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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

SUPPLEMENTAL 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 previously submitted two expert declarations in this matter: Expert Report of Jeffrey E. Keller, MD, dated August 21, 2024 ("Initial Report" or "Keller Report"), and Rebuttal Expert Report of Jeffrey E. Keller, MD, dated November 1, 2024 (" Rebuttal Report" or "Keller Rebuttal Report," and collectively, "Reports").

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

3. My Initial Report was based, in part, upon the review of medical records produced by Defendants that included information regarding medical care up through December 31, 2023. My Rebuttal Report was based, in part, upon the review of medical records produced by Defendants that included information regarding medical care up through mid-April 2024.

4. I now submit this Supplemental Report to update, where relevant, the opinions I offered in my Reports, based on additional documents and medical records I have been provided. These include documents that Defendants recently produced in this litigation: (1) a number of medical files that cover the time period from January 1, 2024 to February 3, 2025; (2) a number of previously-unavailable documents regarding in-custody deaths that occurred in 2024 and 2025; and (3) disease management guidelines ("DMGs") developed by Correctional Healthcare Partners ("CHP") in late 2024. A full list of the documents I reviewed for this Supplemental Report is attached as Appendix C to this report.

5. Having reviewed these recently-produced records, I remain confident in the opinion that I previously offered in my Reports: the medical system at the Jail places incarcerated people at a substantial risk of serious harm, up to and including death.

I. MY REVIEW OF DOCUMENTS REGARDING DEATHS THAT OCCURRED IN THE JAIL IN 2024 AND 2025

6. Plaintiffs' counsel provided me with documents regarding in-custody deaths that were not available at the time that I completed my Reports. To prepare this supplemental report, I reviewed records related to the deaths of the following individuals: Donnell Duckett (died on January 11, 2025), Bobby Patton (died on December 28, 2024), and Alfredo Hernandez (died on November 26, 2024). I was also provided with additional documents regarding the deaths of Chase Mitchell (died on July 15, 2024) and Liutoa Vili (died on February 4, 2024), whose deaths I previously discussed in my Rebuttal Report.

7. Having reviewed these records, it is my opinion that the deaths of Mr. Duckett, Mr. Patton, Mr. Mitchell, and Mr. Vili were likely preventable. In addition, these recent deaths all occurred as a result of various, previously-identified problems with the medical system at the Jail. These deaths therefore further support my opinion that the medical system exposes incarcerated people to a substantial risk of serious harm.

A. Donnell Duckett (24728302), Died January 11, 2025

8. Donnell Duckett was a 68-year-old man who died while incarcerated on 1/11/2025. In my opinion, Mr. Duckett's death was likely preventable.

9. [redacted]

10. [redacted]

11. [redacted]

[redacted]

13. [redacted]

[redacted]

14. [redacted]

[redacted]

15. [redacted]

[redacted]

16. [redacted]

[redacted]

[redacted]

[redacted]

31. **In my opinion, Mr. Duckett's death was likely preventable.**

32. Mr. Duckett died [redacted] even though he was housed in the MOB at the Jail. The MOB is the unit in which the Jail purportedly

provides the highest level of medical care. [redacted]

34. The care provided to Mr. Duckett was deficient in other respects that likely contributed to or caused his death.

35. [redacted]. Very low blood pressure (e.g., systolic pressure of less than 90, diastolic pressure of less than 60) is a symptom suggesting that a person is very sick. At those levels, the

pressure in the blood vessels are not sufficient to profuse blood to the vital organs, including the brain, to maintain critical bodily functions. Accordingly, when presented with blood pressure readings that low, it is imperative that a provider conduct a full physical examination to determine any potential cause of the low blood pressure. If a provider cannot determine the cause from a physical examination, then it is critical to obtain urgent laboratory diagnostics, which generally can only be obtained by sending someone to the emergency department. In addition, it is imperative to take immediate steps to increase the blood pressure.

36. [redacted]. I previously criticized the Jail for repeated failures by providers to conduct evaluations in my prior reports. *See generally* Keller Report ¶¶ 416-426, 442-451; *see also, e.g.*, *id.*¶¶ 137-140 (discussing failures to perform physical examinations relevant to the death of Patricia Adamson); *id.* ¶ 216 (discussing failures to perform physical examinations relevant to the death of Ms. Bartolacci); Keller Rebuttal Report ¶ 117 (identifying failures to examine chronic care patients); *id.* ¶¶ 30-31(discussing failures to perform physical examination relevant to the death of Chase Mitchell).

37. A[redacted]

[redacted]." I previously criticized the Jail's inappropriate use of STATCare. *See, e.g.*, Keller Report ¶¶ 427-441; Keller Rebuttal ¶ 30.

38. [redacted].

39. [redacted]

40. Lastly, I want to briefly address documents that I have received from the San Diego County Medical Examiner that relate to Mr. Duckett's death. On 1/11/2025 (the day after Mr. Duckett's death), on a "Cause of Death Worksheet," a Medical Examiner Investigator indicated that the cause of Mr. Duckett's death was "Hypertensive and atherosclerotic cardiovascular and cerebrovascular disease" with "End stage renal disease contributing," rather than, as found by the treating doctors in the hospital, hypoglycemia and hyperkalemia and that the hypoglycemia had been caused by prolonged starvation.

41. In my opinion given the documents I have reviewed to date, the

Investigator's conclusion is inaccurate. The conclusion appears to be preliminary, as it is shown on a "Worksheet," and not on a final autopsy report. Importantly, the Investigator made the conclusion without evaluating Mr. Duckett's internal organs, such as his heart and brain; without reviewing the medical records from the hospital (which included the treating physicians' conclusions regarding the cause of death); and without reviewing the toxicology report for Mr. Duckett ([redacted]

42. Plaintiffs' counsel have informed me that the documents they provided to me are all of the documents from the Medical Examiner that they have received related to Mr. Duckett's death. The documents provided to me do not include a final autopsy report. If and when I receive the autopsy report, I reserve the right to supplement my opinions regarding Mr. Duckett's death.

B. Bobby Patton (23725430), Died December 28, 2024

43. Bobby Patton was a 46-year-old man who died on 12/28/24 in the Jail. In my opinion, Mr. Patton's death was likely preventable.

44. Mr. Patton was booked into the Jail on November 25, 2024. [redacted]

45. [redacted]

[redacted]

50. [redacted].

53. The Medical Examiner concluded that Mr. Patton died from acute bacterial bronchopneumonia complicating influenza A infection, with substance use disorder and the effects of methadone contributing. SD 1662355.

54. **In my opinion, Mr. Patton's death was likely preventable.** At a high level, it is quite rare for a generally healthy 46-year-old person to die from pneumonia. The fact that Mr. Patton died from pneumonia is suspicious and requires that his death be reviewed very closely.

55. The most serious problem with Mr. Patton's care occurred on the night

before he died, [redacted]. In clinical medicine, this is termed an "Unscheduled Return Visit" or colloquially a "Bounceback." Often, patients who bounce back are following discharge instructions to let a practitioner know that they are getting worse. The medical standard of care for a patient with a significant medical condition (like pneumonia) who reports that they are doing worse is to do another complete medical evaluation in order to see how much worse the patient has become and why. [redacted]

[redacted]

58. It is my understanding that Plaintiffs' expert on substance use and substance use disorder will be offering opinions regarding [redacted]

C. Liutoa Vili (23725430), Died February 4, 2024 (previously discussed in Rebuttal Report)

59. In my Rebuttal Report, I discussed the medical care provided to Mr. Vili, who died while in the custody of the Jail on 2/4/24. Keller Rebuttal Report ¶¶ 32-40. At the time that I wrote my Rebuttal Report, I had not yet received the autopsy report for Mr. Vili, which I understand had not yet been produced to Plaintiffs' counsel. Regarding Mr. Vili, I wrote:

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

Id. ¶ 33. I then proceeded to describe the serious problems with the care that Mr. Vili received for an infection in his leg. *Id.* ¶¶ 34-40.

60. I have now received and reviewed a copy of the autopsy report for Mr. Vili. The Medical Examiner concluded that Mr. Vili had died of "cardiopulmonary arrest" as a result of "occlusive atherosclerotic coronary artery disease," SD 1588555, a process which is often called a "heart attack" by the general public.

61. With this cause of death in mind and after review of Mr. Vili's medical records, **it is my opinion that Mr. Vili's death was likely preventable**.

62. Atherosclerotic coronary artery disease refers to the gradual build up over years of fatty plaques in the arteries going to the heart. Once the plaques get large enough, they can restrict blood flow to the heart, causing a heart attack and sometimes causing sudden death. About 50% of men who have heart attacks have

symptoms of intermittent chest pain, shortness of breath, and weakness before the final heart attack. The medical term for these episodes of chest pain, shortness of breath, and other symptoms that precede a heart attack is angina. Angina can be thought of as a warning signal that a heart attack is coming. In addition to angina, the overall risk of having a heart attack can be calculated using a particular patient's risk factors (such as diabetes, hypertension, and high cholesterol). By calculating risk and by diagnosing angina, high-risk patients can be referred to a cardiologist before they have a heart attack and receive medical therapy that prevents the heart attack, such as the insertion of stents into blocked coronary arteries and/or heart medications that increase heart performance and decrease the likelihood of a heart attack.

63. [redacted]

64. [redacted]

[redacted]

D. Chase Mitchell (24724484), Died on July 15, 2024 (previously discussed in Rebuttal Report)

66. In my Rebuttal Report, I wrote about the death of Mr. Mitchell from sepsis. Keller Rebuttal Report ¶¶ 19-31. From my review of available medical records, I opined that Mr. Mitchell's death was likely preventable. *Id.* ¶¶ 30-31. In particular, I opined that when, on the day before he died, Mr. Mitchell presented with extreme weight loss (25 lbs. in one month) and low blood pressure (91/62), the Jail should needed to either have a provider evaluate him or send him to the emergency department. *Id.* It did neither and, as a result, failed to identify the abscess and related infection by a number of hours. *Id.* Had those been identified sooner, he may have survived. *Id.*

67. I have now been provided with additional documents regarding Mr. Mitchell's death. These documents confirm that Mr. Mitchell's death was likely preventable.

68. First, the Medical Examiner confirmed that Mr. Mitchell died from an infection, specifically, complications from *streptococcus pyogenes* soft tissue infection, including necrotizing fasciitis. SD 1591875. This confirms that

Mr. Mitchell died from infection, as I previously presumed in my Rebuttal Report.

69. [redacted] As I discussed in my prior reports, the Jail's repeated failures to identify deficiencies in care that have caused or contributed to deaths places all incarcerated people at a substantial risk of serious harm. *Id.* ¶¶ 28-242.

70. [redacted]

[redacted].

II. MEDICAL RECORDS FROM 2024 AND EARLY-2025 SHOW THAT THE MEDICAL SYSTEM CONTINUES TO EXPOSE INCARCERATED PEOPLE TO A SUBSTANTIAL RISK OF SERIOUS HARM

71. For my two prior Reports, I reviewed and discussed the medical records for many incarcerated people. The medical records I reviewed for my Initial Report generally ended on December 31, 2023. Those records included records for a number of randomly selected incarcerated people that Defendants produced to Plaintiffs. My review of those records, interspersed throughout the report, revealed serious problems with the medical care at the Jail. *See generally* Keller Report.

72. The records I reviewed for my Rebuttal Report generally ended in early April 2024. These records were primarily records that had been randomly-selected by Defendants, then provided to Defendants' experts for their review, and then ultimately produced to Plaintiffs. My review of these records also revealed serious problems with the medical care at the Jail. Keller Rebuttal Report at 31-39 & Appendix A.

73. Plaintiffs' counsel has now provided me with additional medical records. My understanding from Plaintiffs' counsel is that Defendants produced to Plaintiffs updated records—covering the time period from January 1, 2024 to February 3, 2025—for fifty-five of the individuals for whom Defendants previously produced records that I reviewed for my Initial Report. For these fifty-five records, I requested that Plaintiffs provide to me with the records for any individuals where the sick call request portion of the medical file reflected that the incarcerated person had a serious medical condition or sought care for a serious condition. Plaintiffs

provided me with 29 of the 55 files.

74. Plaintiffs' counsel also provided me with eight other files for patients from whom Plaintiffs' obtained record releases. These files also included records from 2024 and early 2025.

75. My detailed findings with respect to my review of each of the files are contained in Appendix A to this report. I found significant problems with the medical care provided to many of the people whose records I reviewed. These medical files show that, during 2024 and early 2025, the medical system at the Jail exposed individuals to a substantial risk of serious harm and sometimes caused them actual harm. The most egregious cases include:

- Amie Stanley – In April 2024, an OB/GYN identified a lesion on Ms. Stanley the required a biopsy to determine if it was cancer. In October 2024, a different OB/GYN noted that the biopsy appointment was still pending. In November 2024, an OB/GYN inquired about why the biopsy had not occurred and discovered that the hospital had not received a referral. The biopsy finally occurred in December 2024 and showed that the lesion was cancerous. The 8.5 month delay in performing the biopsy was medical mismanagement, delayed the eventual treatment for her cancer, and increased the medical risk for Ms. Stanley.

- [redacted]. At the time, he was in the middle of chemotherapy treatment for testicular and stomach cancer. The Jail moved very slowly to continue his care. As a result, he did not receive his prescribed chemotherapy for the month or so that he was in Jail.

- [redacted]

[redacted]. Moreover, the causes of thrombocytopenia can be very serious, including cancer, autoimmune disease, liver disease, drug side effects, and others. It is therefore essential, as quickly as possible, to determine the cause of thrombocytopenia and to treat it. [redacted]

- [redacted]. Any patient, but especially a pregnant patient, who is vomiting blood, must immediately be evaluated by a medical practitioner. If this cannot be done on-site, the patient must be sent to the emergency department.

- [redacted],

- [redacted].

- [redacted] – Medical staff significantly violated both individual's right to confidential medical care when they evaluated them in late-2024 for rashes in their groins at cell front, rather than in a confidential location.

- [redacted]

  But TED hose are not a treatment for heart failure. And heart failure can only be ruled out by performing a physical examination.

- [redacted].

- [redacted].

76. Even the cases where the failures did not result in tangible, immediate harm to class members reflect serious problems with the system. A system that

consistently provides sub-standard care to patients, like the Jail's system, necessarily exposes those patients to a substantial risk of serious harm. Not every failure to provide adequate care will result in harm. But each failure presents a real risk. It is my opinion that the medical records that I reviewed reflect systemic deficiencies in the Jail's provision of medical care that place patients at a substantial risk of serious harm.

77. In my Reports, I cataloged a variety of serious problems with medical care at the Jail. The additional files I reviewed showed that the same types of systemic problems continued to occur in 2024 and early 2025. Specifically, the medical files revealed problems with:

- Failures to continue medications that class members were taking in the community. *See* Appendix A, [redacted] (diabetes medication not continued because not on NaphCare formulary and not replaced with comparable medication). *See also* Keller Report ¶¶ 285-303.

- Failures to continue treatments that class members were receiving in the community – *See* Appendix A, [redacted] (failure to continue treatments for testicular and stomach cancer). *See also* Keller Report ¶¶ 304-312.

- Failures of the sick call process to address class members' medical concerns – *See* Appendix A, [redacted] (no response to complaint of open sores between testicles and shaft of penis for 10 days); [redacted] (complaints of painful urination and request for STD testing ignored multiple times). *See also* Keller Report ¶¶ 319-367.

- Alleged refusals of care, including refusals being witnessed only by custody staff and inadequate counseling of class members regarding the risks of refusals – *See* Appendix A, [redacted] (reportedly refused

evaluation for scabies, which is communicable, with no follow up). *See also* Keller Report ¶¶ 387-415.

- Failures to conduct any or adequate physical examinations of patients when necessary to provide them with appropriate treatment, including instances where no examination occurred because STATCare practitioners were providing care remotely – *See* Appendix A, [redacted]

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

- STATCare inappropriately serving as a gatekeeper for on-site RNs to request that a patient be seen by an on-site practitioner. [redacted]. *See* Keller Report ¶ 431; Keller Rebuttal Report ¶ 187.

- Failures to conduct diagnostic testing, to review the results of diagnostic testing, and to inform patients of the results of testing – *See* Appendix A, [redacted]

[redacted] *See also* Keller Report ¶¶ 486-497.

- Canceling scheduled appointments with providers without explanation – *See* Appendix A, [redacted]).
- Inadequate custody staffing interfering with medical care – [redacted]"). *See also* Appendix A,

Keller Report ¶¶ 659-664.

- Failures to perform Health Assessments within 14 days of booking and after a year in the Jail – *See* Appendix A, [redacted]). *See also* Keller Report ¶¶ 261-284.

- Lack of confidentiality in medical visits – *See* Appendix A, [redacted]). *See also* Keller Report ¶¶ 665-686.

- Failures to gather vitals signs at visits – *See* Appendix A, [redacted]. *See also* Keller Report ¶¶ 416-417, 443-44.

- Failures to provide appropriate follow-up care/chronic care – *See* Appendix A, [redacted]). *See also* Keller Report ¶¶ 709-731.

78. The medical files also reflected serious and systemic problems in throughout 2024 and early 2025 with the care that the Jail provides to class members

for many common chronic conditions, including:

- Hypertension – *See* Appendix A, [redacted]. *See also* Keller Report ¶¶ 181, 235.

- Diabetes – Appendix A, [redacted]). *See also* Keller Report ¶¶ 526-551.

- Asthma – *See* Appendix A, [redacted],

[1] Here and in Appendix A, I frequently note where the care provided by medical staff was not consistent with the CHP's DMGs, which CHP issued sometime toward the end of 2024 or early in 2025. Freedland Dep. at 61:24-64:8. I do so even though some of the care was provided prior to the issuance of the DMGs. I have cited to the DMGs, even though they may not have been issued at the time that care was provided, because they represent CHP's view of the standard of care for various conditions and that standard very likely did not change between the time the care was provided (sometime in 2024 or early 2025) and when CHP issued the DMGs.

[redacted]). *See also* Keller Report ¶¶ 613-630.

- Hepatitis-C – *See* Appendix A, [redacted]). *See also* Keller Report ¶¶ 507-525.

79. Overall, it is my opinion, from my review of the medical files recently produced by Defendants, that the same types of serious and systemic problems with medical care that I identified in my prior Reports continued to occur throughout 2024 and early 2025. Accordingly, it is my opinion that the medical system at the Jail continues to expose incarcerated people to a substantial risk of serious harm. Second and relatedly, it is my opinion that any changes that the Jail has made or purported to make since I submitted my prior Reports have not been sufficient to ensure that the medical system does not expose incarcerated people to a substantial risk of serious harm.

III. THE DISEASE MANAGEMENT GUIDELINES PRODUCED BY CHP ARE SERIOUSLY FLAWED

80. In my prior Reports, I criticized the Jail for failing to put in place chronic care and disease management guidelines ("DMGs"). *See, e.g.*, Keller Report ¶¶ 37, 501-505, 779; Keller Rebuttal Report ¶¶ 108, 149-150, 204. Since then, it is my understanding that CHP has adopted a set of DMGs for the Jail. I reviewed these DMGs, as well as Dr. Freedland's deposition testimony regarding the DMGs. In my opinion, though the implementation of these DMGs is a step in the right direction,

the DMGs are problematic in a number of respects.

81. **First, the DMGs are not customized for the Jail.** Dr. Freedland stated at his deposition that he copied the DMGs from the Texas prison system with permission. Freedland Dep. at 65:24-67:12. He further testified that he prepared the DMGs for use in the Jail. *Id.* However, the DMGs contain a number of provisions that refer not to the Jail, but to parts of the Texas system or to elements that do not exist in the San Diego system.

82. For example, the DMG [redacted] I am not aware of any such unit in the Jail system. [redacted] .

I am not aware of any such team at the Jail. [redacted] As far as I am aware, no such documents exist at the Jail.

83. The DMGs also contain [redacted].

86. The lack of customization of the DMGs is a problem for several reasons. First, it shows that the Jail leadership has not edited the DMGs and brings up the question of whether the CHP leadership has even read them. If CHP

[redacted]

[2] [redacted]

[3] [redacted]

[redacted]

[4] At his deposition, which occurred on July 17, 2025, Dr. Freedland indicated that CHP had adopted a tuberculosis DMG. I have not been provided with that DMG and do not know if it was implemented prior to the February 3, 2025 fact cutoff in this case.

[redacted]. This omission contrasts with the Texas DMGs, which indicate they were created by "the CMC Pharmacy and Therapeutics Committee through review of the medical literature, review of national treatment guidelines, and evaluation of population-specific treatment data." *See* Texas DMGs, at 1, https://www.tdcj.texas.gov/divisions/cmhc/docs/Disease_Management_Guidelines._2025.pdf. [redacted].

91. Moreover, any organization publishing DMGs must have a plan for when and how to update them. For example, the Texas DMGs that CHP has now borrowed state that "[t]he DMGs are reviewed and/or revised every five years or when new national treatment guidelines, landmark clinical studies, and/or new drug entities become available, whichever is sooner." *See* Texas DMGs, at 1, https://www.tdcj.texas.gov/divisions/cmhc/docs/Disease_Management_Guidelines._2025.pdf. Such a plan is necessary to ensure that the DMGs remain up to date.

92. According to Dr. Freedland's recent testimony, CHP has no written policy regarding and no formal or informal schedule for updating the DMGs. Freedland Dep. at 69:15-70:12.

93. **Fourth, many of the CHP DMGs do not follow nationally accepted standards of care.** I have not compared all of the CHP DMGs with the guidelines

published by the corresponding medical specialist societies. However, I have performed that comparison for some of the DMGs that are most important in a carceral setting, including Type 1 and Type 2 Diabetes and Hepatitis C. I found that these guidelines departed from the nationally-recognized standards of care in multiple, substantial ways.

94. *Type 1 Diabetes Mellitus***.** The standards for medical care of patients with Diabetes are found in the *American Diabetes Association's Diabetes Management in Detention Facilities: A Statement of the American Diabetes Association (2024)* and the *Standards of Care in Diabetes—2024*. Key points ignored by the CHP Type 1 Diabetes Guideline include:

95. If patients were using insulin pumps prior to incarceration (as greater than 50% of all Type 1 Diabetics are), they should be allowed to continue these while incarcerated. *See* Daniel L. Larber et al., *Diabetes Management in Detention Facilities: A Statement of the American Diabetes Association*, 47 Diabetes Care 544, 545 (2024) ("Diabetes in Detention"). [redacted] This omission is particularly troubling given the death of Keith Bach in September 2023. Mr. Bach was a Type 1 diabetic who entered the Jail with an insulin pump but who died when the Jail failed to provide him sufficient insulin for use with his pump. Keller Rebuttal Report ¶ 55-80. The Medical Examiner found the medical care provided to Mr. Bach to be so deficient that it classified the death as a homicide. *Id.* ¶ 78. [redacted].

96. If not using an insulin pump, "[p]eople with type 1 diabetes should be treated with a daily injection of long-acting basal insulin plus rapid-acting prandial insulin at mealtimes .... The dose of premeal insulin should be varied based on meal (carbohydrate) content and a correction factor." Diabetes in Detention at 548.

[redacted]

[redacted].

97. *Type 2 Diabetes*. The CHP Type 2 Diabetes Guideline is inconsistent with the ADA standards of medical care for patients with Type-2 Diabetes in a number of critical respects.

98. "Formularies should provide access to usual and customary oral and injectable medications." Diabetes in Detention at 548. [redacted].

101. *Chronic Hepatitis C Infection*. The standard of care for patients

suffering from chronic HCV infection 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) ("AASLD/IDSA Guidelines"). This guideline contains a section that specifically addresses care for incarcerated patients: HCV Testing and Treatment in Correctional Settings. *See* https://www.hcvguidelines.org/unique-populations/correctional.

102. [redacted].

103. The AASLD/IDSA Guideline states that "Jails should implement opt-out HCV testing consisting of HCV-antibody testing followed by confirmatory HCV-RNA testing if antibody-positive." *Id.* [redacted]

104. The AASLD/IDSA Guidelines state that all "Chronically infected individuals whose jail sentence is sufficiently long to complete a recommended course of antiviral therapy should receive treatment for chronic HCV infection according to AASLD/IDSA guidance while incarcerated." *Id.* [redacted].

105. The AASLD/IDSA recommends using a "Simplified Treatment Algorithm" for eligible patients which includes most jail patients with HCV. *Hepatitis C Guidance 2023 Update: AASLD/IDSA Recommendations for Testing, Managing, and Treating Hepatitis C Virus Infection*, at 4. [redacted].

106. **Fifth, CHP has not provided practitioners in the Jail with any meaningful training on the DMGs, nor has it made the DMGs available in a useful format.** Dr. Freedland testified that the only "training" that CHP has

provided to practitioners is to have informed practitioners of their existence and informed them that they should be used. Freedland Dep. at 60:13-19. In addition, the DMGs are available only in hard copy at the Jail. *Id.* at 60:4-12. In my experience, widespread use of the DMGs could only occur if they are available electronically to practitioners at the same work stations at which they access the electronic medical records. The failure to make the DMGs available electronically is missed opportunity for adoption of these important practice guidelines.

107. **Sixth, it does not appear that CHP practitioners are using the DMGs.** Dr. Freedland was uncertain of the date that the DMGs were disseminated, stating that it was definitely before his July 2025 deposition and after the CHP contract went into effect in June 2024, but that he was unable to specify whether it was before or after December 2024. Freedland Dep. at 61:24-64:8. From the medical files I reviewed, which generally include records up to February 3, 2025, it appeared to me that many CHP practitioners were not using the DMGs, as they were making decisions regarding care that were (1) not consistent with the standard of care and (2) were not consistent with the DMGs.

108. [redacted]

[5] As discussed above, this provision of the DMG is inconsistent with the AASLD/IDSA Guidance.

[redacted]

110. In addition, I found no references to the DMGs in any of the medical records that I reviewed. Though I would not expect practitioners to mention the DMGs in every note they write, I would expect it to be referenced occasionally in order to document why a practitioner made a particular treatment decision.

111. Dr. Freedland testified that he was not aware of any quality assurance efforts to determine whether practitioners are using the DMGs. Freedland Dep. at 64:9-14. Accordingly, CHP does not know whether its providers are using the DMGs.

112. **Seventh, my understanding is that the DMGs are only available to CHP practitioners.** In particular, remote STATCare practitioners who work for NaphCare cannot possibly have access to the DMGs because the DMGs are only available in hard copy at the Jail. *Id.* at 65:11-23 (admitting that the DMGs are not available to STATCare practitioners). This situation is concerning because it means that STATCare practitioners are less likely to provide care consistent with the DMGs. [redacted].

113. Well written, up-to-date, medically-appropriate, and site-specific DMGs that practitioners actually use for a reference reduce patient risk of harm. DMGs decrease risk by providing an easy reference for practitioners regarding how to provide treatment within a given medical system that meets or exceeds the

standard of care for various medical issues.

114. For all of the reasons discussed above, the CHP DMGs, in their present form, do not serve that purpose. [redacted]. Moreover, CHP has not trained its practitioners on the DMGs or conducted any quality assurance to see if they are using them. Putting all of this together, the CHP DMGs, as they are presently written, disseminated, and utilized, do not appreciably decrease the risk of patient harm at the Jail.

IV. DEFENDANTS CONTINUE TO FAIL TO PERFORM 14-DAY HEALTH ASSESSMENTS ON ALL PEOPLE WHO ARE BOOKED INTO THE JAIL

115. In my Rebuttal Report, I discussed my review of medical files to determine whether staff were, as required by policy, conducting Health Assessments within 14 days of booking. Keller Rebuttal Report ¶ 132. For relevant bookings between January 1, 2023 and January 15, 2024, I found that Defendants complied with the policy only 59% of the time. *Id.* In finding that Defendants complied with the policy for 59% of bookings, I assumed that a Health Assessment was compliant if the class member refused the assessment (which, as I explained, was a dubious assumption given other evidence I reviewed). *Id.*

116. I sought to use the 55 records the Defendants produced covering 2024 and early-2025 to determine if Defendants' compliance improved after January 15, 2024. *See supra*, ¶ 73. I found, however, that Defendants compliance had decreased significantly.

117. Following my instructions, Plaintiffs' counsel entered information from

the medical files regarding bookings that met the following criteria: (1) the booking was after January 15, 2024 and (2) the term of incarceration lasted at least 14 days.[6] In total, there were 45 bookings that met the criteria. The results of this analysis are contained in Appendix B to this report.

118. The analysis showed that only 17 of the 45 bookings (38%) potentially complied with the 14-day policy. Twenty-eight of the forty-five bookings (62%) did not comply with the 14-day policy. For 23 (51% of the total) of the non-compliant bookings, the file contained no Health Assessment form associated with the booking. For 5 of the non-compliant bookings (11% of the total), the Jail performed a Health Assessment but after the 14-day deadline set by policy. The 62% overall rate of non-compliance far exceeds the 41% rate of non-compliance I found for bookings up through January 15, 2024.

119. My findings understate the rate of noncompliance. As I did in my analysis in my Rebuttal report, I counted a Health Assessment as compliant if the Jail either conducted a Health Assessment within 14 days or the Jail attempted to conduct a Health Assessment within 14 days but the class member refused. The majority of compliant Health Assessments—12 of 17—were refusals. In only 5 (11% of the total) of the bookings did the Jail actually perform a Health Assessment within 14 days of the booking date. In my prior Reports, I explained my concerns regarding the high rate of refusals at the Jail, as well as the Jail's failures to adequately document refusals. Many of the Health Assessment refusals for the reviewed bookings were deficient, including multiple cases where the file did not include a refusal form for the Health Assessment encounter. If any of the refusals were not legitimate, then the rate of noncompliance would be even higher.

[6] I instructed Plaintiffs' counsel to use a spreadsheet produced by Defendants that showed booking dates for the individuals for whom Defendants produced the updated medical files. I instructed them to look only at bookings between January 16, 2024 and February 3, 2025. After eliminating all bookings shorter than 14 days and those outside the date range, there were 46 bookings. After I received the information from Plaintiffs' counsel, I checked it for accuracy.

120. I also note that counting refusals as compliance generally does not occur in medicine. For example, a jurisdiction that reports a 95% vaccination rate does not report refusals as part of the 95%. The same holds true here. The purpose of the Health Assessments is to establish a baseline for new patients and to ensure they are referred for appropriate care. When a Health Assessment does not occur, regardless of whether it is because the Jail did not conduct it or because the person refused, the negative effect is the same. Either way, the Jail has less information about the medical needs of the individual and therefore is less able to provide appropriate care.

121. The Jail's continued systemic failure to perform timely (or, in many cases, any) Health Assessments places class members at a substantial risk of serious harm. When the Jail does not know, from the outset of incarceration, the medical issues that a person has, it makes it more likely that the Jail will fail to provide adequate treatment to that person. In addition, performing timely Health Assessments depends on having sufficient nursing staff; the routine failure to perform timely Health Assessments strongly suggests that the Jail does not have enough nursing staff.

V. DEFENDANTS CONTINUE TO FAIL TO TIMELY RESPOND TO SICK CALL REQUESTS

122. In my prior reports, I wrote about the substantial risk posed by the Jail's failure to timely and appropriately respond to sick call requests submitted by class members. *See* Keller Report ¶¶ 319-354; Keller Rebuttal Report ¶¶ 133-145.

123. I reviewed the same 29 medical files discussed in paragraph 73 to determine whether, during 2024 and early 2025, Defendants were complying with their policy to conduct a face-to-face evaluation within 24 hours of the receipt of all sick call requests. I found that Defendants continue to fail to comply with their own policy. In 23 of the 29 files (79%), Defendants failed to complete at least one face-

to-face evaluation within 24 hours of the receipt of a sick call request.[7] Most of those files contained more than one such failure. For example, Ronae McClain's file contained 13 sick call requests for which Defendants failed to comply with the policy. Two of the twenty-nine files did not contain any sick call requests.[8] In only 4 of the 29 files did Defendants comply with the policy for all sick call requests, and

[7] [redacted]

[8] [redacted]

in most of those files, there were few sick call requests.[9]

124. My findings from this review establish that, as of early 2025, the medical system still suffered from two serious, interrelated problems, both of which I previously discussed in my Reports. First, Defendants continue to expose class members to a substantial risk of serious harm by failing to respond to their requests for medical care in a timely manner. Unlike people in the community, people incarcerated in the Jail are dependent on Defendants for access to medical care. And the primary means for accessing care is for class members to submit a sick call request. If, as the medical records show, Defendants often wait many days or weeks to begin to respond to those requests, Defendants expose class members to a risk that their unaddressed medical needs will progress and worsen, potentially in ways that cannot be remedied at a later time. Second and relatedly, Defendants likely do not have enough nursing staff working in the Jail. Responding timely to sick call

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[9] [redacted]

requests depends on having sufficient nursing staff to conduct the face-to-face evaluations within the 24-hour deadline set by policy. That Defendants fail to comply with the policy so frequently suggests that they do not have enough nurses working in the Jail.

Dated: August 29, 2025

Jeffrey E. Keller, M.D.

Appendix A

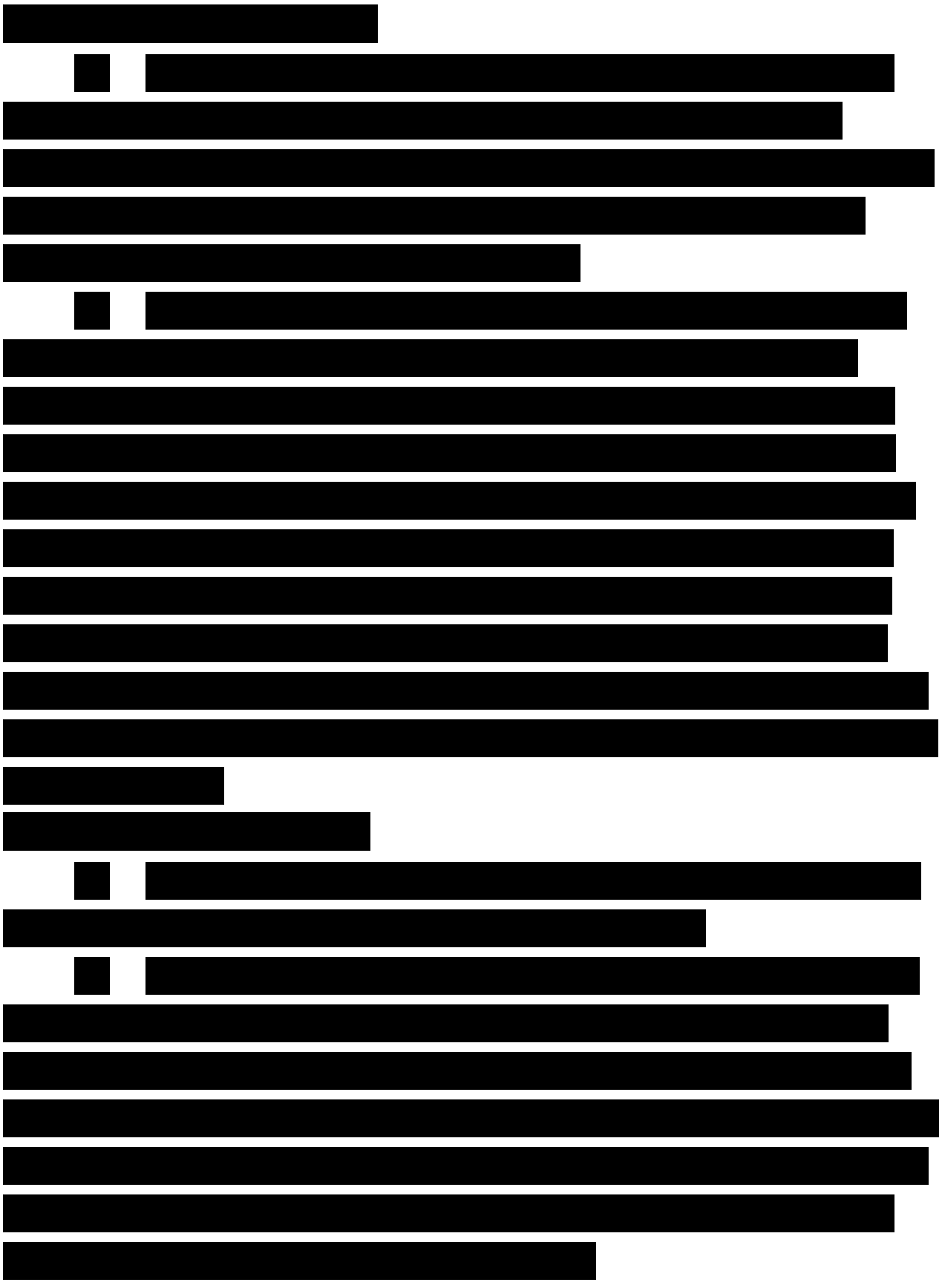
APPENDIX A – Review of Newly-Produced Medical Records

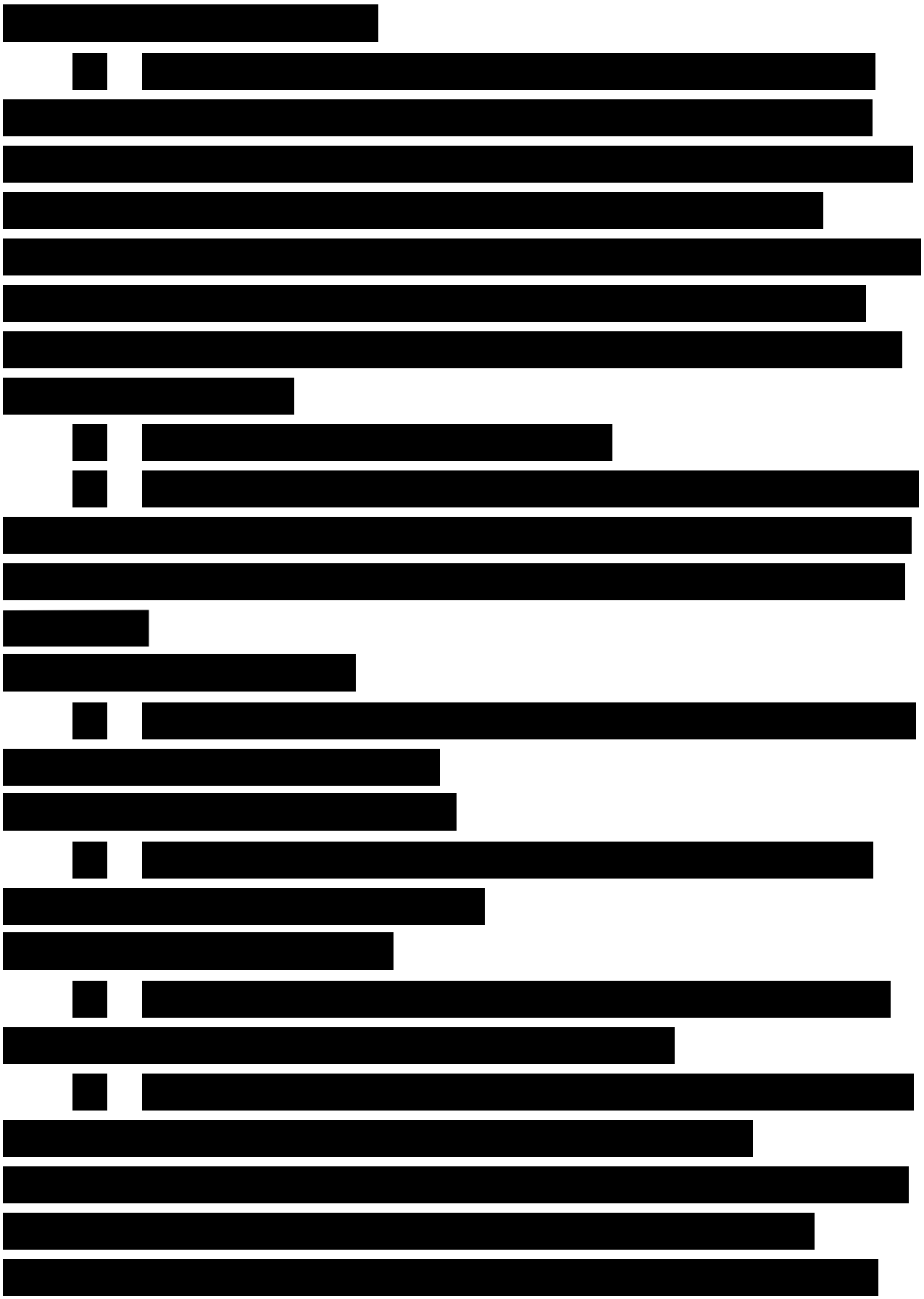
I. [redacted]

Testing and Treatment in Correctional Settings (Dec. 19, 2023), https://www.hcvguidelines.org/unique-populations/correctional. Treatment should not depend on a Fib-4 score.

[redacted]

violated the standard of care. The online medical textbook Uptodate uses the term "Functional Seizures" instead of the older term "pseudoseizures." Uptodate similarly recommends that suspected functional seizures in a patient should be confirmed with a physical examination, labs, EEG testing etc. Uptodate also recommends that a comprehensive care plan be implemented in such patients. *1. Functional seizures: Etiology, clinical features and diagnosis. 2. Functional seizures: Management and prognosis*, Uptodate. [redacted]





[redacted].

[redacted]

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Appendix B

APPENDIX B – Analysis of 14-day Health Assessments from Medical Records

Last	First	Booking #	Dates of incarceration	Date of Health Assessment	Bates	Within 15 days?
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]			[redacted]
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[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Last	First	Booking #	Dates of incarceration	Date of Health Assessment	Bates	Within 15 days?
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
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