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12 Attorneys for Plaintiffs and the
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14 UNITED STATES DISTRICT COURT

15 SOUTHERN DISTRICT OF CALIFORNIA

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

21 Plaintiffs,

22 v.

22 SAN DIEGO COUNTY SHERIFF'S
DEPARTMENT, COUNTY OF SAN
23 DIEGO, SAN DIEGO COUNTY
PROBATION DEPARTMENT, and DOES
24 1 to 20, inclusive,
25 Defendants.

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

**SUPPLEMENTAL EXPERT
REPORT OF KELLY S.
RAMSEY, M.D.**

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

Trial Date: None Set

1 **I. INTRODUCTION**

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

3 1. I have been retained by Plaintiffs’ counsel and previously submitted
4 two reports regarding substance use and substance use disorder treatment in the
5 San Diego County jails in connection with this litigation. *See* Aug. 20, 2024 Expert
6 Report of Kelly S. Ramsey, M.D. (hereinafter, the “Initial Rpt.”); *see also* Nov. 1,
7 2024 Rebuttal Expert Report of Kelly S. Ramsey, M.D. (hereinafter, the “Rebuttal
8 Rpt.”). In those reports, I reviewed extensive evidence regarding substance use and
9 substance use disorder treatment in the Jails and concluded that Defendants fail to
10 protect incarcerated persons from the substantial risk of serious harm posed by
11 substance use. *See generally* Initial Rpt. at 6; Rebuttal Rpt. at 1. Plaintiffs’ counsel
12 asked me to prepare this Supplemental Expert Report regarding newly produced
13 evidence by Defendants regarding substance use and substance use disorder
14 treatment in the San Diego County jails. That evidence consists of the documents
15 listed in Appendix A to this report.

16 2. The evidence considered in this report was made available to me after
17 November 1, 2024, the date of my most recent report in this matter. *See* Rebuttal
18 Rpt. at 48. I understand that this evidence was produced in-line with court orders in
19 this matter and stipulations between the parties after November 1, 2024. I have only
20 considered evidence regarding substance use and substance use disorder treatment
21 through February 3, 2025, which I understand is the fact cutoff date regarding
22 liability at trial. *See* Dkt. 918. This report considers three categories of evidence,
23 summarized below.

24 3. The first category is death records that were produced by Defendants
25 after my November 1, 2024 rebuttal report. These include additional records related
26 to three deaths about which I have already written, as well as records related to two
27 deaths that I did not consider in my prior reports.

28 4. The second category is updated medical records regarding incarcerated

1 persons that I had previously reviewed in my prior reports. Defendants produced
2 updated medical records regarding six incarcerated persons whose records I had
3 received in advance of my prior reports. These updated medical records include
4 treatment from late 2023, all of 2024, and part of 2025.

5 5. The third category is policies related to substance use and substance use
6 disorder treatment that were updated by the Jail between November 1, 2024 and
7 February 3, 2025.

8 6. For the reasons described below, these records confirm that the
9 shortcomings I previously identified in Defendants' substance use policies,
10 procedures, and practices continued throughout late 2023, 2024, and early 2025 to
11 place incarcerated people at substantial risk of serious harm. None of the new
12 evidence produced by Defendants changes my overall opinions that substance use
13 disorder treatment at the San Diego County jails falls below the standard of care.

14 **II. DEATH RECORDS MADE AVAILABLE TO ME AFTER MY**
15 **NOVEMBER 1, 2024 REBUTTAL REPORT DO NOT CHANGE MY**
16 **OPINION FROM PRIOR REPORTS**

17 7. After November 1, 2024, Defendants produced additional records
18 related to three deaths that I had discussed in my prior reports – Richard Woodford,
19 Eric Wolf, and Majid Almajid. Defendants also produced records related to the
20 death of Jose Ramon Cervantes Conejo for the first time after being ordered to do so
21 by the Court on June 4, 2025. *See* Dkt. 926. Because Defendants had withheld
22 those records until ordered to produce by the Court, I had not considered the death
23 of Mr. Conejo in my prior reports. Finally, Defendants produced records in
24 connection with the death of Bobby Patton, who died at Vista Detention Facility on
25 December 28, 2024, after the most recent report I wrote in this matter.

26 8. I have reviewed these newly produced records and they do not change
27 my overall opinions expressed in my prior reports. Instead, these newly produced
28 death records underscore my conclusions that the Jail's policies, procedures, and
practices related to substance use and substance use disorder treatment expose

1 incarcerated persons to a substantial risk of serious harm.

2 **A. Richard Woodford**

3 9. I discussed Mr. Woodford's death at length in both my Initial and
4 Rebuttal Reports. *See* Initial Rpt. at 34-35; Rebuttal Rpt. at 22-27. In my Initial
5 Report, the only information I had about Mr. Woodford's death came from an
6 interview with an incarcerated person in Mr. Woodford's housing unit, but I
7 received Mr. Woodford's medical records in advance of my Rebuttal Report, which
8 allowed me to opine on his death in much greater detail. *See* Rebuttal Rpt. at 24. In
9 that report, I concluded "[i]t is very likely that Mr. Woodford died from
10 inadequately managed withdrawal while in the care of the Sheriff's Department."
11 *Id.* at 27.

12 10. After I filed my Rebuttal Report, Defendants produced several
13 additional records related to Mr. Woodford's death. These records include an
14 autopsy report from the medical examiner, which concluded that the cause of death
15 was an esophageal rupture and hemorrhage (meaning Mr. Woodford bled out due to
16 internal bleeding) due to retching/vomiting. *See* SD_1586147. This cause of death
17 does not change my conclusion that Mr. Woodford died due to the Jail's failure to
18 properly manage his acute opioid withdrawal symptoms. Excessive vomiting is a
19 symptom of opioid withdrawal, so Mr. Woodford's death from internal bleeding and
20 hemorrhage stemming from a rupture in his esophagus due to excessive vomiting is
21 consistent with my prior conclusion that Mr. Woodford died from improperly
22 managed opioid withdrawal.

23 11. Records regarding law enforcement's investigation into the cause of
24 Mr. Woodford's death, which included interviews with multiple incarcerated
25 persons, [REDACTED]

26 [REDACTED]
27 [REDACTED]. *Cf.* SD_1586043-44 (SD Officer Report); Initial Rpt. at 34-35.
28 The autopsy report also includes evidence that Mr. Woodford had been bleeding

1 internally before he was evaluated by medical staff and then “medically cleared” for
2 a return to his housing unit. SD_1586143. Specifically, Mr. Woodford was
3 expelling bloody vomitus (including “black”/old blood vomitus) when he was
4 evaluated by medical. When medical observed that bloody vomitus, they should
5 have transferred him to an outside hospital for emergency care rather than send him
6 back to his housing unit.

7 **B. Eric Wolf**

8 12. I discussed Mr. Wolf’s death in my Rebuttal Report, concluding based
9 on his medical records that he may not have overdosed on fentanyl if the Jail had
10 promptly diagnosed and treated his opioid use disorder (“OUD”) once Jail medical
11 staff became aware of his history of opioid use. *See* Rebuttal Rpt. at 43-44 &
12 App’x A at 47-48. The additional records I received regarding Mr. Wolf’s death
13 [REDACTED]. These records include an autopsy report that confirms he
14 died of a fentanyl overdose and investigative records regarding the source of the
15 fentanyl that killed him. Notably, investigators found that [REDACTED]

16 [REDACTED]
17 [REDACTED]. *See* SD_1586312. This underscores
18 my comments in my earlier reports that [REDACTED]

19 [REDACTED]
20 [REDACTED]. *See* Initial Rpt. at 98-99; Rebuttal
21 Rpt. at 42 (when the Jail “fails to adequately treat withdrawal and substance use
22 disorder, incarcerated persons with substance use disorder will remain at risk of
23 serious harm from overdoses, including death.”)

24 **C. Majid Almajid**

25 13. I briefly discussed Mr. Almajid’s death in my rebuttal report, noting
26 based on the information available to me at the time – which was just Mr. Almajid’s
27 medical record – that the death was notable mainly because it showed the Sheriff’s
28 Office’s exclusive reliance on naloxone in lieu of other appropriate interventions

1 during an overdose. *See* Rebuttal Rpt. at 45. Since that time, I have received
2 [REDACTED] regarding the investigation into Mr. Almajid’s death as well as the medical
3 examiner’s report. *See, e.g.*, SD_1591681 (SDCSD Officer’s Report); SD_1590551
4 (Medical Examiner’s Report). Those records underscore [REDACTED]
5 [REDACTED]
6 [REDACTED]. *See* SD_1591685-86, 1591691-92, 1591699, 1591706-07, 1591727,
7 1591734.

8 **D. Jose Ramon Cervantes Conejo**

9 14. I reviewed records related to the death of Jose Ramon Cervantes
10 Conejo for the first time in connection with this report. I did not review them for
11 my prior reports because Defendants did not produce these records until the Court
12 compelled their production on June 4, 2025. *See* Dkt. 926. [REDACTED]

13 [REDACTED]
14 [REDACTED]
15 [REDACTED]
16 [REDACTED]
17 [REDACTED]
18 [REDACTED]
19 [REDACTED]
20 [REDACTED]
21 [REDACTED]
22 [REDACTED]
23 [REDACTED]

24 15. [REDACTED]
25 [REDACTED]

26 [REDACTED] Unfortunately, as I explained in my Initial Report, the Jail’s policy
27 regarding monitoring intoxicated persons provides only that “an ‘advanced clinical
28 provider *may* keep a patient who is exhibiting mild to moderate symptoms of

1 withdrawal or acute intoxication under observation as deemed necessary.’
2 SD_027129 (emphasis added). This policy is inadequate because . . . situations can
3 change quickly and symptoms in persons not kept under observation will likely be
4 missed until it is too late to intervene and prevent complications.” Initial Rpt. at 34.

5 [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]
9 [REDACTED]
10 [REDACTED]
11 [REDACTED]
12 [REDACTED]
13 [REDACTED]
14 [REDACTED] [REDACTED]
15 [REDACTED]

16 **E. Bobby Patton**

17 16. [REDACTED]
18 [REDACTED]
19 [REDACTED]
20 [REDACTED]
21 [REDACTED]
22 [REDACTED]
23 [REDACTED]
24 [REDACTED]
25 [REDACTED]
26 [REDACTED]

27 17. In my prior reports, I explained that “[b]road access to methadone is
28 necessary to provide adequate care for persons with OUD,” but concluded that

1 Defendants do “not adequately use methadone to treat persons with OUD.” *See*
2 Initial Rpt. at 83-86. Methadone treatment is necessary because “buprenorphine
3 [availability] alone is not enough” as “[s]ome persons with OUD and a higher
4 tolerance to opioids . . . may only stabilize clinically with methadone.” *Id.* at 84.
5 As with any MOUD, methadone “[d]osing must be individualized” and medication
6 should not be abruptly reduced or discontinued, as doing so “violates the standard of
7 care by preventing an incarcerated person from receiving an adequate dose for their
8 OUD.” Rebuttal Rpt. at 34-35. Rapid tapers of methadone can be particularly
9 unbearable for patients because they induce intensely acute OWS. “Unfortunately,
10 tapering individuals off medication, which is not the standard of care, has been the
11 norm historically in the Jail. The Jail has put individuals at risk for overdose and
12 death by tapering them off MOUD.” Initial Rpt. at 65.

13 18. [REDACTED]
14 [REDACTED]
15 [REDACTED]
16 [REDACTED]
17 [REDACTED]
18 [REDACTED]
19 [REDACTED]
20 [REDACTED]
21 [REDACTED]

22 19. Under the standard of care, even in the rare instances where tapering is
23 appropriate, a patient on methadone should be tapered off the medication via dose
24 reductions in stages with assessments conducted after each reduction to ensure the
25 dose reduction is tolerable for the patient before initiating a further reduction. Based
26 on my clinical experience, a humane methadone taper involves decreasing the
27 patient’s dose by 10mg every 1-2 weeks. [REDACTED]

28 [REDACTED]

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[REDACTED]

20. [REDACTED]

[REDACTED] Plaintiffs' counsel have informed me that Plaintiffs' other medical expert will opine in detail on the Jail's treatment of the conditions that caused and contributed to Mr. Patton's death.

21. [REDACTED]

III. UPDATED MEDICAL RECORDS REGARDING TREATMENT THROUGH FEBRUARY 3, 2025 DO NOT CHANGE MY OPINIONS FROM MY PRIOR REPORTS

22. In advance of my August 20, 2024 Initial Report, I was provided with medical records regarding 25 incarcerated persons. See Initial Rpt., Ex. B at 15-16.

1 In advance of my November 1, 2024 Rebuttal Report, I was provided with medical
2 records regarding an additional 41 incarcerated persons. *See* Rebuttal Rpt., App'x B
3 at 1-3. After my November 1, 2024 Rebuttal Report, Defendants produced and I
4 received updated medical records for a total of six incarcerated persons whose
5 medical records I had received in advance of my Initial or Rebuttal Reports. These
6 updated records include medical treatment from late 2023, all of 2024, and part of
7 2025. For the reasons described below, these updated medical records do not
8 change my overall opinions regarding the Jail's substance use and substance use
9 disorder treatment.

10 A. [REDACTED]

11 23. In advance of my Initial Report, I received medical records regarding
12 [REDACTED]' medical treatment that were current as of January 29, 2024.
13 *See* SD_991237-991557. In advance of this report, I received updated records
14 current as of May 20, 2025, *see* SD_1598279-1598658, although I only considered
15 those records if they pertained to treatment through the fact cutoff date of
16 February 3, 2025.

17 24. In my initial report, I noted that the Jail failed to timely start
18 [REDACTED] on buprenorphine despite opioid withdrawal assessments (COWS
19 assessments) indicating he needed the medication at least 72 hours prior to receiving
20 it. *See* Initial Rpt. at 43-44. On review of [REDACTED] updated records, it is
21 apparent that the Jail also failed to timely [REDACTED]

22 [REDACTED]
23 [REDACTED]. *See, e.g.,* [REDACTED]
24 [REDACTED]
25 [REDACTED]

26 [REDACTED]. Specifically,
27 [REDACTED]
28 [REDACTED]

1 [REDACTED]
2 [REDACTED]
3 25. [REDACTED]
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
7 [REDACTED]
8 [REDACTED]
9 [REDACTED]
10 [REDACTED]
11 [REDACTED]

12 B. [REDACTED]

13 26. In advance of my Initial Report, I received medical records regarding
14 [REDACTED] medical treatment that were current as of January 25, 2024. *See*
15 *SD_814808-815324*. In advance of this report, I received updated records current as
16 of May 28, 2025, *see SD_1657740-1658266*, although I only considered those
17 records if they pertained to treatment through February 3, 2025.

18 27. In my initial report, I noted that [REDACTED] was improperly tapered
19 off buprenorphine despite his requests to be added to the medication assisted
20 treatment (“MAT”) program so that he could receive MOUD. Initial Rpt. at 44.

21 28. [REDACTED]
22 [REDACTED]
23 [REDACTED] In my prior

24 reports, I explained that the standard of care for treating OUD is to provide
25 individualized treatment by providing doses of MOUD tailored to the needs of the
26 patient. *See* Initial Rpt. at 64-83; Rebuttal Rpt. at 28-41. Providing adequate doses
27 of MOUD requires timely evaluation, and re-evaluation, of the dose provided to
28 each patient. [REDACTED]

1 [REDACTED]
2 [REDACTED]
3 [REDACTED]
4 [REDACTED]

5 C. [REDACTED]

6 29. In advance of my Initial Report, I received medical records regarding
7 [REDACTED] medical treatment that were current as of January 25, 2024. *See*
8 SD_747906-749190. I did not discuss [REDACTED] medical records in detail in
9 my Initial Report. In advance of this report, I received updated records current as of
10 May 27, 2025, *see* SD_1602076-1602873, although I only considered those records
11 if they pertained to treatment through February 3, 2025.

12 30. [REDACTED]
13 [REDACTED]
14 [REDACTED]
15 [REDACTED]
16 [REDACTED]

17 31. In my prior reports, I concluded that the Jail's intake screening process
18 failed to consistently identify substance use among IPs who are booked into the Jail.
19 *See* Initial Rpt. at 15-20; Rebuttal Rpt. at 6-12. The shortcomings in the Jail's intake
20 screening process are [REDACTED]

21 [REDACTED]
22 [REDACTED]
23 [REDACTED]
24 [REDACTED]
25 [REDACTED]
26 [REDACTED]
27 [REDACTED]
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[REDACTED]

32. In my prior reports, I explained that the Jail’s practice of completing withdrawal assessments once per day falls short of the standard of care, which requires assessments every 4-8 hours depending on the circumstances. See Rebuttal Rpt. at 15-16. [REDACTED]

[REDACTED]

33. [REDACTED]

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[REDACTED]

[REDACTED]

34. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

35. Finally, I explained in both of my prior reports that the Jail had no policies, procedures, or practices whatsoever to treat stimulant use disorder. *See* Initial Rpt. at 96-98; Rebuttal Rpt. at 41-42. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

D. [REDACTED]

36. In advance of my Initial Report, I received medical records related to [REDACTED] medical treatment that were current as of January 25, 2024. *See* SD_786635-787062. I did not discuss [REDACTED] records in detail in my Initial Report. In advance of this report, I received updated records current as of May 28, 2025, *see* SD_1646123-1647157, although I only considered records pertaining to treatment through February 3, 2025.

37. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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3 [REDACTED]
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[REDACTED]

E. [REDACTED]

42. In advance of my Initial Report, I received medical records related to [REDACTED] medical treatment that were current as of January 24, 2024. See SD_785315-785856. I did not discuss [REDACTED] records in detail in my Initial Report. In advance of this report, I received updated records current as of May 28, 2025, see SD_1641800-1642406, although I only considered records regarding treatment through February 3, 2025.

43. [REDACTED]

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[REDACTED]

[REDACTED]

44. [REDACTED]

[REDACTED] I explained in my Initial Report that, when treating acute stimulant intoxication, the standard of care includes regular clinical examinations including taking vital signs. *See* Initial Rpt. at 22. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

F. [REDACTED]

45. In advance of my Rebuttal Report, I received medical records regarding [REDACTED] treatment that were current as of April 19, 2024. *See* Rebuttal Rpt., App'x B at 2. In advance of this report, I received updated records current as of May 27, 2025, *see* SD_1651233-1651979, although I only considered records regarding treatment through February 3, 2025.

46. In my rebuttal report, I conducted a thorough review of [REDACTED] medical records and identified several failures in SUD treatment. These failures included failing to identify [REDACTED] substance use during intake and failing to initiate SUD treatment once medical staff later identified his SUD. *See* Rebuttal Rpt., App'x A at 40. The Jail also failed to treat [REDACTED] for stimulant use disorder despite a history of daily methamphetamine use. *Id.*

47. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] I found

nothing notable in those records regarding [REDACTED] substance use disorder

1 treatment between [REDACTED], 2024. As such, my opinions regarding
2 [REDACTED] treatment from my Rebuttal Report are unchanged.

3 **IV. NEWLY UPDATED POLICIES AND PROCEDURES THROUGH**
4 **FEBRUARY 3, 2025 DO NOT CHANGE MY OPINIONS FROM MY**
5 **PRIOR REPORTS**

6 48. I understand that Defendants updated two of their policies and
7 procedures regarding substance use disorder treatment between my November 1,
8 2024 Rebuttal Report and the February 3, 2025 fact cutoff date. Both updated
9 policies and procedures are in the San Diego Sheriff's Office's Medical Services
10 Division ("MSD") policy manual.

11 49. Defendants updated MSD D.1.1 "Pharmaceutical Operations" on
12 December 23, 2024. *See* SD_1580346-50. This policy and procedure relates to
13 overdose response, which I discussed in both my Initial Report at 98-110, as well as
14 my Rebuttal Rpt at 42-46. The updated policy and procedure does not change my
15 opinions in those reports. My only comment is that Section VI(E) appears to refer
16 to opioid withdrawal when it actually means opioid overdose. But the same
17 shortcomings from my prior expert reports regarding the jail's opioid overdose
18 response policies and procedures remain in place here.

19 50. Defendants also updated MSD E.5.1 "Mental Health Screen and
20 Evaluation" on December 23, 2024. *See* SD_1580363-64. This policy and
21 procedure relates to substance use screening at intake, which I discussed in both my
22 Initial Report at 15-20, as well as my Rebuttal Report at 6-14. Despite the fact that
23 taking a substance use history is part of the mental health screen and evaluation,
24 there is no procedure in place to ensure that individuals who screen positive for
25 substance use are evaluated by a qualified individual in a timely fashion to ensure
26 that their substance use needs are met.

27 **V. CONCLUSION**

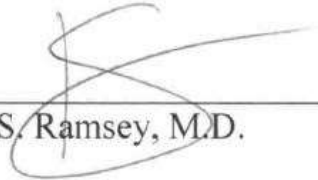
28 51. For the reasons stated above, the evidence recently produced by
Defendants demonstrates that the shortcomings I identified with respect to substance

1 use disorder treatment at the Jail continue through early February 2025 to place
2 people at substantial risk of serious harm. My opinions regarding the Jails' failure
3 to adequately address substance use and treat substance use disorder detailed in my
4 prior expert reports remain unchanged.

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

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Dated: August 22, 2025



Kelly S. Ramsey, M.D.

APPENDIX A

**INDEX OF DOCUMENTS REVIEWED BY KELLY RAMSEY
(for Supplemental Expert Report)**

Autopsy Report, Bobby Patton

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1662351-1662367)

Autopsy Report, Eric Alexander Wolf,

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1587661-1587675)

Autopsy Report, Majid Arif Almajid

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1590551-1590567)

Autopsy Report, Richard Woodford

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1586142-1586160)

Autopsy Report, Timothy Aaron Carlton (Redacted)

Complaint for Damages, *Maritza Benitez v. County of San Diego, et al.*, No. 25CV1143
TWR DDL (So. Dist. Cal)

Crime/Incident Report, Eric Alexander Wolf

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1587834-1587912)

(SD 1588380-1588383) (2 files)

Crime/Incident Report, Richard Woodford

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1586073-1586083)

Custody Records, Bobby Patton

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1662325-1662350)

Death Records, Eric Alexander Wolf (Redacted)

Death Records, Jose Conejo Cervantes

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1660438-1660468)

Death Records, Majid Arif Almajid

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1590886-1590984)

Death Records, Richard Woodford

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1585507-1585559)

Evidence Report, Richard Woodford

CONFIDENTIAL – FOR COUNSEL ONLY (SD 1585409-1585415)

Follow-up Investigative Report, Bobby Patton
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1662958-1662985)
(SD 1662986-1662998) (2 files)

Follow-up Investigative Report, Eric Wolf
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1588407-1588431)
(SD 1588457-1588488) (2 files)

Follow-up Investigative Report, Majid Arif Almajid,
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1591736-1591763)

Follow-up Investigative Report, Richard Woodford
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1586084-1586141)

Grievances, Timothy Aaron Carlton
CONFIDENTIAL – FOR COUNSEL ONLY (SD 713090-713092)

Incident Report, Eric Alexander Wolf
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1586311-1586313)

Incident Report, Timothy Carlton
CONFIDENTIAL – FOR COUNSEL ONLY (SD 713064-713089)

Laboratory Service Report, Eric Alexander Wolf
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1586298-1586310)

Laboratory Service Report, Richard Woodford
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1585401-1585408)

Letter from Michael J. Krugh to Chief Medical Examiner dated June 25, 2024
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1587682-1587806)

Letters from Scott Roller, Lt. Sheriff's Major Crimes Division to Falek Mobile
Health-San Diego; San Diego Fire-Rescue dated January 10, 2024
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1587657-1587660)

Lindsay Winkley, *El Cajon man dies in San Diego County jail; 10th in-custody death this
year*, San Diego Union-Tribune, July 21, 2023 (DUNSMORE0117463-0117464)

Medical Records, [REDACTED]
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1641800-1642406)

Medical Records, Bobby Patton
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1662368-1662548)

Medical Records, Eric Alexander Wolf
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1586349-1587656)

Medical Records, [REDACTED]
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1598279-1598658)

Medical Records, [REDACTED]
CONFIDENTIAL – FOR COUNSEL ONLY (SD_1602076-1602873)

Medical Records, Jose Conejo Cervantes
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1659925-1660437)

Medical Records, [REDACTED]
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1651233-1651979)

Medical Records, [REDACTED]
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1657740-1658266)

Medical Records, Majid Arif Almajid
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1590568-1590885)

Medical Records, [REDACTED]
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1646123-1647157)

Medical Records, Richard Woodford
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1585416-1585506)

Medical Records, Timothy Aaron Carlton
CONFIDENTIAL – FOR COUNSEL ONLY (SD 713093-713347)

NaphCare Death Summary, Timothy Carlton,
CONFIDENTIAL: SUBJECT TO PROTECTIVE ORDER (NAPHCARE041808-041810)

Officer Report, Majid Arif Almajid
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1591681-1591735)

Officer Report, Robert Woodford
CONFIDENTIAL – FOR COUNSEL ONLY (SD 1586037-1586072)

Photographs, Eric Alexander Wolf (Redacted)

Policy/Procedure, Sheriff's Office, Medical Services Division, D.1.1 – Pharmaceutical Operations dated December 23, 2024 (SD 1580346-1580350)

Policy/Procedure, Sheriff's Office, Medical Services Division, E.5.1 – Mental Health Screen and Evaluation dated December 23, 2024 (SD 1580363-1580364)

Report, 2024/2025 San Diego County Grand Jury Final Report

Spreadsheet, JIMS STATCare Alerts, Jose Cervantes, March 28, 2024 to September 26, 2024, CONFIDENTIAL – FOR COUNSEL ONLY (SD 1659822)

Video, Eric Alexander Wolf (3 files)