously ill and can infect others by coughing out tuberculosis organisms that other people inhale into their lungs. Tuberculosis is a serious illness that can cause debilitation and death.

582. The Jail has a program in place to find patients with *active* tuberculosis infections by doing a chest x-ray, which will show typical tuberculosis lesions in patients with active tuberculosis. Patients then can be isolated and treated.

583. However, the CDC recommends that jails should also have a program in place to diagnose *latent* tuberculosis infection in patients at high risk for LTB, such as injection drug users. The goal is to find and treat patients with LTB and cure them before the disease becomes active, causing serious illness and infecting other people.

584. Screening high risk patients for LTB is relatively simple. Screening can be done as a two-step skin test or a simple one-step blood test.

585. In addition, the CDC recommends that jails should test for LTB annually for all employees and for anyone incarcerated in the jail for greater than

one year.[45]

586. Dr. Venters recommended that the Jail begin testing for latent TB infection in 2020. SD_215390.

587. The NaphCare contract requires NaphCare to provide "TB screening, evaluation and treatment … in accordance with NCCHC and CDC recommendations," which would include screening for LTB. Contract No. 566117, *supra* § 2.3.2.3. My review of patient charts and my interviews of incarcerated patients during my inspection show that the Jail is following neither of these recommendations.

588. I found no instance in the cases I reviewed where a high-risk patient was tested or treated for LTB. High risk patients include injection drug users, which includes most patients treated by the Jail for opioid withdrawal.

589. Per CDC guidelines, the Jail should do LTB testing in high risk individuals at booking and every year thereafter. However, the Jail, by policy, does not even consider doing testing for LTB until the patient has been incarcerated for a minimum of two years (*see* the TechCare Health Assessment, which states that LTB screening frequency is "every two years.").

590. It makes no sense medically to ignore the CDC guidelines for testing high risk patients for LTB, especially since the test (especially the one-step blood test) is quick and easy. It only makes sense to ignore these CDC guidelines if the goal is to save money by not providing appropriate medical care.

[45] The Standard of Care for the screening and treatment of tuberculosis in incarcerated populations can be found in several places, including standard medical textbooks (such as the online textbook Uptodate), and guidelines published by specialty organizations. Probably the most cited and respected of these guidelines for tuberculosis is Centers for Disease Control, *Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC* (2006), (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm. This guideline has been endorsed by the National Commission on Correctional Health Care (NCCHC), the American Correctional Association, and the Advisory Council for the Elimination of Tuberculosis. According to this guideline, the San Diego Jail would be categorized by the CDC as a "nonminimal TB risk facility."

591. When LTB is identified, the standard of care is to treat these patients with appropriate antibiotics to eradicate the infection. However, according to its policy, the Jail does not do this.

592. The MSD Operations Manual Tuberculosis (TB) Program states that treatment for LTB will be offered to patients only if "[e]xpected length of stay 6 months or greater." MSD Operations Manual § MSD.T.3 VI(B). The Manual does not state why the County would not treat everyone with a positive test for LTB. *Id.* It makes no medical sense to not treat these patients who have a serious infection. It only makes sense if the goal is to save money by not providing necessary medical care.

593. MSD.T.3 allows patients who do have LTB to remain undiagnosed and untreated. This policy violates the medical standard of care and has undoubtedly led to cases of active TB that could have been prevented had the Jail followed the CDC recommendations.

5. Sexually Transmitted Infections ("STIs")

594. It is my opinion that the Sheriff's Department fails to screen for STIs commensurate with national standards.

595. It is important to screen and treat STIs. STIs are communicable diseases that can easily spread from person to person through sexual contact. Many jail patients do not have easy access to regular healthcare services outside of the jail. They also may not be aware that they are infected. Undiagnosed and untreated STIs can lead to serious health complications, such as infertility, pelvic inflammatory disease, and HIV. Screening and treating STIs in the jail would improve the overall health of patients.[46]

596. As explained above in the section on HCV, jails can adopt either an

[46] Of course, the Sheriff's Department's screening and treating STIs in jail patients would have the additional benefit of preventing the spread of these infections in the broader San Diego community when patients are released.

"opt-out" screening program, in which all patients are automatically screened unless they refuse, and an "opt-in" screening program in which screening is performed only if the patient requests it. Although STI screening guidelines vary depending on gender and sexual activities, key recommendations include:[47]

597. **Syphilis.** Screen for syphilis in all patients (men and women) at increased risk (history of incarceration, transactional sex work, geography, race/ethnicity, methamphetamine use).

598. **HIV.** Screen annually if at risk. Test if patient is seeking evaluation and treatment for STIs.

599. **Hepatitis C.** Screen everyone at least once and repeat test for high-risk individuals. Screen all pregnant women.

600. **Chlamydia/Gonorrhea**. For men, conduct routine screening in correctional settings because they are high-prevalence settings. For women, screen annually if sexually active and under 25. For those over 25 screen if at increased risk (prior infection, more than one sexual partner in the past year, suspicion that a recent partner had concurrent partners, new sexual partner in past three months, illicit drug use, or transactional sex in the past year, among other factors). Rescreen for reinfection approximately three months after treatment.[48]

601. My review of documents, including patient charts and my interviews of incarcerated patients during my inspection of the Jail show that the Sheriff's

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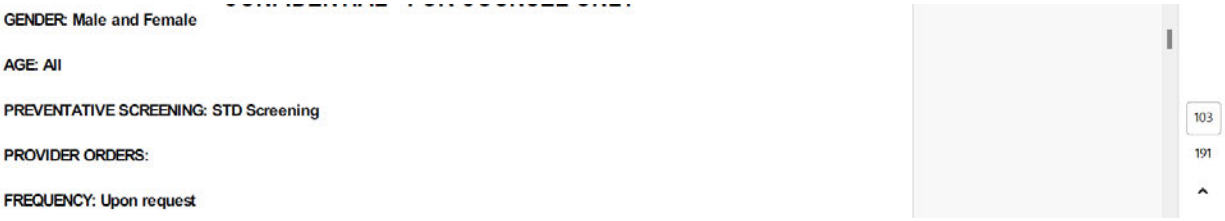
[47] The medical standard for screening for sexually transmitted diseases (STDs) can be found in several places, including standard medical textbooks (such as the online textbook UpToDate), and guidelines published by specialty organizations. The California Department of Public Health has published an excellent guideline that conforms with the U.S. Preventive Services Task Force, Infectious Disease Society of America, and California Department of Public Health (CDPH) Sexually Transmitted Diseases Control Branch (STDCB); *see also* Cal. Dep't of Pub. Health, *California Sexually Transmitted Infections*, CA.gov (Nov. 17, 2023), https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/California-STI-Screening-Recommendations.aspx.

[48] *See California Sexually Transmitted Infections (STI) Screening Recommendations 2021*, https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/California-STI-Screening-Recommendations.aspx.

Department is not compliant with that standard of care.

602. The Sheriff's Department conducts STI screening on an opt-in basis. This is clear from the Preventative Screening section of the Health Assessment form in TechCare states explicitly that STD screening is done "upon request" only.



603. However, "opt-in" programs cannot be effective unless patients are informed of their right to have STI screening done. I have seen no evidence of any effort to inform patients of this program.

604. Choosing to only screen patients for STIs when they request screening and then failing to inform patients of their right to request screening does not make any sense from a medical perspective. It only makes sense as a way of minimizing the number of STI screens done in order to save money by not doing them.

605. In addition, Jail practitioners do not do physical examinations of patients requesting screening for STIs—even when patients request a physical examination. Without a physical examination, medical practitioners cannot find critical evidence of STIs that can only be found by examination, such as herpes, genital warts, trichomonas, syphilitic ulcers, discharge, swollen lymph glands, ectoparasites (like pubic lice), and rashes. Since the practitioners are not doing these exams, they are not finding these infections. As a result, not only are patients being harmed by not being treated, other people are also at risk of being harmed by being infected by these patients. Not doing a physical examination of patients complaining of STIs violates the medical standard of care and causes harm to patients and others.

606. Examples of this substandard care include:

607. [redacted] ([redacted]): On [redacted] 2024, PA Juancho Trinidad

posted a STATCare note that Mr. [redacted] had "concerns [about] sexually transmitted disease(s) and request[ed] further work-up." Medical Record of [redacted] from Booking [redacted], at p. 463. He then wrote that "[n]o clinical assessment [was] performed on this patient. … Check for GC/Chlamydia, syphilis, hepatitis and HIV. FU [follow up] MDSC [MD sick call] prn [as needed]." *Id*. Mr. [redacted] tests were all normal. *Id*. at pp. 474-75. However, as he acknowledged in his note, NP Trinidad did not talk to Mr. [redacted] and did no examination looking for signs of other potential STDs. No other practitioner ever saw Mr. [redacted] face-to-face as a result of this request. This violated the medical standard of care. I saw no documentation indicating that anyone ever reviewed the STI lab tests or communicated the findings to Mr. [redacted] In fact, two weeks after his negative tests, Mr. [redacted] made another request for STD testing, suggested he was unaware of the results. *Id*. at p. 874.

608. [redacted] ([redacted]): On [redacted] 2024, Ms. [redacted] wrote a medical request asking for an HIV test and STI panel. Medical record of [redacted] from Booking [redacted], at p. 896. The next day, NP Daniel Swink wrote a STATCare note that reiterated that Ms. [redacted] had "concerns [about] sexually transmitted disease(s) and request[ed] further workup." *Id.* at p. 489. NP Swink ordered laboratory tests for GC/chlamydia, syphilis, and HIV. *Id.* "If suspect trich or BV, treat empirically." *Id.* NP Swink did not talk to Ms. [redacted] or perform an exam, *id.*, which violated the medical standard of care. NP Swink's order delegated diagnosis and treatment of "trich or BV," though such delegation is inappropriate, as explained earlier in this Report. Trichomonas infection (trich) and bacterial vaginosis (BV) are usually diagnosed during a pelvic examination. I cannot find any record of Ms. [redacted] having a pelvic examination or testing for BV or trich. I cannot find in Ms. [redacted] chart any lab test results for HIV, syphilis, gonorrhea or chlamydia. (Ms. [redacted] did have lab tests that confirmed that she had chronic HCV infection. *Id.* at p. 518.). I cannot find any refusal form or mention of a refusal for these tests. It appears that they were never

drawn. For all of these tests not to have been done and then for no one to notice that they were not done violated the medical standard of care.

609. [redacted] ([redacted]): On [redacted] 2022, Mr. [redacted] requested an evaluation for "bumps on penis." SD_781892. On [redacted] 2022, Mr. [redacted] again requested STD testing. *Id.* NP Nicholas Kahl ordered an STD screen but did not examine Mr. [redacted] SD_782037. On [redacted] 2022, Mr. [redacted] was seen for the "bumps on penis" complaint by RN Romeo DeGuzman. *Id.* RN DeGuzman wrote "C/O (complaining of) penile wart. 'I want the doctor to see it.'" *Id.* But RN DeGuzman did not refer Mr. [redacted] to see a practitioner. *Id.* He wrote instead "Encouraged good hygiene and proper hand washing. Instructed to notify staff for any changes." *Id.* No medical practitioner ever examined Mr. [redacted] for this complaint. This violated the medical standard of care. Genital warts are treatable. The standard of care would have been to treat Mr. [redacted] for this. Genital warts are also transmissible to others. By not treating Mr. [redacted] genital wart, other people may have contracted genital warts from Mr. [redacted]

610. On [redacted] 2022, RN Jamee Barrera wrote "STD labs completed" for Mr. [redacted] SD_782038. However, there is no note that these labs were ever reviewed by a practitioner. In fact, the labs were positive for positive for syphilis. *Id.*, SD_782079. The positive syphilis result was dutifully reported to the Health Department on [redacted] 2022, *id.*, but no medical practitioner documented the results of Mr. [redacted] positive test for a syphilis infection. Since the syphilis infection was never noted, no one from the Jail made any attempt to contact Mr. [redacted] (who had been released) to inform him of his positive syphilis test.

611. Mr. [redacted] returned to the Jail in [redacted] 2023. On [redacted], 2023 and again on [redacted] Mr. [redacted] requested STD testing. *Id.* at SD_781893. On [redacted] 2023, a positive RPR Syphilis screen returned. SD_782087. On [redacted] 2023, NP Frederick Wycoco finally addressed the

positive syphilis screen. SD_782042-43. A nurse noted that Mr. [redacted] syphilis test was positive on [redacted] 2022 "but syphilis was not addressed [at] that time because pt was released." *Id.*

612. In conclusion, the Jail does not follow the standard of care set out by the California Department of Public Health for the screening of STIs. Instead of the recommended opt-out screening, the Jail offers opt-in screening, but without informing patients of their right to request STI screening. Positive screening results are sometimes ignored. This violates the standard of care and harms patients.

6. Asthma

613. It is my opinion that the Sheriff's Department fails to treat asthma consistent with the standard of care, placing patients at a substantial risk of serious harm.

614. Asthma is an episodic disease of the lungs in which an environmental trigger causes constriction of lung passages and increased production of mucous, both of which restrict air movement. Asthma causes wheezing and shortness of breath, and it ranges in severity from mild and easy to treat to severe enough to cause death.[49]

615. Providers can diagnose asthma through a combination of patient history, physical examination, and bedside tests, the simplest of which is a handheld peak flow meter. A diagnosis of probable asthma can be made based upon history alone, provided the patient has typical symptoms that respond promptly and completely to therapy. However, bedside handheld instruments for evaluating asthma complaints should be readily available at the Jail and should be used each and every time an asthma patient is evaluated by a Registered Nurse or a

[49] The standard of care for patients suffering from asthma can be found in several places, including standard medical textbooks (such as the online textbook Uptodate), and guidelines published by specialty organizations. For the sake of simplicity, I chose to refer to standards of care laid out by the medical textbook UPTODATE. *See Asthma*, UPTODATE, https://www.uptodate.com/contents/table-of-contents/allergy-and-immunology/asthma.

practitioner. This was recommended by the NCCHC Technical Support document in 2017. DUNSMORE 0260635. Importantly, because of the episodic nature of asthma—*i.e.*, an asthmatic patient might not have symptoms all the time, but might still require medication—providers should not dismiss a diagnosis simply because a patient is asymptomatic at the time of examination.

616. The treatment of asthma depends on the severity of the patient's symptoms in the past and current examination and beside testing. The simplest treatment is a "rescue inhaler," usually albuterol, that patients use when they have an asthma attack. All patients with asthma should have immediate access to such an inhaler. When patients have many asthma attacks, other medications are added in stepwise fashion, including inhaled steroids, long-acting bronchodilators, and others. Well respected guidelines discuss the proper way to prescribe each of these therapies in a step-wise fashion along with guidance on when to refer to a pulmonologist, how frequently to schedule chronic care visits, etc.

617. Finally, effective asthma management requires a preventive approach, with regularly scheduled chronic care visits during which symptoms and pulmonary function are assessed, control of exposure to asthma triggers and impact of comorbid conditions reviewed, medications adjusted, and ongoing education provided.

618. Both the 2017 NCCHC Technical Assistance Report and Dr. Venters' 2020 Best Practices identified problems with asthma diagnosis and therapy provided to incarcerated patients at the Jail. The NCCHC noted: "Our chart reviews indicated there were no recorded peak flow meter tests for asthma patients. This should be part of routine chronic care for asthma and COPD patients." DUNSMORE 0260635. NCCHC also found that besides for hypertension there were "no other chronic disease guidelines to guide providers," including no guidelines for asthma as would be required by the NCCHC. DUNSMORE 0260643. Dr. Venters recommended that during health assessments, patients should

"have some brief or focused physical examination also performed, such as auscultation of lungs and peak flow testing for patients who report asthma." SD_215371.

619. Despite the recommendation from the NCCHC in 2017 that the Jail have an asthma guideline for medical providers, it still to this date has no adequate written asthma guideline for practitioners. The Sheriff's Department does have a guideline for nurses to assess patients reporting acute asthma attacks. Sheriff's Department, *Standardized Nursing Procedure* § SNP.A.6 (2020). In the community, patients reporting to an ER, urgent care center, or practitioner's office complaining of difficulty breathing due to asthma would always be seen by a medical practitioner. However, SNP.A.6 allows nurses to decide who is sick enough to refer to a practitioner and who is not. They act as gatekeepers to practitioner access. For patients with "acute respiratory distress," SNP.A.6 allows the nurses to administer an inhaled bronchodilator. Nurses may call a practitioner if they think the call is warranted. Such calls are made more-or-less exclusively to remote STATCare practitioners who are not able to examine the patient.

620. STATCare practitioners have a dropdown menu of options they are allowed to prescribe for asthma. The STATCare treatment options are nebulized albuterol or albuterol multi-dose inhaler. However, besides the bronchodilator albuterol, there are other essential therapies for asthma, including inhaled steroids, long acting bronchodilators, and MAST cell stabilizing drugs. These options are not available to the STATCare practitioners, who cannot examine asthma patients anyway since they live remotely. STATCare practitioners may refer patients to be seen by onsite medical practitioners. STATCare practitioners also have the option of discontinuing asthma treatments and even eliminating the diagnosis of asthma entirely from a patient's medical record if they wish.

621. I have seen no other guidelines for asthma care for medical practitioners at the Jail, whether remote STATCare practitioners or onsite

practitioners. This is curious, because such guidelines are readily available in medical textbooks like UpToDate and from specialty organizations whose guidance is available online.[50] This is a problem because asthma is a complicated disease and most practitioners cannot remember the appropriate tests, treatments, and follow-up recommendations for various patients. Without guidelines, asthma patients tend to be under evaluated, undertreated and many are harmed.

622. In the end, my review of documents, including patient charts and my interviews of incarcerated patients during my inspection of the Jail, show that the Sheriff's Department does not comply with the standard of care for asthma therapy:

623. [redacted] ([redacted]): Mr. [redacted] reported a history of asthma at his receiving screening on [redacted] 2023. SD_749433. The history of asthma was referred to PA Nhi Ngoc Dai via STATCare. PA Dai ordered an albuterol inhaler for Mr. [redacted] use but did not examine Mr. [redacted] nor did he or anyone else perform any bedside tests, such as a peak flow meter reading. SD_749447-48. The next day, NP Stacy Thompson discontinued the diagnosis of asthma and Mr. [redacted] access to an albuterol inhaler: "Pt with no documented hx of asthma and has no meds noted in community. Albuterol dc'd." SD_749444. NP Thompson did not talk to Mr. [redacted] examine him, perform any bedside diagnostic testing, or schedule Mr. [redacted] for any future assessments prior to the discontinuation. Asthma is an episodic disease and jail patients may not have had easy access to medical care in the community. To discontinue an inexpensive rescue inhaler and further to eliminate the diagnosis from a patient's chart without an examination or bedside pulmonary tests violated the standard of medical care.

624. [redacted] ([redacted]): Mr. [redacted] reported a history of asthma when he was booked on [redacted] 2022. Mr. [redacted] was seen on

[50] *See, e.g.*, Nat'l Heart, Lung, and Blood Inst., *Asthma Management: Updated Guidelines from the National Heaty, Lung, and blood Institute*, 104 AM. FAM. PHYSICIAN 531 (2021), https://www.aafp.org/pubs/afp/issues/2021/1100/p531.pdf.

[redacted]2022 by NP Nicholas Kahl. NP Kahl noted the history of asthma and that Mr. [redacted] was requesting access to a rescue inhaler. NP Kahl prescribe a Xopenex inhaler that Mr. [redacted] was allowed to keep with him at all times. SD_782035. A task for a chronic care visit for asthma was scheduled for [redacted], 2022, but had not been completed as of his release in [redacted] During a subsequent booking, Dr. Rafi did not see Mr. [redacted] examine him, or do any asthma testing. Instead she wrote a note stating: "Asthma cancelled … Reason no [history of] active asthma requiring recent md use in community." Mr. [redacted] prescription for a rescue inhaler was discontinued. SD_781893. There is no indication that Mr. [redacted] was scheduled for any future asthma assessments.

625. On [redacted] 2023, Mr. [redacted] submitted a sick call request for an "emergency inhaler," stating that he had asthma, was "having trouble breathing," and had already requested an inhaler once before. SD_781893. RN Vanessa Rimando referred this request to STATCare without obtaining any history, doing any physical examination or doing bedside testing. *Id.* On the same day, STATCare PA Juancho Trinidad ordered a "formulary equivalent" to Xopenex which was the generic bronchodilator albuterol. SD_782044. PA Trinidad did not talk to Mr. [redacted] do any physical examination, or perform any bedside tests. *Id.* NP Trinidad also did not schedule Mr. [redacted] for any future chronic care clinics.

626. [redacted] ([redacted]): On [redacted] 2024, Mr. [redacted] submitted a sick call request stating that he had "bad asthma" and "need[ed] [an] inhaler. SD_837817. There is no indication that Mr. [redacted] was seen by a nurse or a practitioner for this complaint or that an asthma inhaler was ordered before he was released from the Jail 10 days later.

627. Jail policy requires a face-to-face visit from an RN within 24 hours of submitting a medical request, such as this one. This did not occur. The medical standard of care requires any patient stating that they have a disease that can cause

sudden death, like asthma, to be seen as soon as possible by a medical practitioner. This did not happen either.

628. [redacted] ([redacted]): On [redacted] 2023, a Registered Nurse completing Mr. [redacted] receiving screen wrote that he had asthma and was using an albuterol inhaler. An albuterol inhaler was subsequently ordered for him. SD_991335. One month later, on [redacted] 2023, the diagnosis of asthma and the albuterol prescription were both cancelled by NP Frederick Wycoco, with the stated reason being "no use of md, no [history of] asthma, no record in surescript." *Id.* There is no indication that NP Wycoco talked to Mr. [redacted] examined him, or did any testing prior to issuing this order.

629. Each of these examples falls below the standard of care and places the patient a risk of harm. Acute asthma attacks can be sudden and severe. Sometime, patients do not have time to submit a medical request form. Without appropriate therapy already prescribed, patients can be harmed and even die from untreated asthma attacks.

630. The fact that three different practitioners (including the Jail Medical Director, Dr. Rafi), discontinued albuterol prescriptions on three different patients indicates to me that this was an unwritten practice of NaphCare to decrease the number of albuterol inhalers prescribed. I suspect, but have no direct evidence, that these three practitioners were told not to authorize asthma treatment for patients who stated that they had asthma but had no current asthma prescriptions in the community. This practice makes sense if the goal was to save NaphCare money, but it does not make sense medically.

631. In conclusion, the Jail fails to provide appropriate asthma screening and treatment to their incarcerated patients, placing them at substantial risk of serious harm. NaphCare appears to have inappropriately instructed practitioners not to prescribe asthma treatment for patients who stated that they had asthma but had no current asthma prescriptions in the community. The Sheriff's Department has failed

to create guidelines asthma chronic care. The Sheriff's Department's guidelines for acute asthma care (SNP.A.3) is inappropriate and does not meet the community standard of care.

IX. The Sheriff's Department Fails to Provide Medically Necessary Vision Care

632. In my opinion, the Sheriff's Department fails to: (1) screen and evaluate patients for eye disease (even for patients at increased risk for eye disease); and (2) timely provide incarcerated people with medically necessary eyecare and prescribed eyeglasses. These failures result in substandard care of those with vision care needs.

A. The Sheriff's Department Fails to Screen or Evaluate People for Eye Diseases, Even Those Who Self-Identify as High Risk

633. Many incarcerated patients have medical conditions of the eye that require medical evaluations and care.[51] Examples include cataracts, glaucoma, keratoconus, and diabetic retinopathy. The Jail has an obligation to evaluate and treat eye diseases in accordance with national standards and with the standard of care in the community. However, the Jail appears to ignore the eye health of its patients who have eye diseases or are at risk for eye disease.

634. Glaucoma is the most common cause of irreversible blindness worldwide. Many patients with glaucoma are asymptomatic early in the course of disease, given the often slowly progressive nature of the condition. Therefore, screening of higher-risk patients is essential to minimize vision loss and prevent

[51] A note about definitions: Optometrists are eye doctors who evaluate and treat most eye diseases. Optometrists evaluate vision deficits and prescribe glasses to correct those deficits. Ophthalmologists are eye surgeons. Ophthalmologists usually do not prescribe eyeglasses; rather, they take care of more complex eye problems. At the Jail, almost all of the referrals for eye/vision evaluations should be to an optometrist first, unless the patient has a known surgical problem. I refer to optometrists in this report except when it is clear that an ophthalmologist must be involved.

blindness.[52] The standard of care for glaucoma screening is that people with diabetes, a family history of glaucoma, or African American and/or Hispanic people should be screened at age 40, and that all people age 55 and older should be screened annually.[53]

635. All people receive a screening eye exam to look for glaucoma, cataracts, retinopathy and other eye diseases beginning at age forty and every 1 to 3 years after age 55. People with known eye disease such as keratoconus or diabetic retinopathy should continue any previously scheduled specialist appointments and screening examinations that had been recommended by their outside vision specialist before they became incarcerated.

636. Unfortunately, the Jail does not provide any recommended eye screening, even for patients who are at high risk of eye disease and request screenings and/or exams. There is no mention eye health in the MSD Operations Manual or NaphCare's Policies and Procedures. The NaphCare Health Assessment Form lists several Preventative Screening considerations at the end of its Health Assessment Form for consideration by the RN doing the exam. However, there is no reference to preventative or comprehensive eye exams based on age or other risk factors as there should be per national standards.

637. The Sheriff's Department fails to provide eye evaluations even to patients who notified Jail staff about their glaucoma. For example, [redacted] ([redacted]), reported glaucoma and cataracts at booking. SD_802998. I searched his 3,707 page medical chart using keywords such as cataract, glaucoma, optometrist, retina, and Snellen. It appears that Mr. [redacted] was never evaluated for

[52] Elaine Han et al.. *Community Vision Screening*. Glaucoma Today 28. 28 (January 2019), https://assets.bmctoday.net/glaucomatoday/pdfs/0119GT_SF_Lee.pdf..

[53] *Primary open-angle glaucoma suspect PPP 2020*. American Academy of Ophthalmology. (2021, October 6). Retrieved August 15, 2024, from https://www.aao.org/preferred-practice-pattern/primary-open-angle-glaucoma-suspect-ppp.

glaucoma or cataracts by a medical provider. His vision was never tested using the standard Snellen Eye Chart. He was never referred to an optometrist for a comprehensive eye exam. This violated the standard of medical care for these conditions.

638. And, as explained in the section above regarding diabetes care, the Sheriff's Department also fails to provide diabetic patients with appropriate eye exams.

B. The Sheriff's Department Fails to Timely and Adequately Address Incarcerated People's Visual Accuity Problems

639. Visual acuity problems are another area of deficiency within the Jail. There are two type of visual acuity problems. People with farsightedness (hyperopia) can see distant objects well but have difficulty with close vision, *e.g.*, reading. People with nearsightedness (myopia) can see close objects but have difficulty with more distant vision. Many patients, especially the elderly, have both problems.

1. There Are Numerous Barriers Preventing People From Timely Receiving Eye Glasses

640. Some vision acuity problems can be addressed with simple, inexpensive reading glasses. Reading glasses are important for incarcerated patients so that they have the ability to read: (1) legal documents; (2) the many forms and signs that the Jail requires them to attend to; (3) educational materials that the Jail provides, for example, the many handouts available in the medical department; and (4) other materials for program participation, education, and recreation. Reading glasses improve the quality of incarcerated life for those who need them.

641. In the community, people who need reading glasses do not have to see a health care professional. Anyone can buy reading glasses of various strengths at any drug store or grocery store. The proper reading glasses are those that make reading most comfortable for the person. In other words, the person needing

reading glasses participates in choosing the correct strength for themselves.

642. However, the Jail requires patients who need reading glasses to submit a medical request. Such patients are then scheduled to see a nurse, who acts as a "gatekeeper" to decide who may receive reading glasses and who may not. It may take days or even weeks for this visit to occur. I have not seen a policy or procedure that lays out what should occur at this meeting, or what the criteria are for the nurse to say approve or deny reading glasses or what strength reading glasses they approve. In practice, leaving these decisions to nurses' discretion leads to some people waiting long periods to receive reading glasses, and other people receiving the wrong level for their needs.

643. The arbitrariness of this system is exemplified by patient [redacted] ([redacted]). On [redacted] 2022, RN Ellen Lastrella approved 3.0 reading glasses for Mr. [redacted] SD_797036. But on [redacted] 2023, a different nurse, RN Arlene Edusada, approved much weaker 1.5 reading glasses for the same patient. SD_797016.

644. Besides taking an unnecessarily long time for a patient who needs reading glasses to get them, this system is a waste of the RNs time. When RNs cannot complete everything they are supposed to do in a shift (like complete all of the 24 hour face-to-face assessments), why are they wasting time being gatekeepers for reading glasses? Reading glasses are quite inexpensive. I suspect that if the Jail performed a time-cost analysis they would find that the cost of a pair of reading glasses is much less expensive than the cost of paying the nurses' salary to see a patient who has requested reading glasses.

2. The Jail Lacks Adequate Policies and Procedures to Ensure IPs Have Access to Distance Glasses

645. Glasses to improve distance vision are a different matter than simple reading glasses because they require a prescription based on the evaluation of an optometrist using sophisticated equipment to measure visual deficits and provide the

right compensation in the glasses. At every visit, optometrists should routinely screen for all of the medical conditions mentioned earlier, such as glaucoma, cataracts and retinal problems.

646. Distance correction is important for many jail patients for many reasons, including the ability to: (1) read the signs the Sheriff's Department posts on the walls and expects incarcerated people to abide by; (2) see what is happening in a dorm area or exercise area for safety and in order to avoid trouble; (3) see facial expressions of fellow incarcerated people, security staff and medical personnel for important non-verbal communication; and (4) see chalkboards, television programs, and other far away media for recreation and education. Distance vision glasses dramatically improve the quality of incarcerated life for those who need them.

647. On the outside, patients who need distance correction can themselves make an appointment with an optometrist.

648. There are several substantial problems in the system for providing incarcerated patients with needed distance eyeglasses at the Jail.

649. First, neither the Sheriff's Department nor NaphCare has any written policies or procedures specifically related to vision complaints, eye complaints, how and when to provide glasses, or when to refer a patient to an optometrist. Neither the MSD Operations Manual or the NaphCare P&P Manual give the nurses any instructions on how they should evaluate these patients or what the criteria are for a nurse to approve the referral to the optometrist. Therefore, the nurses, who are acting as gatekeepers, have no written guidance. They also have no oversight. No one (as far as I could tell) ever reviews and critiques nursing eye assessments. Eye assessments are not followed in any meaningful way in the Jail CQI statistics.

650. Second, the RN evaluation usually consists of the nurse administering a Snellen test for distance vision. Based on the Snellen results, the nurse can approve the referral to an optometrist or deny it based on their own discretion or whim. However, the Snellen test is not a good way to deny someone access to an

optometrist for the following reasons: (1) patients can artificially improve their scores by squinting, leaning, or simply knowing the letters on the chart; (2) Snellen results are also influenced by lighting, distance, and distractions (while patients may have a good Snellen score because the lighting was perfect and there were no distractions in the medical clinic, they may need glasses in their dimly lit housing unit); (3) many patients with a perfect Snellen score (those over the age of 40, with hypertension, or with diabetes) may still need to see an optometrist for a screening exam; (4) penalizing patients for having a good Snellen score (*i.e.*, not allowing them to see an optometrist) encourages patients to give unreliable Snellen results; (5) failing to provide guidance to gatekeeper nurses ensures uneven results; and (6) Snellen tests take nursing time that could be put to better use filling in other yawning gaps in nursing performance, such as 24-hour face-to-face evaluations. In the end, nurses and even primary care medical providers do not have the expertise to evaluate the validity of distance vision complaints. Optometrists do. Therefore, in most cases, incarcerated people complaining of distance vision issues should be referred to an optometrist without the need for this arbitrary gatekeeper screening test.

651. Third, there are substantial delays built into the process of obtaining eyeglasses. At the outset, when an incarcerated patient asks for glasses or asks to see the optometrist, they are required to fill out a medical request form. They are then scheduled to see an RN. This wait can be days or weeks based on my chart review; the Jail does not track this specific statistic in their CQI reports. Notably, this does not happen in the community. If the gatekeeper nurse does approve a visit to the optometrist, the wait to see an optometrist is often several weeks, and sometimes the referral is never completed. Such waits were at times exacerbated by the fact that NaphCare had problems contracting with an offsite optometry group. As explained earlier in this Report, due to NaphCare's failure to pay outside providers, the Jail's relationships with some outside providers were strained.

SD_1572585.

652. Fourth, NaphCare required all referrals to an optometrist to go through their UM review process, resulting in additional delays and irrational denials. By practice, all optometry referrals were sent to the UM nurses in Alabama, who either approved the referral or denied it. Many of the denials contained this as a reason for denial: "Patient is not in custody for a year. Resubmit after a year." Rognlien-Hood Tr. at 158:25-159:11. Where this requirement came from is a mystery to me. In my opinion, if a patient has a medical or accommodation need for eyeglasses at one year, they had that same need at day one. NaphCare's Policy and Procedure manual lists eyeglasses as an "Aid to Impairment" along with crutches and wheelchairs. NAPHCARE001877. Yet when a patient needs a wheelchair, NaphCare does not deny the request because "patient is not in custody for a year." In order to work around this problem of optometry referrals being inappropriately denied by NaphCare, the Sheriff's Department eventually hired its own optometrist separate from its contracted services with NaphCare. Rognlien-Hood Tr. at 156:2-5. This program is new enough that I have no data on what impact this has had on the problem of vison evaluations, vision care, and eyeglass prescription.

653. Finally, there are additional and substantial delays between the prescription of eyeglasses by an optometrist and the receipt of the eyeglasses by the patient. Most jails have a contractual relationship with a company that specializes in providing glasses to incarcerated patients. In my experience, such companies take only a couple of weeks between the receipt of a prescription and the delivery of eyeglasses. I have seen nothing that indicates which entity the Sheriff's Department/NaphCare has contracted with to actually create the prescribed eyeglasses, or any timeline that they must abide by. Notably, the Sheriff's Department's CQI process does not track the average length of time between an optometry appointment and the receipt of the prescribed eyeglasses, and makes no effort to improve its performance.

654. There is substantial evidence of delays in providing vision glasses to patients who need them. The Sheriff's Department contracted with NaphCare in June 2022 for the provision of optometry services. County Contract No. 566117, § 2.3.19.2. In its April 28, 2023 Corrective Action Notice, the Sheriff's Department stated that NaphCare was out of compliance with this provision of the contract, highlighting an "eye glass backlog," but for months, allowed the problem to go unresolved. On September 13, 2023, the Sheriff's Department's Medical Services Administrator, Chris Miedico, wrote to NaphCare's Health Services Administrator, Dr. Michael Farrier, about a "concern with the wait times for the arrival of prescription glasses once a patient has been examined by the optometrist," which could be "upwards of two months." NAPHCARE039577. I agree with Mr. Miedico that this turn-around time is "neither acceptable nor reasonable." *Id*. Dr. Farrier acknowledged that there had been "inordinate delays" and assured that eyeglass deliveries would be expedited. *Id*. On November 9, 2023, Mr. Miedico again wrote to Dr. Farrier asking for updates regarding the potential for sub-contracting with a company that could provide necessary optometry services. NAPCHARE039575.

655. Prescribed eyeglasses and/or contact lenses are a medical necessity for many incarcerated people, which means the denial of such optometry services can have a serious and widespread negative impact on incarcerated people in the Jail. I found many examples of this in the patient charts I reviewed.

656. One example is [redacted] ([redacted]), an incarcerated person who submitted a request for optometry care on [redacted] 2023, stating "I would like to please be seen by optometrist due to poor vs [vision] keep bumping into things." SD_782225. The request was stamped "received" almost six weeks later, on [redacted] 2023. Mr. [redacted] was seen by a nurse and then an NP for this request on [redacted] 2023 and stated that he could not see any letters at a distance of 20 feet. SD_782054-782055. Mr. [redacted] was seen again by a Registered Nurse and Nurse Practitioner on [redacted] 2023, when he again raised concerns about his poor

vision. SD_782064. He was finally examined by an optometrist on [redacted] 2023. SD_782239. The optometrist diagnosed astigmatism and myopia. *Id*. Mr. [redacted] received prescribed eyeglasses on [redacted] 2023, more than five months after his request for medical care for his vision. SD_782064.

657. As another example, on [redacted] 2023, [redacted] ([redacted]) submitted a request for a vision check: "I need seeing plz and thank you." SD_747797. A note on the request form states, "patient with pending RNSC to eval for glasses." *Id.* It does not appear that there was any face-to-face evaluation in response to this request. SD_747539-40. On [redacted] 2023, Mr. [redacted] submitted another medical request: "I would like to have my eyes checked and get glasses please and thank you." SD_747787. Again, there was no face-to-face evaluation. *See* SD_747538-39. On [redacted] 2023, Mr. [redacted] submitted a grievance stating that he had been waiting for an optometry appointment but it had not been scheduled. SD_747780. On [redacted] 2024, Mr. [redacted] stated on a medical request form that he needed an eye exam because he "ha[d] a stigmatism in one [eye] and … [is] near sighted." SD_747772. On [redacted] 2024, three months after he first submitted a grievance regarding his vision needs, RN Marissa Barisan administered a near-vision acuity test to Mr. [redacted] gave him 1.5 reading glasses, and the matter was considered settled. SD_747537. This, however, is not what Mr. [redacted] initially asked for. Mr. [redacted] mentioned astigmatism and nearsightedness, which were never evaluated since his distance vision was never checked and he was never referred to an optometrist. Further, this delay in the provision of even over-the-counter reading classes indicates substandard care, as they should be readily available and freely provided to individuals like Mr. [redacted]

658. In summary, the Jail program for giving necessary vison correction to incarcerated patients is in disarray and the Jail fails in its duty to provide these necessary services to its patients. Several recommendations flow from this finding.

The Jail should have specific policies and procedures on how vision evaluation, optometry referrals, and eyeglass prescriptions will happen. Nurses and corporate UM officers should not be gatekeepers who deny patients access to vision care from an optometrist based on bogus criteria. Patients must be able to see an optometrist in a timely manner, and prescription glasses should be delivered in a timely manner.

X. Custody Staff Interfere with the Provision of Care by Health Care Staff in the Jail, Including by Compromising Patient Confidentiality, Which Puts Patients at Substantial Risk of Serious Harm

659. The NCCHC requires that health care staff have "autonomy" from custody staff when it comes to patient care. In particular, the NCCHC standard requires health care staff and the institutional authority address any policies and procedures that deny direct medical orders, including ones that interfere with the delivery of, the access to, or the quality of health care services deemed necessary by the Health Services Administrator and/or the advanced clinical provider. *Id.*

660. It is my opinion that the Jail fails to meet this standard. In particular, custody staff as a matter of course deny incarcerated people the opportunity to meet confidentially with health care providers, either by requiring that patient meetings take place outside the clinic or by requiring custody staff to be present during clinical appointments.

661. The Jail's policies and procedures provide that health care providers must have "autonomy … in clinical decision making." MSD Operations Manual No. A.3.1 Medical Autonomy. Qualified health care professionals are to "collaborate with custody staff in implementing the plan of care safely and timely" "[a]s needed," but the Jail's procedures are clear that "[u]ltimately, the qualified health provider is responsible for the appropriate management of the patient." *Id.* Custody staff must "support[] the implementation of clinical decisions and aid[] in facilitating necessary housing transfers." *Id.*

662. While these policies and procedures generally are appropriate, in practice, custody staff regularly violate the Jail's policies and procedures requiring

autonomy in clinical decision-making and patient access to health care. Both Dr. Montgomery and Ms. Rognlien-Hood confirmed that custody staff frequently interfere with the provision of health care in the Jail. Dr. Montgomery stated that he "agree[d]" with Plaintiffs' allegations in this case that custody staff "work[] out[side the] scope" of their duties, impeding on the work of health care staff, and provided myriad examples: custody staff arbitrarily cancelled the quarantining of incarcerated people at intake during the COVID-19 pandemic; get involved in decision-making processes between the Jail's medical clinic and the courts; prevent medical staff from providing medications to incarcerated people during lockdowns; and tried to force the Sheriff's Department to accept NaphCare's policies and procedures without question in an attempt to indemnify the County. SD_120011, SD_120015. Dr. Montgomery reported to Sheriff's Department staff that there was a "large disconnect between sworn and health staff" with respect to the use of body scanners, observing that sworn staff order x-rays of patients without consulting with medical staff. SD_212920, SD_212921. I agree with Dr. Montgomery that this practice is problematic, because it results in a lack of proper evaluation, documentation, and follow-up for patients who are at high risk of negative outcomes due to potential abnormalities in their body scans. *Id*.

663. Ms. Rognlien-Hood provided testimony about custody staff interfering in nursing staff's provision of care to incarcerated people, confirming that custody staff at times deny health care staff to see particular patients who they deem too dangerous. Rognlien-Hood Tr. at 143:1-5. This is problematic for several reasons. First, patients deemed hostile and uncooperative commonly have medical or psychiatric issues that are causing or exacerbating their behavior. Examples from my own experience include patients who are delirious from infections or withdrawal; patients cranky due to pain, shortness of breath, or other medical symptoms; and patients who have had strokes. Second, hostile, uncooperative patients become ill just like any other group of patients and may need medical

attention for important medical problems. In my experience, patients sometimes are hostile to custody staff but not to medical personnel who they perceive as wanting to help them. Often, a patient hostile to custody staff is cooperative when receiving medical care. Finally, there are ways of safely restraining uncooperative patients to allow medical evaluation. If custody staff think a patient is potentially dangerous to medical staff, the proper course of action is to create an action plan for how to get necessary medical care to the patient.

664. Ms. Rognlien-Hood also was asked in her deposition whether any health care staff had expressed having issues with the involvement of custody staff in the health care administration or decision-making. Ms. Rognlien-Hood answered affirmatively and offered as an example that health care staff may want to put a patient into the "detention safety program" and "sworn won't put them in there," and vice-versa. *Id*. at 140:8-19. Another example cited by Ms. Rognlien-Hood was the process for "send outs," or when a patient is sent out of the Jail for medical care. *Id*. at 141:17-24. She testified that "[a] nurse will say 'I need this patient to go out,' and sworn doesn't feel they need to go out." *Id.* These examples impede patients' access to care, placing them at risk.

665. Custody staff's involvement in health care decisions at the Jail is particularly pronounced when it comes to confidentiality of medical encounters. It is my opinion that the Sheriff's Department categorically do not provide incarcerated people with adequate confidentiality during medical encounters.

666. It is a tenant of the medical profession that patients have a right to reasonable privacy and confidentiality during their encounters with health care professionals. This standard is important because it facilitates sharing of important medical information between patients and providers regarding concerns, symptoms, behaviors, diagnoses, and treatment—details that patients might be embarrassed or unwilling to share if they were to be overheard by someone else.

667. In the community, confidentiality is achieved by having medical

encounters occur in a room specifically designed for private medical encounters. Another important way that medical professionals in the community ensure confidentiality is by excluding any extraneous people from witnessing or overhearing the medical encounter.

668. Incarcerated patients are no different than patients on the outside, who may be reluctant to discuss intimate details of their medical problems in front of non-medical staff. Indeed, the possibility that patients might be unwilling or embarrassed to describe their medical concerns outside a confidential environment is likely even higher in the correctional setting, where patients may have the impression that, if other incarcerated people know about their medical concern, they could be perceived as weak, subject to ridicule, or even at risk of violence or other victimization. In my experience, incarcerated patients may be at risk of violence if other incarcerated people know that they have certain medical issues, such as HIV, or issues perceived as being transmittable, such as infections and rashes. They may be at risk of victimization if they are perceived as weak or have private information that they do not want shared with others.

669. The NCCHC 2018 Standards for Health Services in Jails addresses confidentiality and privacy in section J-A-07, Privacy of Care. This standard provides "[i]t is essential that in nonemergency situations all protected health information be protected from discovery or access. This means that no conversations concerning a patient's health status, diagnosis, or treatment should be conducted in areas where they can be overheard by other inmates, staff, or visitors…. Health stuff must ensure that all encounters with exchanges of health information, starting with the receiving screening, remain private and that a patient's dignity is protected. Such efforts foster necessary and candid conversation between the patient and health staff."

670. NCCHC's 2017 Technical Assistance Report regarding the Jail's compliance with NCCHC's standards found that the Jail was not in compliance with

NCCHC's privacy and confidentiality standards: "The areas of privacy and confidentiality of care need to be addressed. … procedures [must] be put in place to assure confidentiality when health care is being delivered and discussed." DUNSMORE0260627.

671. Although the Sheriff's Department has a goal of complying with NCCHC's standards, and assuring appropriate privacy and confidentiality of incarcerated patients would seem to me to be "low hanging fruit" that would be relatively easy to implement, as far as I can tell, the Jail has made no effort to comply with the NCCHC's privacy standards.

672. While the Sheriff's Department must consider security concerns related to the administration of health care, the need for security does not take away the obligation to ensure privacy and confidentiality for the patient.

673. The San Diego Sheriff's Department routinely compromises the confidentiality of incarcerated patients. Based on my review of charts and discussions with incarcerated people during my inspections of three Jail facilities, it is evident that most clinical encounters take place in or near the patient's cell-front rather than in private medical rooms designed for this purpose. For example:

674. [redacted] ([redacted]) was examined by a nurse practitioner at his cell door on [redacted]2022 for testicular pain, SD_821714-15, and again on [redacted] 2023 when he was seen at his cell door for painful urination, SD_821689.

675. [redacted] ([redacted]) was examined by a nurse practitioner at his cell door on [redacted]2024 for a hand infection, SD_772666.

676. [redacted] ([redacted]) was examined by a nurse practitioner at his cell door on [redacted] 2023 for a headache, SD_749590.

677. [redacted] ([redacted]) was examined by a nurse practitioner at his cell door on [redacted] 2022 for shoulder pain, SD_796606-07.

678. [redacted] ([redacted]) was examined by a nurse practitioner at his cell door on [redacted]2023 for a complex foot infection, SD_788746.

679. And, [redacted] ([redacted]) was examined by a nurse practitioner at his cell door on [redacted]2022 for hip pain, SD_773765.

680. I could go on and on. The practice of doing most medical evaluations in the patient's housing unit rather than in the medical suite is pervasive.

681. Performing a medical evaluation at a patient's cell door means numerous other people, including other incarcerated people and staff, can see and/or hear the encounter. Many patients will not feel comfortable speaking openly with health care staff or participating in such necessary physical exams for fear of embarrassment, abuse, or retaliation by those who can see and hear the encounter.

682. According to the Sheriff's Department's policies, deputies are also present "when incarcerated persons are being evaluated and/or treated by facility health staff or contract providers." DSB Policy M.15, II.C. Email correspondence between Serina Rognlien-Hood and Christopher Miedico confirms that incarcerated people are not asked for their consent to have a deputy present during their medical evaluations. SD_375953-375954.

683. Deposition testimony also establishes that, even when incarcerated people are escorted to the medical clinic for an appointment, custody staff are *in the room* for the entire appointment. Rognlien-Hood Tr. at 259:21-260:3. She confirmed that custody staff can see a patient while they are being treated and can hear the substance of conversations during these appointments. *Id.* at 259:21-260:7. She also agreed that this can compromise patient privacy with respect to health care. *Id.* at 260:8-261:1. Similarly, Dr. Peter Freedland of CHP, with whom the County just signed another contract for additional medical services, testified that "there's always a deputy" present during medical appointments, even in the medical clinic. Freedland Tr. at 113:1-3.

684. In my opinion, there is no reason that appointments for *every* patient—regardless of security classification level—must be attended by a deputy. Many other jails have privacy policies and procedures that protect incarcerated patient's

rights while also ensuring security.

685. One common way that other jails ensure privacy is by having at all times at least two medical professionals in the medical exam room with the patient, such as a practitioner and a nurse, or an RN and an LVN. Security is nearby but out of earshot of normal volume conversations, so that they can respond quickly if staff raises their voice to indicate there is a problem. Jail policies and procedures can lay out different security procedures for those patients who Jail staff have individually identified as having special security issues warranting custody staff being within a closer proximity to the medical encounter.

686. In conclusion, the Sheriff's Department knows that they are not complying with NCCHC or industry standards to preserve patient privacy and confidentiality. This can harm patients by making them fearful to disclose potentially embarrassing medical complaints in front of security staff and other incarcerated people.

XI. The Sheriff's Department Fails to Maintain Adequate, Accurate, and Complete Medical Records, Which Compromises the Delivery of Care

687. In my opinion, the Sheriff's Department lacks adequate recordkeeping processes, which undermines care for incarcerated people.

688. The standard of care requires that meticulous medical records be kept on every patient and of every encounter with medical personnel. Medical records can be handwritten, but most medical systems now use electronic medical records ("EMR"). The essential attributes of an EMR are (i) simplicity, (ii) efficiency, (iii) confidentiality, (iv) searchability, and (v) report generation. Of course, it is also essential that information input into the EMR is both accurate and complete.

689. The NCCHC 2018 Standards for Health Services in Jails discusses the minimal standards for medical records in "Health Records" (J-A-08).

690. The EMR serves an important function in any system that delivers medical care. Complete, accurate, easy to access medical records are a necessary

component to ensure that an individual receives consistent care. For example, it enables a practitioner who is seeing a patient for the first time to learn what care the Jail previously provided to the patient or why the patient was referred to the practitioner in the first place. A functioning EMR also enables practitioners to monitor an individual patient's health trends overtime, *e.g.*, whether someone's blood pressure has increased since they were booked into the Jail. The EMR is also a critical tool for tracking systemwide trends within the Jail.

691. The Sheriff's Department maintains an EMR for incarcerated people using a system called "TechCare." TechCare is a proprietary product of NaphCare, and the primary method for medical recordkeeping in the Jail. I am aware that Plaintiffs' counsel sought for me to inspect TechCare, but I was not able to do so. Nevertheless, it is my opinion based on the documents I have reviewed that the system has many problems.

692. Leaving aside the wisdom of using the technology of a company that recently lost a portion of its medical contract with the County, my review of records has shown serious deficiencies in TechCare's functionality.

693. TechCare lacks simplicity and efficiency because, among other issues, it has no list of all medical events (including but not limited to sick calls, lab draws, etc.) by date and does not list discharge dates or many other important events related to an incarcerated person's health. These features are important because they allow medical staff to quickly and easily know exactly what is going on with a particular patient, such as the patient had an x-ray but the reading has not returned or the practitioner saw the patient but not everything she ordered has been done yet, etc.

694. TechCare also is lacking in searchability. Ms. Rognlien-Hood testified that "sometimes finding … information [in TechCare] is not user friendly." Rognlien-Hood Tr. at 231:13. Searchability is important because medical records can be long and dense, sometimes many thousands of pages long. It may be important to know, for example, if a patient has had a certain vaccine, or what a test

done last month showed, or what the patient's weight was the last time they were in jail. Without a functioning search tool, it can take a lot of time to find very important information. If that important information cannot be found, medical care can suffer and patients can be harmed. As an example, if I cannot find out what a patient weighed the last time he was in jail, I might not realize that he has gained 75 pounds in 8 months, which should be investigated medically.

695. As one example, [redacted] came to the Jail directly from the UCSD hospital, where he was for two days prior to his incarceration. SD_873242-49. In the receiving screening form for Mr. [redacted] a nurse noted: "rece[i]ved paperwork from UCSD." *Id.* However, in a Progress Note written only two days later, a nurse noted: "No d[i]scharge paperwork from UCSD ava[il]ab[l]e." SD_873259.

696. Another example is that of [redacted], discussed in detail above. Even though Mr. [redacted] medical records had been received from Kaiser on [redacted] 2022, and a TechCare task for review of those records had been created, when a nurse practitioner saw Mr. [redacted] on [redacted] 2022, he documented a plan to send an "ROI for Kaiser … waiting for records to arrive for review. Medical Records of [redacted] as of [redacted] 2023, pp. 109, 533, 552 of 595. An easy to use record system would make it obvious that those records had already been received.

697. Another example is the case of [redacted], also discussed in detail above. On [redacted] 2022, Dr. Christensen completed a task in TechCare to review Ms. [redacted]'s blood pressures. He did so and prescribed a medication for hypertension. However, at that time, Ms. [redacted] had been hospitalized in the Intensive Care Unit for two days. That fact should have been apparent to Dr. Christensen in the EMR.

698. Further, TechCare's reporting capabilities also appear to be substandard. Ms. Rognlien-Hood admitted that some TechCare reports cannot be

run "easily … because of the way TechCare is set up." *Id*. at 89:8-90:7. This impacts the provision of care. Ms. Rognlien-Hood testified that the frequency with which she runs certain critical reports regarding health care operations depends on her workload because running the reports is "very time consuming." *Id*. at 90:8-14. When reports are run, they are often inaccurate, possibly because TechCare pulls information from sources that are not being used by staff to document patient information. *Id*. at 248:13-249:5.

699. Dr. Freedland also testified that he is not a fan of TechCare: "I think there's a lot of good medical EMRs out there that could potentially benefit the [Jail] system more so than TechCare." Freedland Tr. at 32:6-8. Dr. Freedland stated "I'm not sure how it [TechCare] was created. There is a not a lot of ease of use." *Id.* at 32:11-13.

700. The Sheriff's Department was aware of serious issues with TechCare that would impede the provision of proper health care in the Jail, but these issues went unresolved for months if not years. The Sheriff's Department also raised issues with NaphCare at various meetings. For example, Sheriff's Department staff raised questions about inaccuracies in TechCare reporting at Medical Audit Committee meetings, and NaphCare representatives repeatedly stated that they would get answers, but did not do so. Rognlien-Hood Tr. at 244:10-246:1. Additional TechCare issues were raised in the Corrective Action Notices issued to NaphCare by the Sheriff's Department. The Corrective Action Notice issued May 12, 2023 stated that NaphCare was "releasing new TechCare builds without providing advanced notice of the changes or training to County Clinical Staff," resulting in some county staff being "faced with screens and cues they [know] nothing about and have no idea how to complete." NAPHCARE034756. This, according to the Sheriff's Department, "can lead to information being entered into the system that is not followed up [on] creating potential liability to the county." *Id*. I agree that this problem of information being entered into a medical record without

clear steps for follow up can have serious consequences for patient care, and should have been addressed immediately. Instead, the issue appeared in Correct Action Notices for months, and the most recent one I have reviewed simply says NaphCare is "responsive to all related IT concerns" without further detail. SD_1572607.

701. Similarly, I found multiple examples in the medical record of abnormal study results being neglected by the Jail's healthcare staff. The standard of care when any study is ordered is for a medical practitioner (usually the one who ordered the study) to interpret the results (normal/not normal), create a care plan based on the interpretation (if necessary), and communicate the results and the new care plan to the patient. All three steps should be documented in the medical record. And, in a good medical recordkeeping tool, these follow-ups would be triggered automatically. However, it is clear these follow-ups are not occurring; the Sheriff's Department did a CQI study to determine whether this standard of care was being met and found abysmal compliance ranging from 16% to 36% between May 2023 and September 2023. SD_114411.

702. The discussion of diagnostic care earlier in this Report highlights several examples of abnormal test results that were ignored, but which should have been followed up on as a matter of course—and which a robust EMR would have required such a review.

703. In addition to the problems with TechCare's functionality—which the Sheriff's Department has failed to correct despite knowing about them for months—medical records and other documents produced by the Sheriff's Department suggest that staff do not always provide complete documentation of encounters with incarcerated people.

704. For example, Aaron Bonin, whose in-custody death is discussed in detail above, was an incarcerated patient on dialysis for end-stage kidney failure. Before going into cardiac arrest due to his very high potassium level on October 24, 2022, Mr. Bonin was noted as having high potassium levels on October 20 and

October 21. SD_002075, SD_002237-39. The treatment for someone, like Mr. Bonin, who has kidney failure and high potassium is dialysis. However, a nurse the Jail discontinued the dialysis Mr. Bonin's dialysis early, writing: "Pt strongly insisted to stop the treatment." SD_002504. Troublingly, the Jail's analysis of Mr. Bonin's death, which I understand was written by Dr. Montgomery, notes that the recordkeeping about Mr. Bonin's dialysis treatment was poor. SD_055143. Dr. Montgomery wrote: "Appears that approximately 10 events that were not scanned in/recorded … Unclear if the lack of documented treatment record could be considered a refusal. While the patient has a recorded history of frequently refusing medications, there are not that many instances of a recorded refusal of dialysis." *Id.* From the moment that Mr. Bonin supposedly refused dialysis until the cardiac arrest that ultimately killed him, Mr. Bonin was not seen by a practitioner or any other medical staff member to ask why he was refusing dialysis and to inform him why that dialysis session was particularly important. *See* SD_002075-76. In addition, according to Dr. Montgomery, it is not even clear from his medical record whether Mr. Bonin had in fact refused dialysis. Had these incidents more clearly documented, and if the Jail's recordkeeping system had the ability to flag critical lab results and require practitioner sign-off on refusal of critical treatments, Mr. Bonin's death could have been prevented.

705. As another example, which is alleged in the Third Amended Complaint, Plaintiff Andree Andrade suffered multiple concussions while in the Jail, both from falling out of his upper bunk and from being assaulted. After an initial fall from his bunk in June 2022, he was sent to the hospital and informed by medical staff at the hospital that he sustained a concussion. His discharge instructions also include a highlighted section for "concussion" under "injury specific instructions." DUNSMORE0065484-95. However, Andrade's progress notes make no reference to the concussion. DUNSMORE0065226-28. A concussion is a brain injury that is not trivial. It is very important that concussion patients be treated according to

standard concussion protocols whether they are high school football players or patients in a jail. What should have happened when Mr. Andrade returned from the hospital was for a practitioner to have reviewed the hospital discharge diagnosis and create a treatment plan. A robust EMR would force this to happen. Similarly, only days after his first hospital visit, Mr. Andrade was assaulted and again taken to the hospital, where hospital staff again noted that his chief complaint was "concussion/head pain" and again provided him with specific discharge instructions for "concussion." DUNSMORE0065533-42. Again, Mr. Andrade's progress notes make no reference to the possible concussion. DUNSMORE0065233-34. Based on my review of the records, it appears that no one properly reviewed the hospital notes and no one created an ongoing treatment plan. This was essential medical history that was ignored.

706. Complete and accurate reporting in TechCare is particularly important for patients who are transferred between Jail facilities. Both the MSD Operations Manual and NaphCare's Policies and Procedures indicate that the Jail relies almost exclusively on TechCare for continuity of care when an incarcerated person is transferred between two facilities within the Jail. *See* MSD Operations Manual MSD.M.4, Part V (outlining procedures "[i]n the event that a paper record exists"); NaphCare P&P, E-03, NAPHCARE031248 ("A Transfer Summary form should be completed if continuity is not clearly maintained within TechCare from one facility to the next."). And, based on the charts I have reviewed, in practice, transfer summary forms are rarely filled out.

707. As explained above, there are substantial flaws with TechCare and the Sheriff's Department's completion of TechCare documentation, leading to likely gaps in care. Without appropriate documentation, when a patient moves to a new facility, the new nurses and medical practitioners have to reconstruct the patient's history by reading the patient's entire chart. This takes time and effort, and invariably, important things will be missed in some patients during the handoff.

708. Sheriff's Department nursing staff also have voiced concerns about "receiv[ing] transfers with no or inadequate follow-up or second stage [medical evaluation] scheduled." SD_213483. Health care staff at intake facilities should initiate care at the time of screening, so that when patients are transferred to other facilities, which I understand can happen frequently and with little notice, the receiving facility can properly treat them. Otherwise, the failure to initiate proper care at intake can have ripple effects and interfere with continuity of care.

XII. The Sheriff's Department Fails to Provide Necessary or Adequate Follow-Up Medical Treatment to Incarcerated People

709. In my opinion, the Sheriff's Department fails to provide follow-up care to incarcerated people who are sent for medical care outside the Jail—either to the emergency room or for a specialist appointment—thus placing incarcerated people at a substantial risk of serious harm.

710. Appropriate medical care often requires follow-up—in both the community and the correctional setting. Jail patients are frequently sent for medical care and evaluation outside of the jail. Examples include: being admitted to the hospital; being sent to the emergency department for some type of urgent evaluation; being sent for a consultation with a medical specialist outside of the jail, such as an orthopedist, a cardiologist or a neurologist; being sent for some type of diagnostic study that cannot be done in the jail, such as an MRI, echocardiogram or EEG; or being sent for some type of treatment or therapy that cannot be done as the jail, such as physical therapy, infusions for autoimmune disease or radiation treatments for cancer.

711. When jail patients return from any of these off-site appointments, the findings and recommendations made during the off-site appointment must be incorporated into the patient's medical record and the overall medical treatment plan at the jail. This process is often termed "medical follow-up." The following hypothetical cases are given as examples.

a. A patient returns from the emergency department having been diagnosed with a broken arm and the recommendation that the patient see an orthopedist within two weeks so that proper healing of the fracture can be assessed.

b. A patient returns after having an CT done, which showed a brain mass. The radiologist recommends an MRI be done.

c. A patient returns from being hospitalized for dehydration and renal failure and is recommended to have follow-up labs and monitoring.

d. A patient returns from an appointment with a rheumatologist, who would like to see the patient again in one month.

712. "Follow-up" means assuring that these recommendations are followed and that necessary communications with the outside entity occur.

713. The underlying principles and processes for follow-up care are similar to intake and continuity of care issues, discussed earlier in this Report. Patients return from outside medical visits with new diagnoses, new medications, and new recommendations for medical treatment. Therefore, just as a jail must evaluate an incarcerated person's medical condition at booking so that the jail can be sure the patient's care is continued, the jail must ensure that all important findings, diagnoses, and recommendations from off-site visits are entered into the medical record and incorporated into the patient's health care plan.

714. The first (and perhaps most essential) part of follow-up after an outside medical visit is to review the medical records from the outside visit and summarize the important findings into the patient's medical record. This is essential because outside medical records may be hundreds of pages long and often not easily assessed or read by other medical professionals at the jail. This review and summary of outside medical records should contain the following basic information:

a. Who reviewed the records (usually a medical practitioner).

b. What were the discharge diagnoses and major findings.

c. What studies were done and what did they show.

d. Are any diagnostic studies or treatments recommended for the future? Who will schedule these?

e. When will the patient be seen by jail medical staff?

715. In addition, a jail medical professional should speak with the patient face-to-face to ascertain their understanding of the important findings and what should be scheduled in the future.

716. However, the MSD Operations Manual Medical Division says nothing about the appropriate steps to take when patients return after receiving offsite care. NaphCare's Health Care Policy and Procedure Manual No. A-08 says only that "[o]ff-site health care and emergency treatment referral and discharge summaries" should be contained within the patient's health record in TechCare. NAPHCARE001577.

717. In my opinion, this lack of guidance on what is expected of Jail medical staff when patients return from offsite care leads to inadequate documentation and poor medical care that can (and does) harm patients.

718. In my review of medical records, I found that the basic principles of documentation of outside medical records, continuity of care, and appropriate follow up simply do not occur very often at the Jail.

719. Many times, no review of the outside medical records was recorded at all. For example, patient [redacted] was sent to the ER when she had a seizure during a court proceeding on [redacted] 2023. SD_810597. There is no indication that her ER record was even reviewed, and it was never summarized in her records.

720. In other cases, the records were simply noted as "reviewed," but none of the essential information outlined above was entered into the medical record.

721. The deaths of Patricia Adamson and Roselee Bartolacci, described in more detail earlier in this Report, are tragic examples of these failings at the Jail.

722. Ms. Adamson was hospitalized for two days from February 15, 2023 to February 17, 2023 due to hematemesis, *i.e.*, throwing up blood, which is most

commonly caused by an ulcer in the stomach or duodenum. SD_705066. Dr. David Christensen wrote in Ms. Adamson's progress notes on February 20, 2023 that "[h]ospital records [were] reviewed," SD_705067, but made no summary of the medical care provided at the hospital and created no ongoing care and treatment plan for hematemesis/ulcers. NP Lacey Beaston did a brief summary of the hospital records in a chart note on February 23, 2023. SD_705124. She specifically noted the anemia and the hospital plan to transfuse Ms. Adamson if her hemoglobin fell too much. *Id.* NP Beaston also noted the hospital discharge prescription of Protonix. *Id.* However, NP Beaston made no other treatment plan. She ordered no labs to check hemoglobin levels, and no scheduled check ups.

723. Perhaps because there was no easily accessible summary of the medical records and no treatment plan, when Ms. Adamson began shortly thereafter to have other abdominal symptoms commonly associated with ulcers ("early satiety, nausea and bloating") the nurse practitioner who saw her on April 29, 2023 did not mention her hospitalization two months previously and did not consider the possibility of an ulcer. SD_705537. Four days later, Ms. Adamson died of a perforated gastric ulcer.

724. In my opinion, not appropriately reviewing Ms. Adamson's medical record and not developing a medical care plan based on her hospital findings were important contributing factors in her death. She went to the hospital due to the complications of ulcers. She died three months later from the complications of ulcers that had been ignored at the Jail in the intervening three months.

725. Ms. Bartolacci was hospitalized for thirteen days from April 26, 2023 to May 10, 2023, with serious, life-threatening problems, including malnutrition, dehydration, acute renal failure, sepsis, hypokalemia, anemia, cardiac dysrhythmias, and more. SD_711885. While she was in the hospital, many diagnostic studies were done, including ultrasounds, cardiac studies, and x-rays, many of which were abnormal. SD_712354-56. Ms. Bartolacci also had severely abnormal metabolic labs, such as a critically low potassium level. She was so sick that she required 13

days in the hospital to recover.

726. However, when she returned to the Jail on May 10, 2023, a STATCare practitioner, Chelsea Lowery, Corp NP, wrote only "Hospital d/c summary reviewed." SD_711885. She wrote nothing else. None of the essential elements of several days of hospitalization was summarized.

727. NP Lowery did schedule an MD Sick call visit for Ms. Bartolacci, but, when that visit occurred two days later, Dr. David Christensen appears not to have seen the hospital records at all. He wrote nothing about them. Instead, Dr. Christensen, wrote that the patient "refused provider eval." *Id.* at p. 298. Nothing further was scheduled. There was certainly no treatment plan incorporating what was learned about Ms. Bartolacci's frail medical condition during her 13 days in the hospital. Ms. Bartolacci died approximately two weeks later.

728. In my opinion, not appropriately reviewing Ms. Bartolacci's medical record after her 13-day stay at the hospital and not developing a medical care plan based on this review were important contributing factors in her death from the same problems that had been treated at the hospital, namely malnutrition, dehydration, and hypokalemia.

729. Another example is [redacted] ([redacted]), a [redacted] year old woman with a documented history of coronary artery disease, who had, as a result, been treated with a coronary stent. SD_754185-88. At her booking on [redacted] 2023, Ms. [redacted] was sent to the hospital. She refused evaluation at the hospital but was nevertheless cleared and returned to the Jail the same evening. SD_754188. On [redacted] 2023, Dr. David Christensen noted "Scripps [redacted] after visit summary reviewed," but he did not provide a summary of what had occurred. SD_754732. On [redacted] 2023, Ms. [redacted] was again sent to the hospital for chest pain. SD_754219-20. She was admitted and had EKGs (all abnormal), SD_754213; a cardiac stress test done (that was interpreted as "nondiagnostic"), SD_754212; and labs which showed "stage 3 chronic kidney disease," SD_754208. The discharge

papers sent back to the Jail with Ms. [redacted] included the findings of her echocardiogram: "Conclusion Left ventricular systolic function is severely decreased. LVEF [left ventricular ejection fraction] is 25%"—anything below 30% is severely abnormal—"Moderate to severe mitral regurgitation. Severe tricuspid regurgitation. There is severe pulmonary hypertension." SD_754215. In other words, Ms. [redacted] had been diagnosed with severe, life-threatening heart disease and moderate kidney disease.

730. She returned to the Jail on [redacted] 2023. The next day, NP Lacey Beaston noted that Ms. [redacted] "had a cardiac work up including labs and an echo" but evidently did not look at the echocardiogram report nor did she note the diagnosis of stage three kidney disease. SD_754738. Ms. [redacted] continued to complain of chest pain thereafter and was evaluated by nurses, who sent EKGs to STATCare midlevel practitioners for interpretation. SD_754746, SD_754739. The severely abnormal echocardiogram was finally noted four weeks later, on [redacted] 2023, by NP Beaston. SD_754749. It took another month to get UM permission for a cardiology consult, which finally occurred via telemedicine on [redacted] 2023. SD_754755. Ms. [redacted] was finally sent to the hospital for a cardiology evaluation on [redacted] 2023, SD_754764, and [redacted] 2023. SD_754772. At the [redacted] 2023 visit, the hospital conducted another echocardiogram and determined that the first echocardiogram was actually not Ms. [redacted] but had been mistakenly included in her chart. The severely abnormal echocardiogram attributed to Ms. [redacted] should have been identified far sooner than three weeks later. Had it been a real finding, Ms. [redacted] could easily have died within those three weeks.

731. In summary, the Sheriff's Department has no Policy or Procedure for ensuring appropriate follow-up and continuity of care after Jail patients return from outside medical appointments. Because of this, appropriate follow-up and continuity of care does not occur. This leads to patient harm, including death.

XIII. The Sheriff's Department Fails to Provide Adequate Discharge Planning Services and Medication for Incarcerated People Being Released from the Jail

732. In my opinion, the Sheriff's Department lacks adequate discharge planning services to ensure the health care of individuals being released from the Jail. Discharge planning from a jail is essential because these patients, who suddenly have no or limited options for medical care once released, are liable to have their health seriously deteriorate without that care. Without care, many of these people will return to the Jail. Without community resources for medical care, they will return to the Jail in worse shape than they were before. From a public health perspective, these patients return to the larger San Diego community. Their problems receiving proper health care will result in worsening community problems, ranging from transmission of communicable diseases that were not treated to overburdening first responder and emergency room resources in the community because they have nowhere else to go. For those of us who have practiced jail medical care, the problem of slow deterioration of incarcerated and formerly incarcerated patient health over time due to lack of resources is a common experience.

733. The standard of care for discharge planning in a jail is similar, if not identical, to the standard for discharge planning in the community. In the community, there is a standard of care as to the responsibilities of the medical staff when a patient is being discharged from a hospital, a nursing home, or any other inpatient facility. The medical staff has the responsibility to ensure *continuity of medical care* after the patient leaves the facility. One can find the essentials of this standard of care in many places. For the purposes of this report, I used the online medical textbook *Uptodate*, and specifically, the chapter "Hospital discharge and readmission" written by E. Alper, et al. *Uptodate* states that "[d]ischarge planning is the development of an individualized discharge plan for the patient, prior to leaving the hospital, to ensure that patients are discharged … with provision of

adequate post-discharge services." Based on my experience practicing medicine in carceral settings, this is the appropriate standard of care in the Jail as well.

734. Per *Uptodate*, elements of discharge planning include "[p]lanning and coordinating with whatever entity will take over medical care after discharge." This includes "communication between the [facility] and the clinic or medical practitioner that will take over care after discharge"; ensuring the "clinic or medical provider [] receive[s] the jail medical record"; considering whether the patient "ha[s] a family or other sources of medical support"; "[m]edication reconciliation, which includes determining what medications the patient is to take after discharge and how the patient will get them"; and providing the patient with instructions about their main medical problems, as well as what to do and who to see if these problems arise. *Uptodate*, Hospital Discharge and Readmission, Alper, et al., Feb 3, 2023. Based on my own knowledge and experience, this is an appropriate standard of care.

735. The Jail has a poor track record with regard to discharge planning. In 2017, the NCCHC Technical Assistance Report concluded that "there was no evidence of [discharge planning] in the medical records we reviewed [at the Jail]." DUNSMORE0260675.

736. The Jail's policies regarding discharge planning are minimal, providing guidance only about providing medication upon release. NaphCare Policy & Procedure Manual, E-10 Discharge Planning, June 1, 2022, SD_073589; MSD Operations Manual D.1.1, Pharmaceutical Operations § IX. Discharge Medications.

737. This lack of adequate policies and procedures relating to discharge planning guarantees failure of the program. As with every other Department function, the Sheriff's Department must lay out the standards of discharge planning that they expect from their employees and contractors. Discharge pharmaceuticals is just one part of the discharge process. Discharge planning must take into account, for example, disabilities. Alarmingly, I understand the Sheriff's Department released a person with a mobility disability from Central Jail at close to midnight on

May 31, 2024 without his wheelchair, underscoring the harm that can occur if specific discharge planning policies are not in place. Declaration of James Clark, June 12, 2024. Discharge planning must also consider ongoing medical treatments. How will the patient continue cancer treatments after release? If a patient is released before receiving a scheduled surgery, what does that patient need to do now? Having no policies about these and many other discharge considerations means that Jail patients will inevitably be harmed when necessary medical and social needs are not met. The medication discharge policy is also insufficient, as explained in more detail below.

738. Rather, the Sheriff's Department attempted to rectify its poor performance regarding discharge planning by hiring NaphCare as the primary provider of health care services in June 2022. Specifically, the County's contract with NaphCare states that the County and NaphCare "shall implement a system of discharge planning per the NCCHC standard." Contract No. 566117, , NAPHCARE000568. It also says the County and NaphCare must "ensure all discharge planning activities are documented using Techcare," and moreover, the "Release/Discharge Summary screen shall be used to provide medical information to the patient, medical facility or another state prison system." NAPHCARE000569.

739. I understand that the Sheriff's Department is renegotiating much of its contract with NaphCare, and, as of July 1, 2024, and contracted with CHP for provision of on-site medical care, including "Discharge of Patients." Contract No. 571418, SD_1579722. However, Dr. Freedland testified that "We're [CHP] not typically involved in the discharge process." Freedland Tr. at 149:19-20. It appears that NaphCare will remain fully in charge of the discharge planning program.

740. My review of documents has demonstrated that the Sheriff's Department has not implemented a comprehensive system of discharge planning, it failed to ensure that NaphCare implement such a system, and it has not taken

sufficient steps to remedy those flaws in its new contract with CHP. The Sheriff's Department thus fails to meet the standard of care regarding discharge planning.

A. Coordinating Ongoing Medical Care with Outside Agencies

741. The County is responsible for ensuring that there is a system in place to plan and coordinate continued patient care with outside agencies. As noted above, however, there are no San Diego County policies requiring that any such coordination occur.

742. The County's contract with NaphCare provides that "[a]s part of discharge planning, case managers, medical and mental healthcare professionals shall help arrange follow-up appointments for the patient." Country Contract No. 566117, NAPHCARE000569; *see also id.* ("Case managers and Contractor [will] arrange an appointment prior to release."); NAPHCARE000568 ("[D]isposition choices include referrals for case management[.]"); *id.* (requiring "[t]he development of a plan to address key issues such as continued medical and mental healthcare, housing, medical insurance, transportation, Social Security Disability, and employment").

743. NaphCare employs two discharge planners for the Jail, but the scope of their duties had yet to be determined as of June 2024—two years after the contract was signed. In her June 7, 2024 deposition, Angela Nix, testifying on behalf of NaphCare, stated that the job duties of the two discharge planners were "currently [being] develop[ed]." Nix II Tr. at 78:6-7. In particular, "we are working with the County to decide how those particular positions are going to function, if it's going to be a clinical discharge planner, or someone that is more of a clerical or administrative [sic]." *Id.* at 77:18-22. Ms. Rognlien-Hood similarly testified that implementation of discharge planning in conjunction with NaphCare was "still a work in progress." Rognlien-Hood Tr. at 250:2-7. Dr. Montgomery echoed these sentiments, testifying, "I'm unclear what NaphCare's discharge planners are actually doing." Montgomery II Tr. at 265:25-266-1.

744. To the extent that the NaphCare discharge planners' work—if they have even started—is be governed by NaphCare's existing policies and procedures regarding discharge planning, those fall far short of what is required in the contract. Notably, the policies and procedures imply that incarcerated patients must specifically ask for discharge planning in order to receive it, stating that "[p]atients who are aware in advance of their release date may inform health staff" who will then begin discharge planning, such as a provider "review[ing] the medications and determin[ing] which medications need to provided and for what duration." NaphCare Policy & Procedure Manual, E-10 Discharge Planning, NAPHCARE000932. The NaphCare policies and procedures also state that appointments and resource information are not provided to everyone, but rather, are "made available to the patient upon his/her discharge from the facility and appointments made when possible." *Id.* The term "when possible" seems to allow NaphCare an excuse anytime they fail to provide appropriate discharge planning. Given that there are only two discharge planners in comparison to thousands of people that are discharged every month (the Jail's average daily population is approximately 4,000 people, but the Jail regularly books that many people or more each month), it is likely that it will frequently not be "possible" for the two discharge planners to arrange continuity of care for everyone.

745. The NaphCare policies and procedures fall short of the standard of care. There is no mention of any forward planning of continuity of medical or mental health care for patients who need this upon release. There is no plan to coordinate medical care with community clinics that would be willing to see former Jail patients. There is no consideration of their obligations toward patients with disabilities when these patients leave the Jail. Instead, the Jail has put the onus on the patient to inform the Jail staff that they would like help coordinating their medical care after discharge. No outside entity requires this. No hospital will fail to do discharge planning because the patient did not ask for it. Again, requiring

patients to ask for discharge planning seems to be a subtle way to deny them this service and to excuse the fact that NaphCare did not provide this service.

746. Nor does it appear that CHP will be taking over the discharge planning function at the Jails. Although the new contract generally states that CHP will be responsible for "Discharge of Patients," SD_1579722, there is no language in the CHP contract requiring them to set up a discharge system, as there is in NaphCare's contract. And, as Dr. Freedland testified in his deposition, "we're not typically involved in the discharge process." Freedland Tr. at 149:19-20. In other words, CHP is unlikely to have an already developed discharge planning model that could be implemented in San Diego.

747. In practice, discharge planning is, in fact, not occurring at the Jail. Dr. Montgomery confirmed this at his deposition, testifying that the Sheriff's Department does not have policies or practices for systematically providing incarcerated individuals with comprehensive discharge planning related to their health care. Montgomery II Tr. at 254:17-257:7. Rather, such care—which includes things like referring individuals to offsite clinics for continued care or connecting individuals with community health resources—may occur on an ad hoc basis if Dr. Montgomery or Ms. Rognlien-Hood happen to be notified by another agency like the County's probation office. *Id.* at 257:3-7.

B. Discharge Medications

748. With respect to discharge medication, the Sheriff's Department's policies and procedures require that incarcerated people receive only a 10-day supply of medication, and only for certain limited medications, defined vaguely as "critical medications." MSD D.1.1 § IX(A). Although Dr. Montgomery testified that the Jail provides individuals of 30-day supplies of all medications now, this is not set forth in official policy. Montgomery II Tr. at 259:22-24.

749. The fact that there is no official policy requiring provision of 30-day supply is important because the Sheriff's Department cannot hold people

responsible if they fail to adhere to it. In addition, without a formal policy, actual practice can eventually devolve to the discretion of whether the clinician that sends the prescription personally thinks a certain medication is "critical." NaphCare's policies and procedures demonstrate the haphazard nature of the discharge medication policy in the Jail, stating that "[p]atients who are aware in advance of their release date may inform health staff. The provider will then review the medications and determine which medications need to provided and for what duration." NaphCare P&P, E-10 Discharge Planning, NAPHCARE000932. Without written guidance as to what is or is not a "needed" medication, different providers will inevitably make different decisions so that some patients will receive certain medications upon discharge and others will not. The language also indicates that the provider only has to do this if the patient requests this in advance.

750. As recently as December 29, 2023, the Sheriff's Department was still discussing how to implement a process to ensure continuity of medication after release, indicating challenges still exist and the Jail has not adequately addressed the issue. MSD Leadership Meeting, Agenda, December 29, 2023, NAPHCARE037026.

751. The Sheriff's Department also had problems ensuring continuation of Suboxone prescriptions for individuals receiving MAT upon discharge. In November 2023, for example, pharmacies required "prior authorization" from a physician to release 30-day prescriptions to discharged individuals due to a disagreement with NaphCare, resulting in medication delays. Email from Kelly Donahue to Kathy Myers et. al., November 30, 2023, SD_661566.

752. For patients requiring medication following release, these issues can be very harmful. For example, on [redacted] 2023, Sheriff's Department medical staff requested a MAT medication for [redacted], who was scheduled to be released on [redacted] 2023. Email from RN Stephen Yi to Dr. Elliot Wade and Dr. Nas Rafi, [redacted] 2023, SD_364617-18. However, no prescription had

been issued by the date of Mr. [redacted] release, causing him to miss a dose and go into withdrawal. SD_364617.

753. More importantly, real discharge planning would attempt to address the problem of how patients will get their medications *after* 10 or 30 days. If a patient has no prescriber to reorder prescriptions and no insurance or money to pay for prescriptions, giving them 10 or 30 days' worth of medications is just kicking the can down the road. Inclusive discharge planning thinks of what will happen later. The Sheriff's Department does not come close to doing so with respect to discharge medications.

C. Patient Instructions

754. The County is responsible for ensuring that NaphCare complies with its contractual obligations to provide patients at discharge with "educational information regarding their specific illness and the importance of follow-up appointments and medication continuity, from a healthcare provider." NAPHCARE000569. The patient also should "receive[] a comprehensive packet that contains essential community resources." *Id.* However, NaphCare policies and procedures state that this only occurs "[s]hould the health care staff be notified prior to a patient's discharge." NaphCare P&P, E-10 Discharge Planning, NAPHCARE000932.

755. In practice, judging by the lack of documentation in the dozens of records I reviewed of individuals who had been discharged from the Jail at least once, few patients receive any packet providing information about community resources. Even if they do, and the practice is just not documented, I am not aware of any evidence regarding exactly how any patient can access these resources if they lack money, insurance, the ability to travel, disabilities that would interfere with reading the material, etc. In the end, simply handing an information packet to some (but not all) incarcerated people at discharge is not adequate discharge planning.

D. Documentation and Information Transfer.

756. NaphCare's policies and procedures further state that "[a]ll discharge planning, including medical and mental health referrals, is to be documented in the patient's health record." NaphCare P&P, E-10 Discharge Planning, NAPHCARE000933. I found no record of any discharge planning in the patient records I reviewed. This means that either no discharge planning occurred, or the Jail failed to comply with policies and procedures regarding documentation.

757. With respect to information transfer, NaphCare's policies and procedures simply state that a "release summary is available in Techcare for assistance in discharge planning, especially in those patients discharges to another correctional facility." NAPHCARE000933. The County's contract with NaphCare goes further as to what is required, stating that the "Release/Discharge Summary screen shall be used to provide medical information to the patient, medical facility, or another state prison system." County Contract No. 566117, NAPHCARE000569. I saw this screen completed in only a few (no more than 10 percent) of the charts I reviewed. Where this summary screen was completed, there was no indication why it was generated in those cases but not others, or who the summary was sent to. The County's contract with NaphCare states that the summary screen "shall be used to provide medical information to the patient," but there is no explanation as to how a departing patient requests a copy or how it is provided when requested. *Id.* There is also no mention in the policies and procedures of how an outside medical clinic should request a copy of this summary screen.

758. The evidence I reviewed also shows a clear lack of training on how to prepare for discharge of incarcerated people with serious medical concerns so that such individuals can continue their medical care without dangerous interruption. There is often complete confusion among staff leading up to a discharge. Emails from April and May of 2023 regarding discharge medications for an incarcerated person with diabetes demonstrate that even Dr. Montgomery, Ms. Rognlien-Hood,

and Brandy Rafail, a Supervising Detentions Nurse, were ignorant about the Sheriff's Department's policies related to discharge medication. Emails between Brandy Rafail, Serina Rognlien-Hood, and Jon Montgomery et. al., April 28, 2023 to May 1, 2023, SD_371720-22. The emails indicate that Ms. Rognlien-Hood had previously told providers that the Sheriff's Department did not and could not provide critical medications except for "ones that ask," and after confirming that she was supposed to provide the medications to all incarcerated people, Ms. Rafail responded with surprise. SD_371720.

759. Another example of harm stemming from the Jail's inadequate discharge planning policies and practices is an incarcerated person named [redacted], who was kept in custody for an extra week because the Jail could not provide him with an inhaler at discharge. Email from Christopher Miedico to Charles Cinnamo et al., March 9, 2023, SD_555896.

760. Discharge statistics are not tracked in the SDSD's CQI program as they should be. As one example, I have seen no statistics on how many discharge prescriptions are actually picked up by the patient versus how many patients never pick up their discharge prescriptions.

* * *

761. The Jail's lack of adequate discharge planning policies and practices places incarcerated people at a substantial risk of harm.

XIV. The Sheriff's Department Fails to Maintain Adequate Quality Assurance/Quality Improvement Processes to Ensure Appropriate and Timely Medical Care

762. Continuous Quality Improvement ("CQI") is the process of ensuring that medical care within a particular system is adequate, appropriate, and meets the medical standard of care.

763. A robust CQI program is critical to any healthcare institution—especially one with hundreds of staff working in tandem every day. The point of CQI is to allow leadership in a large institution to ensure that all the different actors

in the system are following policy and that those policies are working toward the goal of providing appropriate medical care. In a large institution, having adequate policies is necessary to ensure that healthcare is provided consistent with the standard of care; however, good policies are not sufficient to ensure good care. In addition, the institution must ensure that staff are trained on those policies. It must ensure that statistics are kept on whether those policies are being followed. It must analyze those statistics to understand where medical care has fallen short of the standard. And, it must implement changes, including by holding staff accountable, when the standard of care is not met.

764. All hospitals and other large outside medical programs, like HMOs, have a CQI program. Likewise, NCCHC considers a CQI Program "essential" for their accreditation. The NCCHC Standards for Health Services in Jails devotes five full pages to CQI. *See* J-A-06. The 2017 NCCHC Technical Assistance Report was critical of the Jail's CQI program. They recommended establishing "monitoring activities and thresholds for studies," completing both process and outcome studies and evaluating the effectiveness of the CQI program annually. DUNSMORE026025-26. And, in 2020, Dr. Venters devoted an entire section of his report on his recommendations for improving the Jail's CQI program. SD_215363-67.

765. The contract that the Sheriff's Department signed with NaphCare in April 2022 requires a CQI program and has a long list of requirements for that program beginning at section 2.3.26. See NAPHCARE000052.

766. In my experience and in my opinion, CQI should include the following elements:

767. **Policies and Procedures.** The first part of a CQI program is defining standards for medical practice and what is minimal acceptable care. This is usually a manual of formal policies and procedures or less formal written guidelines. The manual should be updated at least yearly. Clear and precise policies are critical

because, without them, it is impossible to hold staff accountable for failing to follow the policy.

768. **Training**. Medical and security personnel must be trained so that they know how the overall system works and what their role is. There must be training when the person is hired; periodic ongoing training that covers any changes in the overall health delivery program (such as changes in policies and procedures); and extra training in any weak areas as they are discovered.

769. **Competency Review.** The CQI program must evaluate the performance of medical employees to ensure competency. This is usually done by the use of two types of performance reviews. The first is a peer review. A peer is someone with the same training performing the same job as the person being reviewed, *e.g.* a physician reviews a physician, a nurse practitioner reviews a nurse practitioner, an LVN reviews an LVN, etc. The peer reviews a random sampling of patient charts (usually ten) and writes an evaluation of performance. The second performance review is that of a supervisor evaluating the performance of someone they supervise, *e.g.* the Medical Director evaluates a physician's performance, a Nursing Supervisor evaluates an RN's performance, and a Supervising Physician evaluates a physician Assistant's performance. Both types of performance reviews should occur at least yearly.

770. **Statistics.** The CQI program must gather and disseminate meaningful statistics. These statistics should be reviewed and analyzed periodically (usually monthly) to identify important trends and problems.

771. **Studies.** The CQI program should do periodic (usually quarterly) pre-defined intensive studies of specific health care issues. The NCCHC defines two types of CQI studies: Process Studies, in which a health care process is evaluated for efficacy and efficiency, and Outcome Studies, in which a health care outcome (*e.g.*, normal blood pressures in a patient being treated for hypertension) are evaluated.

772. **Investigations.** Significant bad patient outcomes such as deaths should

be formally investigated to try to determine one or more root causes of the bad event. In a hospital, this is the role of the M&M Committee. As discussed above, the Jail likewise should have a committee to investigate deaths and sentinel events to improve health care in the form of training, changes in programs, discipline, etc.

773. My review of the CQI program at the Jail found significant problems.

A. The Jail's Policies Are Not Sufficiently Clear, Allowing Staff to Escape Accountability

774. There are multiple sets of policies that appear to govern health care at the Jail: the MSD Operations Manual, NaphCare's policies and procedures, plus the dropdown menus in STATCare, just to name a few. It should go without saying that these dueling policies can cause confusion for the individual healthcare provider, who may not know which guidance to follow in a particular situation.

775. For example, the Sheriff's Department contract with NaphCare requires "continuity for patients on pharmacologic therapy," NAPHCARE000039, and states that "Contractor typically approves non-formulary orders," NAPHCARE00006. However, NaphCare in fact discontinues long-acting insulins at booking as part of the "STATCare Intake Assessment and Orders," which contains this directive to the STATCare practitioners: **"All long-acting insulins will be substituted with Novolin N BID at an equivalent dose unless there is documented evidence that the patient cannot or should not be transitioned."** *See, e.g.*, SD_790712. These directives are contradictory and therefore confusing.

776. In addition, the existence of multiple competing policies may also make it difficult to hold a staff member accountable who is not following the right policy. For example, if a STATCare practitioner chooses to continue a patient's long acting insulin, in accordance with the Sheriff's Department's directive of continuity of care, will they be subject to discipline from NaphCare for disobeying the directive that "All long-acting insulins will be substituted?"

777. This potential for confusion—and inability to hold staff accountable—

is also the reason that an institution's policies need to be updated regularly to reflect actual practice expectations.

778. The Sheriff's Department, however, does not regularly issue formally updated policies. With the exception of two policy sections regarding pregnant incarcerated people, to my knowledge, the MSD Operation Manual has not been updated since 2022. One example of a policy that appears not to have been updated appropriately in the Operations Manual is MSD.W.2 Wound Care Management, last updated on January 4, 2022. This guideline states that "On site collaboration is key to the success of the program and includes the facility physicians, registered nurse practitioners (RNP), nursing supervisor, charge nurses and nursing staff." *Id.* However, from my review of patient charts, it appears that most wound management decisions are made by remote STATCare practitioners based on photographs sent to them. This guideline does not mention STATCare and so is outdated, since STATCare appears to have taken over most wound management. Other medical treatment guidelines have been referred to (and relied on) by Jail practitioners which are not included in the copy of the Operations Manual sent to me, such as PTG.H9, which evidently is a Hepatitis C treatment guideline. SD_754905.

779. As former-Commander of Operations Christina Ralph testified, the Sheriff's Department knows that they need "to update all of the policies and procedures to move towards the NCCHC accreditation." Ralph II Tr. at 47:10-12. Similarly, the NCCHC Technical Report was critical of the Jail for not having chronic disease treatment guidelines. DUNSMORE0260676-77. The Sheriff's Department contract with NaphCare required the development of these guidelines. NAPHCARE000039. Yet I understand that such guidelines are still not available at the Jail.

780. Instead of revising its Operations Manual, it is the norm for the Sheriff's Department to issue a "training bulletin" (or similar informal announcement) of a new policy. In effect, the Sheriff's Department then expects

staff to know that what is written in the Operations Manual is incorrect and to rely on the Training Bulletin instead.

781. A good example of this is when, in response to two deaths from complications of diabetes within two weeks, Dr. Montgomery issued Medical Directive: #7 – "Internal Transition of Care for the Management of All Patients with Diabetes" on December 3, 2021. SD_169026. Dr. Montgomery then rescinded Medical Directive #7 with Medical Directive #7A, issued on August 16, 2022. SD_3759270. Medical staff were expected to follow these medical directives even though I see no indication that the underlying Operations Manual and Policies and Procedures had changed.

B. The Sheriff's Department Does Not Provide Adequate Training, Meaning that Some Staff May Not Know the Governing Policy

782. Dr. Venters stated in his recommendations that: "Appropriate training of correctional health and security staff represents a best practice for reducing mortality and morbidity among incarcerated people. … [O]ngoing, regular training is also required for health and security staff." SD_215373. The NCCHC agrees. Indeed, training was mentioned 166 times in the 2017 Technical Assistance Report with several recommendations for improved training and documentation of training for security and health staff.

783. Despite this, essential training is still not being performed on a consistent basis. As part of its contract with the County, NaphCare was to provide training to all staff, including County staff and even non-medical staff. *See* § 2.5, NAPHCARE000086-87. While NaphCare has produced training materials as part of this case, I do not have specific information showing that nurses, mid-levels, and physicians are being trained regularly and on the correct topics. *See* Nix II Tr. at 28:4-29:10, 37:7-47:4. In fact, Angela Nix, NaphCare's 30(b)(6) witness, did not "know what [the County's] timeline for training and education is for their staff." *Id.* at 28:1-2.

784. Ms. Rognlien-Hood testified in her deposition that NaphCare's new employee orientation "didn't do an adequate job." *See* Rognlien-Hood Tr. at 121:1-7. She also stated in an email on February 22, 2023 that: "Naphcare's training thus far have been pointless"; "[n]o classroom/book training has been given"; and "[t]raining has confused the staff." SD_375922.

785. Dr. Freedland, who just won a bid to provide physicians and mid-level providers at the Jail through his company CHP, testified that he did not know if NaphCare's training included a requirement that physicians ask patients if they mind if a deputy is present during their care. Freedland Tr. at 112:15-18. Dr. Freedland also testified that once his new contract was in place, he would hire a "full-time trainer … to … make sure the staff was trained properly, and have them sign off they are trained properly." *Id*. at 133:6-22. Since the contract did not start until July, I do not have access to any new training that will be provided by the CHP trainer. But Dr. Freedland said the new training would not include how to handle mentally ill patients who refuse treatment. *Id*. at 134:2-15. Given the cases I have seen in this Jail, including but not limited to those described in this Report, that omission is unfortunate.

C. The Sheriff's Department Does Not Track or Analyze the Right Data to Ensure that Adequate Medical Care Is Provided

786. Statistics are powerful tools to improve the quality of medical care in a system—as long as the right statistics are tracked and the statistics are properly analyzed. In some cases, the Sheriff's Department does not track the right statistics, as noted throughout this Report. For example, the CQI evaluation of off-site specialty consultations and other off-site medical care, should contain information about current contracted off-site specialists; the average time taken to get UM approval and the percentage not approved (broken down by specialty); the average wait times for appointments with each particular specialist; and problems encountered in making and keeping these appointments, such as the reason for all

missed or rescheduled appointments.

787. However, CQI reports about off-site appointments that I reviewed did not contain this information. I was able to read only how many off-site appointments were completed in a given month, and occasionally how many were cancelled due to refusals, or discharges, etc. But, as explained earlier in this Report, these CQI reports did not give me an accurate reading of the health of the off-site program.

788. Another example of a missing basic CQI statistic is the number (and percentage) of patients who fail to pick up their prescriptions from the pharmacy after discharge.

789. The Sheriff's Department CQI program tracks in custody deaths, but as I point out elsewhere in this Report, [redacted], and I have not seen any statistics presented about morbidity events (also called sentinel events, *i.e.*, a serious bad patient outcome that does not result in death). A good example of a sentinel event that would be tracked at a hospital would be Diabetic Ketoacidosis ("DKA"). DKA is caused by very high blood sugars that cause the diabetic patient to lose water and become profoundly dehydrated and also results in the patient's blood to become seriously acidotic. DKA usually occurs over several days. If a hospitalized diabetic patient develops DKA, administrators at the hospital would ask themselves "How did this happen? How did we miss this developing for days?" The DKA is therefore a sentinel event that triggers an investigation. Similarly, any diabetic who becomes sick enough to need to be admitted to the hospital should be classified as a sentinel event and investigated. However, I have seen no evidence that DKA or any other sentinel event is tracked in the Jail.

790. Also, the statistics the Jail does collect are not properly analyzed. One CQI report documented that almost 20 percent of all patients scheduled for offsite medical appointments over a six month period refused to go to the appointment.

NAPHCARE026024. As explained earlier in this Report, this statistic is not credible on its face, but the point here is that this striking statistic was not flagged for investigation. The important question is: why does the Sheriff's Department have a refusal rate of 20% for off-site medical care that the patients themselves supposedly want? This would be an easy CQI study to do. Simply pick a random sample of refusals and interview the patients. But I do not see any evidence that this study has been done.

791. NaphCare's 30(b)(6) witness Angela Nix stated that she did not "know specific CQI programs at the site level at San Diego." *See* Nix II Tr. at 34:9-10. Ms. Nix also did know if CQI is discussed at site level meetings. *Id*. at 34:14-16. Ms. Nix further testified that although she had attended 8 to 12 of San Diego's patient care coordination committee meetings, she could not recall any discussion of improvement or recommended changes. *Id*. at 35:7-13. Since the NaphCare contract calls for NaphCare to provide CQI and training, this testimony is worrisome.

D. The Sheriff's Department's Peer Review Process for Medical Staff Is Inadequate

792. Peer reviews are an important component for ensuring that medical staff are performing competently. As the NCCHC 2017 Technical Assistance audit pointed out in 2017, peer reviews should be completed yearly. DUNSMORE0260697.

793. Although peer reviews (as well as "Focused Professional Practice Evaluations" and "Ongoing Professional Practice Evaluations") were required by NaphCare's original contract, § 2.3.27.1, NAPHCARE000055, NaphCare has not been reliably completing them. In a May 26, 2023, email, Dr. Montgomery implied not only that NaphCare had not been doing Peer Reviews as required by their contract, but also that NaphCare did not seem to understand what a Peer Review was. SD_227522.

794. Even as of October 17, 2023, it is not clear that NaphCare had implemented a full Peer Review program. The Sheriff's Department had pointed this out in its Corrective Action Notice. SD_1572597.

795. In conclusion, none of the elements that I would expect to see in an adequate CQI program are present in the Jail's medical system at this time. If CQI is inadequate, mistakes—particularly repeated systemic mistakes like those I have identified throughout this Report—are missed. That places incarcerated people at risk of harm.

XV. The Sheriff's Department Systematically Fails to Maintain Sufficient Numbers of Health Care Professionals, Resulting in Deficient Care

796. Plaintiffs' Third Amended Complaint alleges that the Sheriff's Department has an "insufficient number of health care professional to provide minimally adequate care to the approximately 4,000 incarcerated people in the Jail." Dkt. 231 at ¶ 42. Based on my review of the records and inspection of Jail facilities, I agree, and it is my opinion that the Jail's inadequate health care staffing ratios is a major contributing factor to the many failures outlined earlier in this report. The recently negotiated contract with CHP will not solve these problems.

A. The Jail Has Experienced a Shortage of Healthcare Staff for Several Years

797. The Sheriff's Department's systemic failures to provide adequate medical care to incarcerated people are myriad: initial health assessments for newly booked incarcerated people are delayed or missed entirely, *supra* at Part II; sick call requests are ignored or responded to days later, *supra* at Part IV; patients are documented as having "refused" appointments without being informed of the appointment or counseled about the risks of refusal, *supra* at Part V; vital signs and other physical examinations are not completed, *supra* at Part VI; and medical care is provided by remote providers or nurses acting outside the scope of their practice, *supra* at Part VI, to name a few. Chronic understaffing contributes to all of these

problems.

798. My review of the records in this case shows that the Sheriff's Department knows—and has known—that additional medical staff are necessary to provide adequate care at the Jail. This chronic staffing shortage persists at all levels: nurses, mid-level practitioners, and physicians.

799. According to Dr. Montgomery, as of March 30, 2021, the Jail "has experienced a chronic staffing shortage for decades." SD_172496. Indeed, a funding "priority list" for the Medical Services Division, dated August 9, 2019, explains that additional funding for 47 full-time equivalent ("FTE") RN positions and 34 LVN positions was needed "to bring MSD to appropriate staffing levels to meet current and future program needs, including for intake, medication coordination, and other critical functions. FY 20-25 Five-Year Financial Forecast – Priority List, August 9, 2019, SD_057768. A presentation regarding the FY 2021 – 2022 financials for the Medical Services Division shows that the Sheriffs' Department's own staff had a 39% vacancy rate for budgeted positions, including 92 vacant positions in the nursing unit. QA/QI Financials Presentation, SD_395977.The Jail's contract with NaphCare in 2022 did not remedy the Jail's persistent staffing problem. As Dr. Montgomery stated in a May 26, 2023 email: "It has been shown that far more staff members are needed than [NaphCare] initially estimated." SD_227522.

800. Administrators for the Sheriff's Department and NaphCare have admitted to these staffing inadequacies. Ms. Rognlien-Hood spoke extensively in her deposition of the problems the Jail has had with understaffing and shortages in nursing staffing, including listing the many ways that Jail has been forced to try to compensate for those shortfalls: (1) overtime; (2) nursing supervisors working clinical duties instead of their own supervisory work; (3) having "off-site" personnel help with triage; (4) rotating nurses from facilities less understaffed to facilities more understaffed; and (5) hiring Certified Nurse Assistants ("CNAs"). Rognlien-

Hood Tr. at 55:6-56:20, 67:19-69:5. In the end, the Jail simply has been forced to try to get as much done as possible with fewer nurses. Kenneth Jones also acknowledged understaffing among nurses, admitting that understaffing impacted care, including blood draws and other labs. Jones Tr. at 129:17-133:7. Despite acknowledging understaffing, Mr. Jones could not recall every commissioning a study to evaluate the extent of nursing understaffing. *Id.*

801. As just one example of medical staff shortages in the Jail, a schedule of shifts at Central Jail on July 1, 2023 showed 9 out of 20 nurses assigned to work were absent with "no replacement." SD_726781. The unfilled shifts included two of three RN sick call nurses and both MOB nurses. SD_726781. This was not an unusual situation. On July 16, 2023, 10 of 21 nursing shifts at Central Jail were unfilled, including both receiving nurses, both RN sick call nurses, and both MOB nurses. SD_726809.

802. Ms. Rognlien-Hood also testified that the Jail had approximately 30 RN and 40 LVN vacancies as of February 14, 2024, Rognlien-Hood Tr. at 52:22-53:3, and that historically, the number of vacant nursing staff positions had been in the "high 50s," *id.* at 53:16-22. This testimony is at least consistent with, and may even downplay, the actual number of vacancies evidenced by the documents I reviewed. For example, Sheriff's Department data shows as of November 1, 2023, there were approximately 108 vacant nursing positions across various the Jail facilities. SD_114288. In a presentation regarding the 2021-2022 fiscal year budget for the Medical Services Division, the Sheriff's Department reported 92 vacant positions in its nursing unit. SD_395975. In its fiscal year 2020-2025 financial forecast, the Sheriff's Department admitted there were not "appropriate [nursing] staff levels to meet current and future program needs" and that nurses were required to perform administrative tasks that took them away from their critical job duties. SD_057768. As of November 1, 2023, 32% of the authorized healthcare positions within the Jail were vacant—including nursing vacancies across multiple Jail

facilities. Healthcare, Authorized Positions as of 11/1/2023, SD_114288.

803. Nor has the Jail been able to retain the medical staff that it does have. An internal Sheriff's Office "Naphcare Briefing" dated April 24, 2023 states that there has been "Unprecedented 1 MD separation every month since Naphcare contract awarded." SD_152275-152276. In addition, CHP had "Lost 3 NPs already" and "CHP stated (more) layoffs are imminent." *Id.* In addition, "Gap created in OBGYN services by not hiring timely (6 weeks), SDSD had to hire locum tenens (UNI) for several weeks." *Id.* NaphCare compounded this problem by refusing to provide medical oversight for the UNI nurse practitioner. Further evidence of excessive turnover is found in CQI staffing reports, which show that the number of nurses leaving employment at the jail exceeds the new hires. See, for example, SD_114481, which shows a net loss of 8 nurses for the three-month period covered by the study.

804. The Sheriff's Department has tried to compensate for being chronically short staffed at the nursing position by requiring mandatory overtime.[54] The current system still relies heavily on overtime shifts to cover for being chronically short staffed, as I noticed during my tour of the Central Jail on February 6, 2024. On that day, the nursing duty board showed around 50% of nursing positions filled with overtime workers. The habitual use of overtime, whether mandatory or not, is bad in the long run because it eats into home life and can lead to increased anxiety, depression, fatigue and sleeplessness. In hospitals, nurses working too many hours have been shown to have decreased short-term memory and make more medical mistakes.[55] Overtime has also been found to increase job dissatisfaction among

[54] It eventually discontinued the use of the word "mandatory" overtime in order to "boost morale." Rognlien-Hood Tr. at 57:11-17.

[55] T. Bell et. al. *Fatigue in nurses and medication administration errors: A scoping review.* J. CLIN. NURS. 2023 Sep.;32(17-18):5445-5460.

M. Watanabe et al., *The effect of quality of overtime work on nurses' mental health and work engagement*, J. NURS. MANAG. 2018 Sep;26(6):679-688.

nurses and increase burn-out and turnover. You can fill staffing shortages with overtime in the short term, but in the long term, overtime will result in more nurses burning out and leaving, which leaves you even shorter-staffed in the long term.

805. The County also tries to compensate for work backlogs caused by short staffing by having nurses in supervisory positions work clinical shifts. Ms. Rognlien-Hood herself has done this. *E.g.*, Health Assessment Form, [redacted] [redacted] [redacted] 2023, SD_781311. This is not a good solution for being short staffed. If supervisors are working busy clinical shifts, they cannot perform their supervisory jobs and supervisory tasks also do not get done.

806. At one point, the Sheriff's Department even considered having sworn staff fill medical positions to compensate for these staffing shortages. In a November 22, 2021 memoranda from a lieutenant in the Detention Support Division to now-Sheriff, then-Undersheriff, Kelly Martinez, the Sheriff's Department set forth its dangerous and misguided plan in the event the medical services division suffered a "staffing loss that places services at risk," stating that it might "trigger sworn staff being utilized for the distribution of medication." SD_651265. The fact that the Sheriff's Department even felt like she needed to come up with a plan to rescue the nursing staff is itself evidence of serious nursing staffing issues. However, while well intentioned, this is a bad idea. Officers are not trained, would have no idea what they are doing and would inevitably make serious mistakes resulting in medical harm to patients. Such a plan would never be considered in a hospital. No hospital would ever allow any non-medical staff (like security or housekeeping) to pass meds because they were short staffed on nurses.

807. Ms. Rognlien-Hood noted in her deposition that the Sheriff's Department began hiring CNAs around early 2023 in another attempt to ease the burden of RN understaffing. Rognlien-Hood Tr. at 55:23-56:2. CNAs are not nurses. They have little training, and in hospitals and nursing homes, are used for non-medical tasks such as transporting patients, feeding and bathing patients,

changing bedding, etc. CNAs can indeed have a role in patient care, but they are not qualified to do patient examinations or evaluations like RNs do.

808. Ms. Rognlien-Hood envisioned CNAs doing jobs that nurses were doing but that did not require nursing skills, such as picking up Medical Request Forms from the lock-boxes. Rognlien-Hood Tr. at 189:8-13. However, it is evident from my review that CNAs duties are creeping into duties that are inappropriate for them. As an example, [redacted] was rounded on by CNAs instead of nurses on [redacted] 2023. SD_785988-785989. CNA Dhameera Fields took vital signs on patient [redacted] on [redacted] 2024 and wrote "Abnormal Vitals Signs/Readings Informed Nurse 7404 per protocol. Pulse 130." SD_822177. I have not seen the protocol that CNA Fields referred to. Also, despite using CNAs for various duties in lieu of nurses since early 2023, I have not seen any Sheriff's Department job description for CNAs, nor any policy and procedure on what specific duties the CNAs are taking over from the nurses, who supervises the CNAs, and how using them affects the Staffing Matrix.

809. In addition, like medical staff, custody staff is chronically short-staffed, which negatively impacts medical operations. Ms. Rognlien-Hood acknowledged this issue in her deposition, stating that she receives reports from providers that "[c]linic was slow [on a particular day] because they didn't have deputy staff to bring everybody on the list to them." Rognlien-Hood Tr. at 75:19-21. Ms. Rognlien-Hood also testified that due to a chronic lack of custody staff during the day, health care staff were forced to change the times of blood draws to the evenings, which is not the ideal time to draw blood. *Id.* at 70:9-23. Medical clinics are sometimes outright cancelled due to "sworn availability." Medical Services Division QA QI Meeting, October 17, 2023, p. 20; *see also* SD_114467 (noting "missed clinic appointments" due to "unavailability of escorts"); SD_278070 ("26 deputies down, no deputy for medical this AM"). The Sheriff's Department's inability to transport incarcerated people to medical appointments due to staffing

shortages prevents health care staff from treating patients, which precludes administration of care that meets medical standards.

810. Dr. Montgomery discussed renegotiating NaphCare's contract to increase staffing in February 2024. Montgomery II Tr. at 285:7-13. This was apparently unsuccessful, as Dr. Freedland admitted in his deposition that physician and midlevel staffing levels were too low, Freedland Tr. at 162:15-163-4. I understand that staffing issue to be the main reason that the Sheriff's Department negotiated a new contract with Dr. Freedland's company CHP to provide significantly more onsite medical practitioner coverage. As explained below, that contract will not rectify the inadequacies of medical care at the Jail.

B. The New Contract with CHP Will Not Solve the Jail's Problems

811. The County's recent contract with CHP is designed to "provide on-site Health Care Providers for primary care and urgent care at specified County detention facilities." SD_1578715. Notably, the contract increased physician and midlevel staffing at the Jail by almost 300%. It also increased the County's annual spending on physicians and nurse practitioners in the Jail from approximately $8.3 million to $22.6 million per year.

812. This increase could be beneficial to the class members since it amounts to an almost tripling of the previous annual spend. It is also an acknowledgment that the County was woefully underspending before and short-staffed previously.

813. However, it is worth notable that that CHP's bid for the new contract envisioned even *more* staff, which Dr. Freedland explained was the amount that he thought would "work" "best." Freedland Tr. at 126:2-3. CHP's bid would have added 41.2 full-time equivalent practitioner positions across the seven Jail facilities. SD_1579755-1579760. The ultimate contract added only 28.4 full-time equivalent "personnel" positions and 2 administration positions. SD_1579731.

814. Even setting aside this disparity between what Dr. Freedland thought would be enough to "work" and what the Sheriff's Department ultimately agreed to,

based on my knowledge of this Jail and my experience in correctional medicine in general, I have doubts that this new contract will solve the Jail's problems for four reasons. First, the new contract does not address the nursing staff shortage. Second, the very nature of private correctional health contractors leaves them unstable. Third, this contract fractures medical care into silos, each apparently acting independently from each other. Fourth, even on its face, this contract leaves several deficiencies in the Jail's delivery of medical care in place and will accentuate other problems.

1. Ongoing Nursing Shortage

815. As explained above, it is indisputable that the Jail is facing a nursing shortage. But the new contract with CHP adds no nurses (nurses at the Jail are employed directly by the County), and therefore cannot solve this problem.

816. Nurses are essential at every stage of a patient's interaction with medical services at the Jail—just as they are essential at every stage in every outside medical clinic, office and emergency department. In the Jail, Registered Nurses do the Receiving Screen and the Intake screen. RNs do the Second Stage Evaluation. RNs do withdrawal assessments. LVNs pass all medications. RNs triage medical requests and do the face-to-face evaluations. RNs are essential for the proper function of sick call. RNs do most of the work when patients are discharged. And I am only scratching the surface. There are few other categories of employees who can step in and assist the nurses with their work when they are short staffed. Security cannot do nursing work.

817. These nursing shortages have already had serious consequences for patient care. As an example of the pressures that experienced nurses feel due to short staffing, RN Marisol Gomez-Mercado sent an email to Union Representative Jaime Medina on August 7, 2023 with the subject, "Insufficient staff at LCDRF," stating: "I am sure you are aware of the staff shortage at LCDRF, including on 8/6/23…. I am requesting to not be assigned (as M1 or P1) as I recognize the

expectations of duties are unrealistic and jeopardize the safety of patients and myself. Last night I was assigned to cover P1, P2 and Gatekeeping." SD_235886 The response from Union Representative Jaime Medina stated, "[y]es, I am aware of the short staffing issues at the Sheriff's Department." SD_235886. He instructed RN Gomez-Medina on how to submit an "Assignment Despite Objection Form." SD_235886. The pressure of trying to maintain operations while short staffed is very stressful on the health care staff who are working and trying to do the work of two (or three) staff members day after day. Such stress inevitably contributes to even more turnover.

818. I have seen no indication that additional nurses are being hired for the Jail. Absent additional nurses, many of the Jail's health care problems will remain.

2. Instability Created by Private Correctional Healthcare Providers

819. As indicated in the section above and described in the Background section of this Report, the healthcare delivery at this Jail has been subject to multiple changing, and at times overlapping and confusing, contracts with private healthcare providers over the past several years.

820. It is my opinion that this kind of instability is a hallmark of the private correctional healthcare industry,[56] particularly in comparison to the business of providing medical care in the United States *outside* the jail or prison context. This instability has historically resulted in "revolving door" contracts, boom and bust cycles, and frequent corporate failures and bankruptcies. In my opinion, the only guaranteed way to avoid these revolving door contracts, which risk creating

[56] This industry includes a number of large correctional healthcare companies with multi-state operations, as well as mid-size companies with regional operations. These companies have included companies such as Corizon (until recently, one of the largest for-profit correctional healthcare companies) as well as companies known as Wellpath, TurnKey, NaphCare, Advanced Correctional Healthcare, Southern Health Partners, Centurion, and Wexford Health Services, among others. Many smaller companies also exist, whose operations are more geographically limited.

confusion and therefore gaps and potential harm to patients, is for correctional medicine to be run directly by the government.

821. Unlike healthcare delivery systems outside of prisons and jails, nearly all correctional medical systems (which are run by state and local governments) have a set dollar amount of money budgeted for medical care for incarcerated people. In order for a private correctional healthcare company to gain a contract with a state or local government, the company must submit a bid, most often through a competitive bidding process in response to a government Request for Proposal, as both NaphCare and CHP did here. Contracts are generally awarded to the lowest or near-lowest bidder. Once the contract is obtained, the amount of money that can be charged for the duration of the contract is pre-set.

822. In order to make a profit, therefore, a correctional healthcare company must create a budget where its anticipated expenses are less than the contractual payments. The problem, however, is that these budgets are inherently difficult to predict. If the company's expenses unexpectedly rise (*e.g.*, unanticipated increased costs for attracting and retaining qualified medical professionals), the company cannot automatically pass these unanticipated expenses on to the County. It must fulfill the terms of the contract for the contract's duration at a loss—unless it can convince the County to re-negotiate the contract. This model is unlike the business of providing medical care outside the jail and prison context, where if a hospital has to spend more than anticipated, it can bill that excess to its patients and recover the unanticipated costs.

823. To win a typical 5-10 year contract to provide medical services in corrections, a company must parse its bid to the lowest feasible amount—and sometimes even an unfeasible amount. Otherwise, that company will never win any bids. However, the bidding process is risky. Medical costs have historically risen faster than inflation. Unanticipated medical events like the COVID pandemic and the opioid crisis can overwhelm a budget. A company that tries to mitigate its risk

by bidding higher to fully account for the uncertain future will often lose the bid to the company that did not plan for such events and so bid less. A won contract can easily turn into a long-term money loser for the company.

824. Correctional healthcare companies also must compete for nurses, physicians, and other medical staff with outside hospitals, clinics, and private medical practices. Correctional medicine is a more difficult job than working at other outside practices and so should be compensated at a substantially higher rate. However, this basic fact has not generally been acknowledged by correctional medicine companies, with the result that they offer salaries too low to consistently attract qualified medical professionals. Working at an outside hospital or clinic often offers better pay, better working conditions, and less stress. As a result, most correctional medical companies that I am aware of are seriously short staffed and have high rates of turnover among their medical professionals.

825. In addition, most jails and prisons also have significant staff shortages of correctional officers, and this impacts medical costs. If there are not enough officers to transport incarcerated people, then medical appointments must be rescheduled, which has significant costs. Facility wide "lock-downs" similarly impact the delivery of medical care. Jail and prison overcrowding makes it more difficult to provide medical care and thereby increases costs. All of this also increases stress and dissatisfaction among the health care staff and leads, again, to turnover and short-staffing.

826. A correctional medicine company that has bid a particular contract too low to be profitable has three options: invoke the termination clause of the contract and simply walk away; ask for an increase in funding from the county or state; or provide substandard medical care. Since many (maybe even most, in my experience) initial bids are too low, either from ignorance, bad luck or by design, asking for more money before the end of the contract is very common. And when the for-profit company asks for more money than their original contract, the implicit

threat of just walking away from the contract—leaving a prison or jail without *any* healthcare system in place—hangs over the negotiations.

827. Of course, once the company has been awarded enough money to make the enterprise profitable, other correctional medicine companies will notice and will promise to do the same job for less when given the opportunity. And the cycle of "bid low, ask for more money, get replaced by a new company" repeats itself.

828. The result has been chronic instability in the for-profit correctional medicine industry. It is a rare jail or prison that has had a single contracted medical provider for, say, twenty-plus years. Stability like that is noticed and coveted. There will be no shortage of companies offering to do the same job for less money.

829. More commonly, local and state governments have a revolving door of medical contractors over the years. My home state of Idaho is a case in point. Since privatizing medical services in the state in 1996, five separate companies have held the Idaho DOC contract.

830. Instability has also been true at the Jail that is the subject of this case, where, in just a few years, COAST held the medical contract, then CHP, then NaphCare, and now CHP/NaphCare together. To think that the CHP/NaphCare hybrid will solve the Jail's myriad problems is naïve, in my view. More likely, the County will, in the future, fire one or both and turn to a different for-profit medical provider, as have many other counties and states before them.

831. This brings up the underlying question: Why is the San Diego County Sheriff's Department contracting with for-profit companies to provide medical services at all? Many jails, including large jails, have not privatized their medical services. The ostensible reason for privatization is this statement at the beginning of both the NaphCare contract and the new CHP contract: "The Chief Administrative Officer made a determination that Contractor can perform the services more economically and efficiently than the County, pursuant to Section 703.10 of the County Charter." NAPHCARE000001; SD_1579624.

832. I am highly skeptical of this statement. I am not aware of any literature, research, or other evidence that shows that jails using for-profit medical companies operate "more economically and efficiently" than jails that do not. If there is any written documentation of the Chief Administrative Officer's "determination," I would like to see the logic and research behind this decision.

833. Although there are advantages and disadvantages of using for-profit correctional medicine companies versus keeping medical care within the County, I believe that, overall, the reverse is true. The Sheriff's Department could operate the Jail medical program more economically and efficiently itself with the added benefit that medical operations would be more stable.

3. Siloed Medical Care Between NaphCare and CHP

834. Even setting aside my concerns with the instability of private correctional contractors, the truncated and siloed nature of healthcare delivery at the Jail under this system is likely to create confusion among staff and harm patients.

835. A well-run healthcare system has clear lines of responsibility and centralized control of all elements of that system. Clarifying who is in charge of healthcare is an essential step towards San Diego's creation of a healthcare system that provides adequate care for incarcerated persons.

836. As I understand it, the Jail now has three independent "silos" of healthcare delivery in the Jail: (1) CHP medical practitioners; (2) NaphCare practitioners (including mental health, dental, medication assisted treatment for opiate use disorder, STATCare) and training; and (3) Sheriff's Department employees, such as the nurses, and medical supervisors such as Dr. Montgomery.

837. It is not immediately clear to me who is supposed to report to whom in this system. According to an email from the Sheriff's Department to the *Union-Tribune* newspaper regarding this three-way responsibility:

> **Please explain the division of labor between NaphCare and CHP, and how will the medical director delineate two different contractors? Who answers to whom, and is that a model any other**

jail facilities use?

> a. NaphCare still has overall responsibility for healthcare of our incarcerated population. CHP will be the exclusive provider for on-site clinical services and licensed healthcare practitioners, including doctors and nurse practitioners. CHP will manage and direct the physicians and nurse practitioners and will be giving clinical direction to our internal nursing staff as part of the comprehensive healthcare model. Naphcare will continue to manage and provide direction to all other services in the jail system. CHP, NaphCare and SDSO staff will continue to work collaboratively to provide comprehensive healthcare services in our jail facilities.

838. To me, this sounds like gobbledygook. And it fails to resolve critical questions, particularly around the use of STATCare, which I understand will still be in place at the Jail, making diagnoses, ordering tests, and prescribing medications independently from the CHP practitioners. *See* Freedland Tr. at 178:3-7 (CHP has no oversight over STATCare). As explained earlier in this Report, documents I reviewed showed STATCare practitioners repeatedly failing to meet the standard of care for patients in the Jail. The new CHP contract does not make clear how—or even if—CHP's practitioners can correct those errors.

839. Indeed, some medical records I reviewed suggest that nurses in the Jail contact STATCare asking for *permission* to have an on-site practitioner see patients. *See, e.g.*, [redacted] Medical Record, SD_754743 ("Can I schedule onsite provider to see [Ms. [redacted]]?"). In effect, NaphCare providers working remotely will have the power to gatekeep patients from CHP practitioners on the ground in the Jail. More clarity is needed for this to be a functioning healthcare system.

4. Deficiencies in New CHP Contract

840. The new CHP contract also leaves in place several concerning practices highlighted throughout this report.

841. It does not make any changes to the deficient M&M process, which has thus far largely failed to address the root causes of the many deaths at the Jail, *see supra* at Part I. The new contract does not require CHP to conduct any on-site

M&M reviews at the Jail. Freedland Tr. at 130:16-131:1.

842. The contract does not address chronic care either, *see supra* at Part VIII. Chronic care is only mentioned once in the contract, in the definition of what "clinic" means. SD_1579719. But CHP is specifically not responsible for developing chronic care guidelines defining how often various chronic care clinics should be held and what should be routinely done during chronic care clinic visits. *Id.* Presumably, NaphCare retains the obligation to develop and implement chronic care guidelines. Therefore, NaphCare will again decide who is scheduled for CHP practitioners to see.

843. Notably, although CHP is required to provide a full time "Specialty Physician" at Central Jail under the contract, SD_1579716, it does not specify what kind of specialist (endocrinologist? dermatologist? orthopedist?) or if multiple specialists can work part time to fulfill the 40 your per week requirement. There is also no indication whether this unidentified "specialty physician" will provide a solution for the Jail's persistent failure to provide meaningful chronic care. *See id.* And, it is not clear whether this specialist will have any authority over STATCare, in order to correct, for example, STATCare's dangerous and substandard treatment of type 2 diabetes.

844. The contract also leaves NaphCare in charge of the medical formulary and Utilization Management ("UM"), the flaws in which are described earlier in this Report, *see supra* at Part VII. CHP will continue to have no say in formulary and UM processes, despite the fact that CHP practitioners have expressed dissatisfaction with both processes. *See, e.g.*, Freedland Tr. at 39:19-40:14; Dr. Orem interview during Jail inspection.

845. The contract is also silent about where the clinics will take place and minimum requirements for what should happen at those clinic visits. It thus leaves in place the current bad habits of practitioners doing "clinic visits" at the patient's cell and not doing a physical examination or vital signs. It similarly will not correct

the problem of practitioners making diagnoses and prescriptions without examining the patient at all. *See supra* at Part VI.

846. Finally, the contract requires CHP practitioners to attend certain County sponsored training, *e.g.*, orientation, SD_1579722, but it does not require CHP to provide any training to its own employees, nurses, or custody staff.

847. In summary, the CHP contract does not attempt to correct or even address several deficiencies in medical care at the Jail, as raised in this Report.

CONCLUSION

848. Based on a reasonable degree of certainty, it is my opinion that the healthcare delivery system in the Jail suffers from a number of systemic flaws, which place incarcerated people at a substantial risk of serious harm. These flaws are not new. The Sheriff's Department has been repeatedly informed of these issues in reports from the NCCHC, Dr. Venters, and the State Audit, going back to at least 2017. The Sheriff's Department has nonetheless failed to correct these problems and continually fails even to identify these errors in their M&M and CQI processes. None of the changes the Sheriff's Department has made or claims to be making so far are likely to solve these problems. Therefore, these failures will therefore likely lead to more bad outcomes, including deaths of incarcerated people.

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 and the accompanying exhibits are a fair and accurate representation of the subject of my anticipated testimony in this case.

Dated: August 21, 2024

Jeffrey E. Keller, M.D.