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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

v.

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

Defendants.

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

SUPPLEMENTAL EXPERT REPORT OF PABLO STEWART, M.D.

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

Trial Date: None Set

1. I have been asked by Plaintiffs' counsel to write a supplemental report regarding the current matter before the court concerning the provision of mental health care in the San Diego County Jail (hereinafter, the "Jail") system. This report is a supplement to my August 19, 2024 expert report ("August 2024 Report"), and my October 31, 2024 expert rebuttal report, Stewart Rebuttal Report ("October 2024 Rebuttal Report") (filed at Dkt. 937-5, 796-5).

2. This supplemental report is based on information that was not made available to me at the time that I completed these reports, including information produced in discovery that occurred in this case in 2025.

3. For this report, I have reviewed updated mental health and medical care records, from late 2023, 2024, and through February 3, 2025, for incarcerated persons whom I reviewed and discussed in my previous reports. I have also reviewed additional incarcerated persons' mental health and medical care records from late 2023, 2024, and through February 3, 2025, which I understand were produced by Defendants through discovery that occurred in 2025.

4. The materials I reviewed in preparing my opinions and findings are listed in **Exhibit A**.

5. The opinions in my previous expert reports remain unchanged, and the findings I provide in this supplemental report serve only to further reinforce those opinions.

I. FINDING #1: THE JAIL'S FAILURES TO ADEQUATELY IDENTIFY AND TRACK PATIENTS' MENTAL HEALTH NEEDS PERSIST.

6. In my previous report, I identified multiple systemic deficiencies with respect to the intake screening process, such that the system did not timely, effectively, or adequately identify and meet the mental health needs of incarcerated people when admitted at the Jail. August 2024 Report ¶¶ 24-52. Based on my supplemental review, my opinions as to the systemic deficiencies regarding

identification and tracking of people with mental health needs remain the same. These systemic deficiencies continue to place people with mental illness at substantial risk of serious harm. For example:

[redacted]

[redacted]

13. This is a patient who requires an individualized plan for meaningful and robust mental health treatment, yet there is no indication of such an individualized plan or that any such treatment is being provided to him.

14. In my previous report, I noted several ways that the system of identifying incarcerated people's mental health needs was inadequate, including that even the identification of a person's elevated suicide risk would not lead to clinically indicated treatment planning or meaningful treatment services. These same systemic deficiencies show up in the updated records I received, with [redacted] case an illustrative example.

II. FINDING #2: DANGEROUS SYSTEMIC DEFICIENCIES IN THE PROVISION OF ESSENTIAL MEDICATIONS AND PSYCHIATRIC CARE CONTINUE TO PUT PATIENTS AT GREAT RISK OF HARM.

15. In my previous reports, I described my extreme concern about systemic deficiencies in the provision of essential medications to people with mental health

treatment needs in the San Diego County Jail. I outlined how the resulting failures and delays in the provision of medications and psychiatric care put patients in this Jail system at substantial risk of serious harm. August 2024 Report ¶¶ 53-95.

16. Having now reviewed updated and additional records, the level of my concern remains extreme. My findings and opinions are unchanged. I provide below some illustrative examples of patients who continue to be placed at enormous risk, and who have in fact been harmed by the persistence of these systemic psychiatric care deficiencies.

[redacted]

[redacted]. His psychiatric care did not meet the standard of care, and highlights serious deficiencies with the psychiatric care system at this Jail.

[redacted]

[redacted] Such delays in psychiatric follow-up in this Jail system are pervasive, and they are dangerous.

[redacted] The failure to monitor for such medication side effects, and to address them as warranted, signals a dangerous systemic deficiency in the Jail's psychiatric care system.

[redacted]

[redacted]

30. The standard of care for prescribing practices caution against abruptly restarting high doses of these sorts of medications after a period of nonadherence; doing so can lead to dangerous side effects such as oversedation, gastrointestinal issues, and sudden dangerous drops in blood pressure. [redacted]

[redacted]

32. This patient demonstrates the unsafe prescribing practices, the insufficient monitoring and follow-up protocols, and the failure to adhere to the standard of care for psychiatry, systemic deficiencies that expose [redacted] and other patients to unnecessary and preventable harm.

[redacted]

[redacted]

III. FINDING #3: THERE IS STILL NO LEVEL OF CARE SYSTEM, AND THE JAIL SYSTEM CONTINUES TO DENY PEOPLE THE MENTAL HEALTH TREATMENT THAT THEY NEED.

36. In my previous report, I discuss in detail my finding that the San Deigo County Jail system lacks an adequate levels of care system and fails to provide minimally adequate treatment to people with mental health needs, causing unnecessary suffering and putting people at substantial risk of harm. August 2024 Report ¶¶ 96-181.

37. Based on my review of updated and additional records, I can discern no indication that the San Deigo County Jail system has, since that time, implemented

an adequate level of care system or is providing treatment programming that comes close to meeting the needs of the patient population. Instead, I found that patients continue to be denied clinically indicated treatment programming, *including* in units that are ostensibly designated for a "mental health population." For example:

[redacted]

40. In any minimally adequate Jail mental health system, one would expect to see meaningful effort to provide this sort of patient structured treatment activities, with proactive clinical and custodial efforts to bring him into a group setting. Here, the records reflect what I observed in multiple patients' record review and during my site visit – that is, patients are left isolated and undertreated because they are deemed "too unstable," without sufficient clinical interventions, *even* in the acute care unit.

[redacted]

[redacted]

46. In all, this patient did not receive anything close to minimally adequate treatment – not with respect to clinical contacts, nor psychiatric care, nor protection from the well-known risks of decompensation in Administrative Separation. The deficiencies I found in my previous reports show up, in the same substantive ways, in this patient's records into early 2025.

IV. FINDING #4: THE JAIL'S USE OF SOLITARY CONFINEMENT REMAINS EXTREME WITH RESPECT TO HARMFUL CONDITIONS AND LACK OF TREATMENT

47. I remain gravely concerned about the Jail's use of solitary confinement, and the lack of adequate treatment provided to people with mental health needs in such conditions. The current use of solitary confinement in this system puts people at unnecessary and serious risk of harm.

48. I have provided extensive discussion about the widely accepted reality that solitary confinement conditions can cause healthy people to develop mental illness and place people with existing mental illness at enormous risk of deterioration, decompensation, and substantial risk of psychosis, self-harm, and suicide. May 2, 2022 Stewart Decl., Dkt. 119-7, ¶¶ 24-33.

49. I have also provided my detailed findings about how the San Diego County Jail use of solitary confinement has caused, and continues to cause, serious and unjustified harm on a broad scale. August 2024 Report ¶¶ 182-283. As I have noted, this Jail's isolation units (called "Administrative Separation") constitute some of the harshest, most restrictive forms of solitary confinement I have ever witnessed

in any jail system.

50. Having reviewed additional and updated records of incarcerated people with serious mental health treatment needs who have been held in these solitary confinement units more recently, I see clear evidence in records from late 2023 through early 2025 that they continue to suffer and to face substantial risk of serious harm. The systemic deficiencies I have identified remain unremedied. For example:

[redacted]

[redacted] The conditions and lack of treatment, and the continued placement of people with mental illness in highly restrictive settings, place people at grave and unacceptable danger. [redacted]

[redacted]. [redacted]

[redacted]

[redacted]

[redacted] In my experience, even a minimally effective quality assurance program would have identified and addressed this sort of dangerous failure in the provision of psychiatric care.

[redacted]

64. This case illustrates several aspects of the dangerous conditions and lack of adequate care that persist in this Jail system, especially in the Administrative Separation units.

V. FINDING #5: THE GRAVE DEFICIENCIES IN SUICIDE PREVENTION PRACTICES AT THE JAIL PERSIST.

65. Given the long history and considerable public attention of suicides in the San Diego County Jail system, my work in this case has included substantial consideration of the suicide prevention policies and practices in this system. I describe several deficiencies on this topic in my previous findings. August 2024 Report ¶¶ 284-350.

66. While I am relieved to hear that the number of suicides has reportedly decreased more recently, my review of the updated and additional records makes plain that major deficiencies with respect to suicide prevention policies and procedures remain essentially unchanged since the review I conducted for my previous reports. For example:

[redacted]

[redacted]

70. [redacted] recent treatment has been deficient in ways that are entirely consistent with the systemic deficiencies related to suicide prevention and mental health treatment that I identified in my previous findings.

[redacted]

[redacted] Based on my experience and expertise, it is my strong opinion that this very serious suicide attempt was preventable with appropriate provision of mental health care and, in particular, the appropriate

involvement and intervention of psychiatry (which did not occur).

VI. FINDING #6: UPDATED RECORDS EVIDENCE CONTINUED DEFICITS IN STAFFING THAT PREVENT THE PROVISION OF CLINICALLY NECESSARY MENTAL HEALTH CARE.

76. In my previous reports, I explained in detail how the San Diego County Jail lacks sufficient mental health staffing resources to meet the treatment needs of the Jail population, and that the Jail's extremely unusual staffing structure is dysfunctional and ineffective in ways that impede necessary systemic improvements to the Jail mental health care system. August 2024 Report ¶¶ 351-388.

77. Based on my review of updated and additional records, I can easily discern that these systemic deficiencies have continued. The staffing structure that includes (a) county-employed mental health clinicians (inappropriately supervised and directed by the Sheriff's Office leadership), and (b) private contractor-employed psychologists, psychiatrists, and psychiatric nurse practitioners (who seem to operate independent of county policies and procedures, and with no clear supervision or effective accountability structure), is unchanged.

78. The continued lack of adequate staffing is a primary contributor to the (a) untimely provision of mental health treatment (including with respect to psychiatry), (b) the grossly inadequate mental health treatment programming, (c) the lack of an adequate level of care system, and (d) the pervasive failure to provide confidential mental health contacts (with a staggering reliance on non-confidential cell-front contacts). I found each of these systemic deficiencies in my previous reports, and have found them again as part of this updated supplemental review. In short, my opinions as to the systemic deficiencies with respect to staffing as it impacts the Jail mental health care system are unchanged.

VII. FINDING #7: THE JAIL'S DENIAL OF CONFIDENTIALITY IN THE PROVISION OF MENTAL HEALTH CARE HAS NOT CHANGED, AND STAFF CONTINUE TO MISUNDERSTAND AND MISREPRESENT WHETHER CLINICAL CONTACTS ARE CONFIDENTIAL.

79. In my previous reports, I describe in detail how and why confidential mental health contacts are the standard of care, both in the community and in detention settings. The failure to provide confidential treatment in San Diego County Jail puts people at substantial risk of serious harm by hindering their ability to share information and to receive adequate treatment. August 2024 Report ¶¶ 389-401.

80. As described in several of the individual patient reviews in this supplemental report, the San Diego County Jail still fails to provide necessary confidentiality in the provision of mental health treatment. The vast, overwhelming majority of mental health encounters are not confidential in this Jail system. This critical systemic deficiency has not been addressed.

81. Staff continue to misunderstand confidentiality requirements and, in turn, misrepresent which clinical contacts are confidential. [redacted]

82. And just as alarming, clinicians still frequently mark the cell-front contact as "confidential," *even* where they document that *custody staff was present* (Based on my experience, the necessity of custody staff's presence "for safety" in such a scenario is hard to believe, given that the patient is behind a locked cell door).

VIII. FINDING #8: JAIL CUSTODY STAFF CONTINUE TO EXERT IMPROPER AND DANGEROUS CONTROL OVER CLINICAL MENTAL HEALTH CARE DECISIONS.

83. In my previous declaration, I identified practices by which San Diego

County Jail custody staff improperly control and direct the placement and treatment of people with serious mental health needs, in ways that are inconsistent with the standard of care and that put people at substantial risk of serious harm. May 2, 2022 Decl. ¶¶ 17-76; August 2024 Report ¶¶ 403-417.

84. Based on my review of the updated and additional records, I can discern *no* changes to critical systemic deficiencies I previously identified relating to custody's improper control of and interference with the provision of clinically indicated care.

85. I have observed no records indicating that mental health staff assess incarcerated people *prior* to their placement in Administrative Separation to identify clinical contraindications with such placement and to prevent any such contraindicated placement. This practice is well-established in the field of detentions and jail mental health care as necessary to prevent foreseeable and serious risk of substantial harm.

86. I have observed no records indicating that mental health staff meaningfully assess incarcerated people while they are housed in Administrative Separation to identify signs of decompensation, or that they have been given direction and authority to remove patients who are decompensating or at risk of decompensating. This practice is also well-established in the field of detentions and jail mental health care as necessary to prevent foreseeable and serious risk of substantial harm.

87. I have observed no records indicating that the San Diego County Jail system has eliminated the blanket bans on people designated by custody as "Protective Custody" or "Administrative Separation" from the Outpatient Stepdown (OPSD) units, which are currently the only Jail-operated housing locations outside of the acute care Psychiatric Services Units (PSUs) designated to house and serve people with serious mental health needs. This exclusion remains completely unacceptable and puts people at unnecessary risk.

IX. FINDING #9: THERE MUST BE FULL AND MEANINGFUL IMPLEMENTATION OF THE COURT-APPROVED REMEDIAL PLANS TO ADDRESS THE SYSTEMIC DEFICIENCIES RESULTING IN THE IMPROPER AND DANGEROUS PUNISHING OF PEOPLE WITH MENTAL HEALTH NEEDS OR AN INTELLECTUAL DISABILITY.

88. In my previous findings, I discuss my concerns with this Jail's policies and procedures that result in improper and dangerous punishments for people with serious mental illness or intellectual disability. August 2024 Report ¶¶ 418-426.

89. I am aware that, since that time, a Joint Motion and Order regarding the Americans with Disabilities Act claim in this case has been submitted and approved by the court. In that document, there are remedial provisions that I perceive as serving to address my concerns on this topic. *See, e.g.*, Dkt. 792-2, ¶¶ 125-129.

90. Full and meaningful implementation of those remedial provisions will be absolutely essential to providing a remedy to the systemic deficiencies I identified.

X. FINDING #10: THERE MUST BE FULL AND MEANINGFUL IMPLEMENTATION OF THE COURT-APPROVED REMEDIAL PLANS TO ADDRESS SYSTEMIC DISCRIMINATION AGAINST PEOPLE WITH MENTAL HEALTH AND INTELLECTUAL DISABILITIES.

91. In my previous findings, I discuss my concerns with this Jail's policies and procedures that result in harmful discrimination against people with mental health disabilities or intellectual disabilities. August 2024 Report ¶¶ 427-430.

92. Again, I am aware that the Joint Motion and Order regarding the Americans with Disabilities Act claim in this case contains remedial provisions that I perceive as serving to address my concerns on this topic, including the concerning discriminatory practices of (1) failing to place incarcerated people with mental health or intellectual disabilities in the least restrictive setting appropriate to their individual needs and circumstances; (2) placing such people in more restrictive

settings due to their disability and (3) denying such people access to services, programs, and activities that similarly situated, non-disabled individuals receive (*e.g.*, classes, recreation, job opportunities, etc.). *See, e.g.*, Dkt. 792-2, ¶¶ 76-81 ("Program Access").

93. Full and meaningful implementation of those remedial provisions will be absolutely essential to providing a remedy to the systemic deficiencies I identified.

XI. FINDING #11: DISCHARGE PLANNING REMAINS A COUNTY-WIDE, SYSTEMIC FAILURE

94. I continue to have significant concern regarding the inadequacy of discharge planning services at the Jail. As I have discussed, this is an essential component of an adequate jail mental health care system. It is absolutely necessary to ensure medication and treatment continuity, linkages to community-based service providers, and resources to prevent people with mental health needs from being subjected to a substantial risk of serious harm upon release. August 2024 Report ¶¶ 431-439.

95. I emphasize here that this is an effort that requires a *multi-agency* solution, including with the County's Behavioral Health Services Department, Public Health Services Department, Public Defender, and Probation Department.

96. Based on my supplemental review, discharge planning services at the San Diego County Jail remain inadequate and will require additional focus and resources in order to achieve a systemic remedy. For example:

[redacted]

[redacted]

100. This case illustrates persistent systemic deficiencies to provide adequate discharge planning services, and to ensure appropriate *coordination* across county agencies to facilitate continuity of care for people with mental illness upon release. While my review suggests that Jail staff are in some respects working to enhance discharge planning efforts within the Jail, it is clear that more resources and attention, including from other County agencies, are needed to meet the needs of discharging people who have ongoing mental health treatment needs.

CONCLUSION

101. As I have previously noted, in my more than 35 years evaluating and working in detention facilities, I have come across very few, if any, mental health care systems so lacking in effective systems and levels of care to meet the needs of the incarcerated population with serious mental health treatment needs, and to protect people from serious harm.

102. Based on my supplemental review of records through February 3, 2025, the systemic deficiencies I identified in my 2024 reports have persisted. It remains the case that remedial action to address these systemic deficiencies is urgently needed.

103. 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 23, 2025

Pablo Stewart, M.D.