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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

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

Plaintiffs,

v.

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

Defendants.

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

EXPERT REPORT OF JAY D. SHULMAN

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

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I, Jay D. Shulman, declare:

1. I am Jay D. Shulman, a dentist experienced in the field of Correctional Dentistry. I have been retained by Plaintiffs' counsel in the above-captioned case as an expert in dental care in correctional institutions. In particular, I have been asked to render my opinion with respect to whether there are current systemic deficiencies in the dental care provided to people incarcerated at the San Diego County Jail (the "Jail"). My background and experiences relevant to my expert testimony in this proceeding are set forth below. A true and correct copy of my *curriculum vitae* is attached hereto as **Exhibit A**.

EDUCATION AND QUALIFICATIONS

A. Clinical, Management, and Academic Experience

2. I have been a dentist for 53 years and have had careers in the military, dental education, and correctional dentistry consulting. I am certified by the American Board of Dental Public Health, one of the 12 specialties recognized by the American Dental Association. Moreover, I have extensive experience auditing and monitoring educational, military, and correctional dental programs.

3. During my 22-year military career, I had clinical, research, administrative, and command assignments in the United States, Okinawa, and Germany. Among my assignments, I served as the Army Surgeon General's Dental Public Health Consultant and wrote dental public health policy, procedures, and technical guidance. As Commander of the 86th Medical Detachment, I directed dental care delivery for the Army in North Central Germany, operated six clinics with 20 dentists and 60 ancillary personnel, and was responsible for the dental health of 25,000 soldiers and family members.

4. I have written 60 peer-reviewed articles and six book chapters, served as a reviewer for national and international dental journals, and served on the editorial board of the *Journal of Public Health Dentistry*, the official journal of my specialty. Many of the papers I wrote during my academic career related to the

epidemiology of oral disease, such as dental caries, periodontal disease, and oral lesions. Ten publications relate to correctional dentistry. A complete list of my publications is included in my *curriculum vitae*.

B. Correctional Dentistry Experience

5. I have served as a correctional dentistry consultant, court expert/representative, and expert witness several times since 2005. As a court expert in two major class action settlements involving incarcerated person dental care, I developed an audit process based on reviewing clinical dental records[1] and performed system-wide audits of correctional dental programs in California (at the time, roughly 170,000 people incarcerated in 33 institutions) and Ohio (at the time, roughly 50,000 people incarcerated in 30 institutions) over a five-year period. In 2014, I was retained as a dental expert by the U.S. Department of Justice in an investigation of a prison's dental care under the *Civil Rights of Institutionalized Persons Act* and served as a consultant to the Santa Clara County Counsel in a pre-litigation assessment of jail dental care. I was recently a member of a Rule 706 expert medical team in class action litigation involving health care in the Illinois prison system.[2]

6. I have performed clinical dentistry and supervised dental and dental hygiene students at the Dallas County Juvenile Detention Center. My work in the military and correctional dentistry, as well as my training in Dental Public Health focusing on population-based care, have given me unique expertise to discuss not only specific incidences of dental care, but system-wide deficiencies in dental care and the effects those deficiencies are likely to have on incarcerated populations. A complete list of the cases for which I served as an expert is in the Consultant

[1] Throughout this declaration, I use the terms "dental chart" and "dental record" interchangeably.

[2] *Don Lippert et al. v. John Baldwin, et al.*, Case No. 10-cv-4603 (N.D. Ill.); Document #: 767 Filed: November 14, 2018.

Activities section of my *curriculum vitae*.

BACKGROUND & SUMMARY OF OPINIONS

7. I have been asked to render my opinion with respect to whether people incarcerated in Jail facilities are subjected to a substantial risk of serious dental injury caused by systemic deficiencies and whether the deficiencies are amenable to a common remedy that will reduce the risk of harm.

8. In their Third Amended Complaint, Plaintiffs allege that dental care at the Jail is inadequate and places incarcerated people a risk of harm. Dkt. 231 at ¶¶ 356-365. In particular, Plaintiffs allege that incarcerated people who require dental care wait an unreasonable amount of time to see a dentist, *id.* at ¶ 358, and that care at the Jail "is almost exclusively limited to extracting teeth," *id.* at ¶ 360. As explained in more detail below, I agree.

9. My opinions are based on a review of dental records of incarcerated persons as well as documents, reports, and depositions available at this time, as listed in **Exhibit B** to this declaration; my inspection of the Jail; and the scientific literature. In addition, the opinions are based on my 53 years of professional experience in dentistry and are made to a reasonable degree of certainty. My understanding is that San Diego County Jail officials are aware of the dental treatment delays and deficiencies outlined in this report and the ensuing suffering caused to *Dunsmore* class members.

10. It is my opinion as outlined below that the consistently inadequate dental care documented in the records I reviewed is attributable to systemic problems caused by inadequate dentist staffing and inadequate policies and procedures in San Diego County's dental care program as administered by NaphCare. Specifically, San Diego County's and NaphCare's policies and practices show lack of routine care and inadequate diagnosis and treatment of dental conditions, all of which combine into a system that fails to adequately identify, or properly and timely treat, dental issues experienced by incarcerated people. San

Diego's and NaphCare's policies on these issues are in many cases themselves below the standard of care. These failures place all incarcerated people at risk not only of preventable pain, but also of advanced tooth decay, advanced periodontal disease, and unnecessary loss of teeth. The inadequacies in dental care experienced by the plaintiffs are typical of the risk of inadequate dental care for all incarcerated people. Consequently, all people incarcerated in San Diego are at risk for preventable pain and tooth morbidity. In my experience as Court Expert/Monitor in *Fussell v. Wilkinson* and *Perez v. Tilton*, both large class actions, I have seen systemic problems of this type addressed successfully by mandated changes in the dental care system.

11. The information and opinions contained in this report are based on evidence, documentation and observations available to me. I reserve the right to modify or expand these opinions should additional information become available to me.

12. I am being compensated for my work at a rate of $350 per hour for general work including document review, $175 per hour for travel, and $500 per hour for depositions and testimony, in addition to travel expenses.

A. Inadequate Urgent Care

13. In my opinion, based on a reasonable degree of certainty, the Jail's treatment of incarcerated people with painful conditions is untimely and inadequate—both onsite and via offsite referrals.

14. In my opinion, based on a reasonable degree of certainty, the Jail's assessment and onsite treatment of incarcerated people who complain of painful dental conditions is inadequate because it is untimely.

15. In my opinion, based on a reasonable degree of certainty, the Jail's referral process for providing incarcerated people with oral surgery treatment is inadequate and results in untimely care.

B. Inadequate Routine Care

16. In my opinion, based on a reasonable degree of certainty, the initial and annual examinations provided in the Jail are inadequate because they are not informed by periodontal probing and bitewing x-rays. Consequently, caries (known colloquially as "cavities") and periodontal disease are underdiagnosed, allowing these conditions to progress to the point there is preventable pain, loss of tooth structure or tooth loss.

17. In my opinion, based on a reasonable degree of certainty, the diagnosis of caries is inadequate because it is not informed by intraoral (primarily bitewing) x-rays. In addition, it is my opinion, based on a reasonable degree of certainty, that the Jail fails to provide permanent restorations on a regular basis and, in fact, has a *de facto* extraction only policy.

18. In my opinion, based on a reasonable degree of certainty, the diagnosis and treatment of periodontal disease in the Jail is inadequate and below accepted professional standards, resulting in delayed (or no) diagnosis, gratuitous pain, and tooth loss.

19. In my opinion, based on a reasonable degree of certainty, the preventative care provided to incarcerated people in the Jail—in particular cleanings—does not happen routinely in practice and is therefore inadequate.

20. In my opinion, based on a reasonable degree of certainty, the Jail's provisions of endodontic treatment, *i.e.*, root canals, is inadequate.

C. Inadequate Dentist Staffing

21. In my opinion, based on a reasonable degree of certainty, the Jail does not have enough dentists to treat painful dental conditions and provide routine care to longer-term incarcerated people given the average daily population.

D. Inadequate Program Monitoring

22. In my opinion, based on a reasonable degree of certainty, the Jail's dental program is inadequately monitored. Consequently, program deficiencies are

not identified and remedied timely.

STANDARDS FOR CORRECTIONAL DENTAL CARE

23. In stating the standards for correctional dental care throughout this report, I rely on several sources, as explained below, as well as my experience in the field. These sources and their key points are listed below. In my opinion, the standard articulated throughout this report is the level of practice necessary to ensure that incarcerated people are not at unreasonable risk of gratuitous pain, tooth morbidity, and tooth loss from untreated dental conditions.

A. Correctional Organizations

24. The major correctional organizations that address jail and prison dental care are the National Commission on Correctional Health Care ("NCCHC") and the American Correctional Association ("ACA"). While the ACA deals with all aspects of corrections, the NCCHC focuses on health care. Both the ACA and NCCHC publish standards that are updated periodically and offer to evaluate jails and prisons based on those standards. Both organizations publish dental (oral care) standards for jails and prisons.

25. The NCCHC Jail Standard[3] requires that "[i]nmates' dental needs are addressed." In particular, the NCCHC compliance indicators are that: care is timely[4] and includes immediate access for urgent conditions; includes an initial oral examination; oral treatment, not limited to extractions, is provided according to a treatment plan that includes a system of established priorities for care when, in the dentist's judgment, the patient's health would otherwise be adversely affected; and x-rays are used in the development of the treatment plan. Standard J-E-06. I focus on NCCHC Oral Care Standard J-E-06 because it is incorporated into Section 2.3.10

[3] Standards for Health Services in Jails (2018) National Commission on Correctional Health Care Oral Care Standard J-E-06 (essential).

[4] A further discussion of the standard for "timeliness" is addressed *infra*.

(Oral Care Services) of the NaphCare contract. As that document states, "Contractor shall be the prime provider for oral care services and shall provide dental staffing. Contractor oral care services shall comply with NCCHC standards by which patients receive dental treatment, not limited to extractions." (2.3.10.2) and "[…] Contractor shall ensure that patients' serious dental needs are met in compliance with NCCHC, and other applicable standards." (2.3.10.3). County Contract No. 566117, SD 122497.

26. The ACA Oral Care Standard 5-6A-4360 is like the NCCHC's Oral Care Standard, except that the ACA also specifies that a periodontal assessment using either Periodontal Screening and Recording ("PSR") or the Community Periodontal Index of Treatment Needs ("CPITN") should be part of a dental examination.[5]

27. Notably, while both the NCCHC and ACA oral care standards provide useful guidance and baselines for what a correctional institution's dental policy must include, they are insufficiently detailed to constitute the entirety of an institution's dental policy. Critically, neither set of standards include specific timeframes for specific dental care and instead state only that care must be "timely." Timeliness standards for providing care have therefore been refined on an *ad hoc* basis through litigation. The amount of pain reported by the offender is a critical component in assessing timeliness.[6] This report sets out minimum time frames for certain components of care, *e.g.*, dental examinations, but notes that other time frames may be based on the reasonable exercise of a dentist's clinical judgment.

28. Furthermore, the standards developed for jails are insufficient for

[5] Performance-Based Expected Practices for Adult Correctional Institutions, 5th ed. American Correctional Association, August 2018; p. 176-177.

[6] Shulman JD, Makrides NS, Lockhart A (2017). The Organization of a Correctional Dental Program. In Cohen F., ed. Correctional Health Care: Practice, Administration, and Law (Chapter 8, pp. 1-23). Kingston, NJ: Civic Research Institute, p.8-3 (*hereinafter* "Shulman et al.").

institutions housing both pre-trial and sentenced individuals. Notably, the NCCHC standards for jails is identical to the standard for prisons, except that the jail standard requires that a dentist perform an initial oral examination within 12 months of admission while the prison standard requires that the dentist's initial examination be performed within 30 days of admission. This means that a person in California who receives a sentence to be served in county Jail will have to wait 12 months for an initial examination, while someone sentenced to prison will receive an initial examination within 30 days, resulting in an unfair disparity. As explained in more detail below, because the Jail at issue in this case houses people serving sentences, those individuals should not be required to wait a full year for initial examinations.

B. Dental Organizations

29. While the American Dental Association does not define any standards of care specific to correctional dentistry,[7] it does establish standards that relate to clinical dental practice. The ADA also publishes the accepted professional standard for procedure definitions, the Code on Dental Procedures and Nomenclature ("CDT"). These codes and their definitions are the standard in dentistry. Similarly, the American Academy of Periodontology ("AAP") focuses on the diagnosis and treatment of periodontal disease.

30. The American Dental Hygienist's Association ("ADHA") defines standards for dental hygiene practice.[8] Among the elements of a periodontal assessment are periodontal charting including documenting probing depths, bleeding points, suppuration, gingival recession, and loss of clinical attachment. *Id*. p. 7.

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[7] Graskemper, JP (2004). The standard of care in dentistry. Where did it come from? How has it evolved? *Journal of the American Dental Association*; 135(10), 1449-1455.

[8] American Dental Hygienist's Association. Standards for Clinical Dental Hygiene Practice chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.adha.org/wp-content/uploads/2022/11/2016-Revised-Standards-for-Clinical-Dental-Hygiene-Practice.pdf. Viewed May 13, 2024.

C. Regulatory Organizations / Institutions

31. State boards of dentistry define the scope of practice for dentists, dental hygienists, and dental assistants based on the states' dental practice acts. With respect to dental hygienists and dental assistants, the boards set forth what each category may do and the level of dentist supervision that is required for the procedures they perform. The California Dental Practice Act defines the scope of practice for dentists, dental hygienists, and dental assistants, as well as what level of a dentist's supervision[9] (either "general" or "direct") is required for each activity.

32. In California, most of a dental assistant's activities must be performed under direct supervision of a dentist. However, a dental assistant may, *inter alia*, operate x-ray equipment and apply topical fluorides under the more permissive "general" supervision of a dentist.[10]

33. In addition to performing all duties assigned to dental assistants, registered dental hygienists under general supervision may, *inter alia*, (1) perform scaling and root planing; (2) polish and contour restorations; (3) apply pit and fissure sealants; (4) perform a preliminary examination, including but not limited to: periodontal charting, intra and extra-oral examination of soft tissue, charting of lesions, existing restorations and missing teeth; and (5) provide direct supervision of dental assistants.[11] A registered dental hygienist may treat patients of record in a dental practice; that is, patients who have been examined, have had a medical and dental history completed and evaluated, and have had oral conditions diagnosed and

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[9] The supervision of dental procedures based on instructions given by a licensed dentist who is required to be physically present in the treatment facility during the performance of those procedures. Source: California Business and Professions Code, Division 2, Article 9

[10] California Dental Board. Dental Assisting Table of permitted Duties. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.dbc.ca.gov/formspubs/pub_permitted_duties.pdf. Viewed May 30, 2024.

[11] California Code Regulations, Title 16 § 1088. RDH Duties and Settings.

a written plan developed by the licensed dentist. Also, if a dentist has already conducted a preliminary oral exam, the dentist can direct a dental hygienist to perform some procedures necessary for diagnostic purposes.[12]

34. Critically, the roles of both dental assistants and dental hygienists are very limited in comparison to a dentist's scope of practice. Because, in this Jail, a dentist does not perform a preliminary examination at booking, a dental hygienist or a dental assistant may not take x-rays on a dental sick call patient in the absence of a dentist.[13]

35. The Food and Drug Administration ("FDA") provides guidance on the use of x-rays in dental practice. The recommendations published in conjunction with the ADA are a professional standard.[14]

D. United States Department of Justice ("DOJ")

36. The Civil Rights Division of the U.S. Department of Justice ("DOJ") administers the *Civil Rights of Institutionalized Persons Act* ("*CRIPA*"), which authorizes the Attorney General to enforce the constitutional rights of incarcerated persons who are subject to unconstitutional conditions. The DOJ sends teams to

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[12] Dental Hygiene Board of California. Required and Prohibited Conduct. https://www.dhbc.ca.gov/licensees/conduct.shtml#duties. Viewed May 30, 2024.

[13] "Section 1684.5 of the Business and Professions Code, which specifies that it is unprofessional conduct for a dentist to allow any treatment to be performed on a patient who is not a patient of record of that dentist, which is defined as a patient who has been examined, has had a medical and dental history completed and evaluated, and has had oral conditions diagnosed and a written plan developed by the licensed dentist. Section 1684.5 provides several exceptions, which are that a dentist may, after conducting a preliminary oral exam, permit a dental hygienist to perform allowable procedures necessary for diagnostic purposes, or to perform the following prior to the dentist's examination: (1) Expose emergency radiographs upon direction of the dentist. (2) Perform extra-oral duties or functions specified by the dentist. (3) Perform mouth-mirror inspections of the oral cavity, to include charting of obvious lesions, malocclusions, existing restorations, and missing teeth."

[14] American Dental Association and Food and Drug Administration (2012). Dental Radiographic Examinations: Recommendations for Patient Selection and Limiting Radiation Exposure.

correctional institutions[15] and based on the team's report, may: issue formal findings, send a compliance letter, file a statement of interest in lawsuit, or initiate a lawsuit themselves. The findings and decisions in litigation that the DOJ initiates and participates in help to define the contours of adequate dental care.

37. According to the DOJ, incarcerated persons' dental care must be consistent with generally accepted professional standards, and enough treatment capacity must be provided to ensure care is provided in a timely manner.[16] *See also* Lake County Letter, p. 89 (setting forth DOJ recommendations for Lake County Jail in Indiana, including "ensure that inmates receive adequate dental care in accordance with generally accepted professional standards of care. Such care should be provided in a timely manner").[17] Its position is that offenders' dental care should be consistent with generally accepted professional standards and sufficient treatment capacity must be provided to ensure care is provided in a timely manner.[18]

E. California Department of Corrections and Rehabilitation ("CDCR")[19]

38. The California Department of Corrections and Rehabilitation ("CDCR") dental policies and procedures ("Dental P&P") are also a source of

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[15] I was a member of such a team.

[16] *U.S. v. Lupe Valdez, Sheriff of Dallas County, Texas*. Civil No. 307 CV 1559-N (N.D. Texas 11/06/07), R.8, Agreed [Consent] Order, p. 12, ¶ 13.

[17] Lake County Jail Settlement Findings Letter. Re: Investigation of the Lake County Jail. December 7, 2009. Accessed at: http://www.justice.gov/crt/about/spl/documents/Lake_County_Jail_findlet_12-07-09.pdf February 4, 2021.

[18] *See, e.g.*, United States v. Dallas County, Texas; Lupe Valdez, Sheriff of Dallas County, Texas (in her official capacity), Civil No. 307 CV 1559-N (N.D. Tex.), 2007 U.S. Dist. LEXIS 98386, ¶ 13 (injunction related to conditions of confinement in the Dallas County and Cook County jails); United States v. Cook County, Illinois, et al., Case 1:10-cv-02946, Document 3-1 (filed May 13, 2010), ¶ 58.

[19] The CDCR dental policies and procedures ("P&P") are set forth in the Health Care Operations Manual, Chapter 3, Article 3 ("Dental P&P").

guidance for the standard of care. These Dental P&P, which emerged from the 2005 *Perez* settlement agreement and more than 5 years of federally supervised monitoring, have been in effect for almost 20 years. While the Dental P&P governs dental treatment of people incarcerated in prison, it is a useful point of reference for the treatment of those incarcerated in the Jail with sentences of a year or more[20] as well as clinical issues common to jails and prisons.

39. CDCR's dental treatment priorities are based on a Dental Priority Classification System. The Dental Priority Classification System includes two levels of routine care: interceptive and rehabilitative care. Interceptive care is primarily for treating conditions that—absent prompt treatment—would likely worsen. Examples are advanced decay, and non-surgical periodontal treatment (specifically, scaling and root planing). Rehabilitative care comprises chewing difficulty due to an insufficient number of posterior teeth, gingivitis and slight (early) periodontal disease, decay or tooth fractures that require definitive restorative materials, and root canal treatment for anterior teeth, which are restorable with available restorative materials.

F. Scientific and Correctional Literature

40. The scientific literature, specifically the dental literature, sets forth the foundation that underlies the standard of care with respect to the diagnosis and treatment of conditions such as dental caries and periodontal disease. *See* **Exhibit D**. The correctional literature applies the scientific literature to the correctional environment.

METHODOLOGY

41. As explained *supra*, the purpose of this report is to analyze the policies and practices of the Jail's dental system and the way those policies and practices

[20] In fact, before the passage of AB 109, many people incarcerated in jails would have been CDCR prisoners.

create risk for the incarcerated population.

42. The report is based on my inspection of three of the Jail facilities and my review of documents, in particular: (1) incarcerated person dental charts,[21] including and sick call requests and grievances related to dental care; (2) Sheriff's Department and NaphCare dental policies and procedures, including nursing protocols for dental pain; (3) the deposition transcripts of Sheriff's Department and NaphCare employees; and (4) other documents produced to Plaintiffs' counsel regarding dental care, including but not limited to email correspondence and sick call request lists. (As noted above, a detailed description of the materials I reviewed is Exhibit B).

43. A summary of the site inspections and additional explanation on my review of incarcerated dental charts are below. Additional detail on the charts I reviewed is set forth in **Exhibit C**.

A. Site Visits

44. On February 6 to 8, 2024, I visited three facilities along with Plaintiffs' counsel and physician and psychiatrist experts to inspect the dental clinics of the three facilities. Only one facility (Las Colinas) had a dentist present.

45. Each jail I visited had a dental clinic. I visited Central on February 6, 2024. The clinic has two treatment rooms (operatories), neither of which was being used at the time. Both treatment rooms are adequate from a dental perspective.

46. I visited George Bailey on February 7, 2024. The clinic has one treatment room. A dentist was not present; however, I spoke with a dental hygienist (Claudia, last name unknown) who had recently started working at the jail. She told me that she does cleanings (prophys) but does not provide periodontal treatment (i.e., scaling and root planing). She told me that she does not document periodontal

[21] Many of the charts produced by Defendants were difficult to review, as they are missing the letters "l" and "i," making them nearly impossible to search electronically.

probing but does "spot probing" (see discussion of periodontal disease *infra*).

47. I visited Las Colinas on February 8, 2024. The clinic has two treatment rooms. A dentist, who I believe to be Dr. Patel, was present; however, she told me that she had been directed not to speak to me. Counsel for the Sheriff's Department, who was present for the inspection, stated that her office had not issued any such instruction. It is therefore my understanding that the direction not to speak to me was issued by NaphCare. There were no patients in the clinic at the time I was there. I returned to the clinic later in the day and was told that Dr. Patel was examining patients in the housing units since the dental assistant was out sick.

48. While all the treatment rooms were adequate from a dental perspective for current staffing, any clinic with only one treatment room (such as George Bailey) is limited because a dentist and dental hygienist cannot work at the same time. When dentist staffing is increased substantially (as I believe it must be), it is likely that clinics will have to be expanded or an additional shift added.[22]

B. Chart Reviews

49. Although my opinion is based in part on my review of the individual treatment records of a subset of the *Dunsmore* class, as explained in more detail below, my review of those records was not an end in itself; rather, it was a means to illuminate systemic problems.

50. All people need dental care at some point during their life, and such a need may arise during any person's incarceration. However, not every person incarcerated in the Jail has requested dental care. As a result, selecting a random sample of the incarcerated population to review their medical records is not an efficient way to analyze the Jail's dental care system. Rather, any analysis of medical records should focus on those individuals who requested either routine or urgent dental care during the period of interest.

[22] This was done in CDCR to accommodate increased staffing resulting from the *Perez* settlement. Shulman p. 30.

1. Selection of Dental Records

51. My preference is to select records randomly from a list of individuals who requested care. From my experience performing epidemiologic and health services research in the military, academics, and monitoring correctional dental care, I am confident in stating that random sampling is the gold standard that inferences made from randomly sampled data are reliable.

52. I was provided with such a list (SD 727540) and requested that I be allowed to select a random sample of those records for review. Through counsel for the Plaintiff class, I identified a random sample of dental records from the list from Defendants. To ensure that the sample of 1,773 entries was random, I first sorted the dataset by "Booking Number," then selected the first 40 names of individuals who were identified at booking as having a condition associated with urgent care such as infection, abscess, or pain; the first 80 names of individuals with urgent care complaints whose appointment was not made at booking; and the first 40 individuals who requested care for the treatment for cavities (*i.e.*, routine care). However, I was informed by Plaintiffs' counsel that Defendants were not willing to provide the set of records I requested.

53. Rather, Defendants provided 45 records that they had selected; 24 were categorized as "requests for dental services," and 21 were "outside dental referrals." According to correspondence from Defendants' counsel, the "requests for dental services" group were selected by "[r]eviewing actively pending dental sick calls" and were "[r]andomly selected"; the "outside dental referrals group" were selected by "[r]eviewing Utilization management queue to identify people who were approved for dental care." I understand that Plaintiffs' counsel requested additional information about this selection process, including what randomization method was used to "randomly" select records from the dental sick call list, but no additional information was provided. Since I did not select these records, I am forced to accept Defendants' representation that these records are truly a random sample of class

members who sought dental care during their incarceration in the Jail.

54. I also reviewed ten charts of incarcerated people based on interviews I performed in the housing areas during the inspections. I introduced myself and asked if they would like to talk to me about any dental issues. I asked those who had issues if they would consent to my reviewing their dental chart.

2. Calculation of Wait Times

55. As explained in more detail below, the standard of care requires people complaining of pain to be evaluated *by a dentist* within the following time frames:

a. Incarcerated people complaining of a toothache should be **seen by a dentist within 3 business days**, unless they have been started on antibiotics, are experiencing severe pain, or their pain cannot be managed by analgesics, in which case they should be **seen by a dentist the next business day**.

b. Incarcerated people referred to an oral surgeon for the extraction of infected teeth should have the teeth extracted **within three weeks**.

56. For each dental record I reviewed, I calculated the number of days between a person requesting dental care and being seen by the dentist. My focus in reviewing the records was therefore on sick call request slips regarding dental issues, forms memorializing the outcome of dental examinations, progress notes and sick call summary entries related to dental issues, and offsite consultants' treatment plans and operative notes. I assume that I have been provided with the complete set of records for each individual, *i.e.*, that I was able to see all records that the examining dentist had at the time of treatment. I also reviewed all x-rays that were present.[23]

[23] Only panoramic x-rays were present in the charts I reviewed. The panoramic x-rays taken at the Jail did not have the dates on which they were taken. Notably, Defendants in this litigation represented that all x-rays taken had been produced to Plaintiffs' counsel. Email from E. Pappy to H. Chartoff, May 17, 2024. However, in at least one instance, there is reference to a bitewing x-ray taken by Dr. Patel, which is not present in the chart I reviewed. SD 842916 – 842921.

57. In assessing timeliness, I started the "clock" on the date recorded by the incarcerated person on the sick call request slip describing the painful condition. If that date was not legible, I used the date stamped by the Sheriff's Department as the day the sick call request was received. If another part of the medical record, *e.g.*, the sick call summary or progress notes, indicated that the incarcerated person had a dental complaint related to pain and the sick call request was not in the chart, I used that date on the other record as the start date.

58. I stopped the clock when the incarcerated person was seen by a dentist to assess the problem—irrespective of the treatment provided (if any)—the date on which the person was documented as having refused the dentist appointment, the date the incarcerated person was discharged, or the date on which the chart was pulled for production.[24]

59. Notably, based on the documents I have reviewed, I have some skepticism that the Sheriff's Department is appropriately documenting refusals, *i.e.*, that incarcerated people are not refusing dental appointments, but are merely not being told that they had the appointment. As noted throughout Exhibit C, nearly all the refusal forms I saw were not signed by the incarcerated person, or even signed by healthcare staff. Rather, they were signed by deputies only. In addition, Plaintiff Ernest Archuleta reported in his deposition that several of the "refusals" in his own medical record were not correct, and he had not actually refused medical care or treatment as his record reflected. *See* Archuleta Tr. at 187:9-18. It should go without saying that failing to alert incarcerated persons with a painful dental condition that they have an appointment with a dentist and therefore denying that person the opportunity for treatment falls below the standard of care.

[24] Most of the incarcerated persons who submitted sick call requests stating pain were triaged by nurses and provided with analgesics or referred to a nurse practitioner to evaluate a possible infection. In many cases, the nurses did not make a referral to dental sick call. However, a nurse appointment is not a substitute for evaluation by a *dentist*.

60. However, for purposes of calculating the timeliness of the Jail's dental care, this report assumes that each of these refusals was valid. As explained below and in Exhibit C, even with that assumption, urgent dental care appointments in the Jail are rarely timely. To the extent that "refused" appointments were not truly refused by the patient, this report is therefore an **understatement** of the true wait time for dental care in the Jail. Similarly, when an incarcerated individual was discharged with an open urgent care request, I used the individual's discharge date as the endpoint of the timeliness calculation. As with refused appointments, these discharge dates **understate** the true wait time—had the person remained in the Jail's custody, the clock would have kept running until they received treatment. Notably, 22 percent of all endpoints were calculated based on a discharge date, rather than a treatment date (*see* Table 1, Col. E). In other words, a significant portion of the requests for urgent care made in these records were simply never answered by a dentist; the patient complaining of pain was simply released, after waiting in pain for far longer than the standard of care would dictate.

61. To determine timeliness of offsite consultations, I calculated the time between when the referral was initiated and the surgery was completed. However, when relevant, I also note the time when, in my opinion (based on reviewing the chart and x-rays), the referral should have been initiated.

62. I report the median wait time because the median (rather than the mean) is a robust and resistant estimate of the population and is particularly useful when a distribution is not symmetrical as is this one, since there are more long wait times than short wait times. The median is less influenced by these outliers than the mean.[25]

63. I reviewed 55 charts; 45 selected by the Defendants' counsel, and 10

[25] Reigleman RK and Hirsch RP, 2nd ed. Studying a study and testing a test. How to read the medical literature. Little Brown & Company, 1989.

selected based on cellside interviews with incarcerated persons.

64. The Table below summarizes my findings.

Table 1. Summary of Chart Review - Urgent Care Provided Onsite					
Defendants' Selections				**Mv Selections**	**All Charts**
	Offsite Referrals	**Requested Services**	**All Defendants' Selections**		
	A	B	C	D	E
Number of Charts	21	24	45	10	55
Number of Urgent Care Wait Times Calculated	85	74	159	21	199
Median Wait Time (Days)	22	25	24	23	24
Number of Documented Refusals	4	12	16	6	22
Number of Imputed Endpoints	13	23	36	8	44
Imputed Endpoints (%)	15.3	31.1	22.6	20.0	22.0
Untimely (>3 Business Days) Wait Times	71	67	138	38	176
Untimely (> 3 Business Days Wait Times (%)	83.5	90.5	86.8	95.0	88.4

Table 1. Summary of Chart Review - Urgent Care Provided Onsite					
Defendants' Selections				Mv Selections	All Charts
	Offsite Referrals	Requested Services	All Defendants' Selections		
Untimely (>7 Days)	69	65	134	36	170
Untimely (>7 Days) (%)	81.2	87.8	84.3	90.0	85.4

65. The 45 charts provided by the Defendants represent 159 dental visits for urgent care or open treatment requests that were pending when the incarcerated person was discharged or the chart was pulled,[26] of which 85 were from the referral group and 74 were from the requested dental services group.[27] The median wait time for these urgent care dental visits was 24 days. The median wait time for dental visits in the outside referral group was 22 days, while that of the patients who requested dental care was 25 days. The 10 charts I selected represent 21 urgent dental visits, for which the median wait time was 23 days. The median urgent care wait time for all 55 charts reviewed was 24 days, for 199 total appointments.

66. Of the 199 onsite urgent care appointments (across all 55 charts) for which wait times were calculated, 176 (88.4%) were untimely; that is, outside the 3 business day window. Even using the 7-day "standard" suggested by NaphCare, *see*

[26] There were 36 (22.6%) such occurrences where the computed wait time represented underestimates.

[27] Several of the wait times were calculated using the date the chart was copied as the endpoint.

SD 1572589, 170 (85.4%) would be untimely.[28]

67. Of the 21 charts in the offsite referral group, 15 documented completed surgery, and 6 endpoints were imputed. While most of the referrals were made by dentists, four were made by physicians. The median time to completion of surgery was 94 days.[29]

C. San Diego County Jail Population

68. The *Criminal Justice Realignment Act of 2011* made significant changes to the sentencing and supervision of persons convicted of felony offenses; one the most significant changes being the place where the sentence for certain crimes is to be served. Couzens and Bigelow, p. 6.[30] As a result, the populations of county jails and the median sentence lengths have increased, turning transitory jails into hybrid jail/prison facilities. For example, I am aware of at least one individual serving a fifteen-year sentence in the San Diego County Jail.[31] The provision of dental care in county jails has been substantially impacted since 2011 since the longer sentences carry with them a responsibility for providing more comprehensive care.

69. Prior to realignment, it was not unusual for dental care provided to people incarcerated in jails to be restricted to treating conditions associated with pain (*i.e.*, urgent care), while treatment for non-painful conditions (*i.e.*, routine care) was not provided. However, people incarcerated for a longer stays require a larger array of dental services. Consequently, jails must be prepared to provide longer-

[28] It is notable that there is only a 3 percentage point difference in untimely urgent care appointments between categories.

[29] It is notable that referrals made by the medical department led to more timely surgery because these referrals were generally to hospital emergency departments which bypassed the cumbersome NaphCare utilization management process.

[30] Couzens, J. R., & Bigelow, T. A. (2017). *Felony sentencing after realignment*. Retrieved August 13, 2024 from *www.courts.ca.gov/partners/documents/felony_sentencing.pdf.*

[31] *See* San Diego Who's In Jail search of [redacted].

term incarcerated people with the dental services that would have been provided if they were incarcerated in CDCR. Since California jails have evolved into a jail-prison hybrid, the scope of services provided and standard of care for San Diego County Jail should consider both jail and prison standards. Indeed, the Sheriff's Department's Chief Medical Officer, Jon Montgomery, agrees. As he explained in an email:

> In the California detentions / corrections system, individuals could potentially serve their prison time in a jail setting. A generalized "blanket" refusal of services (in this case, a root canal) … just because they are in jail … is discrimination by geographic location, and would be considered "deliberate indifference."

SD 227525.

70. To illustrate, the table below shows that in 2022 1,541 incarcerated people (2.9%) were in custody for more than six months, and 897 incarcerated people (1.6% of releases) were in custody for a year or more. So, while it is true that the vast majority are transients for whom only urgent care need be provided, there is a significant population for whom urgent care alone is insufficient.

Table 2. San Diego Sheriff's Department Releases from Custody by Length of Stay (LOS), 2022[32]

LOS Group	Number of Releases	Percent of Releases	Cumulative Percent
0 to 7 Days	39,857	73.9	73.9
8 to 14 Days	2,413	4.5	78.4
15 to 30 Days	2,309	4.3	82.7
31 to 90 Days	4,521	8.4	91.1
91 to 180 Days	2,362	4.4	95.5
181 to 365 Days	1,541	2.9	98.4
366 to 730 Days	602	1.1	99.5
731 or More Days	295	0.5	100.0
Total Releases	53,900		

[32] Data from "San Diego County Sheriff's Department Releases from Custody by

71. The demographics shown above have implications for dental staffing. First, jail admissions, as a class, have a substantial need for urgent care since many people bring with them the result of years of dental neglect. It is often not until they are incarcerated and are deprived of the drugs and alcohol that modified their threshold for pain that they become aware of their dental problems.[33] On the other hand, while people incarcerated in prison may have substantial urgent care needs when they are admitted, once they are stabilized, there will be less demand for urgent care. For that reason and the volume of admissions, jails require more dentists than prisons to provide timely care. Makrides et al., p. 557. Second, there should be sufficient staffing at the Jail to provide routine care to longer-term incarcerated people.

OPINIONS

72. My opinions and basis for them are as follows.

73. Dentists in a correctional setting should be prepared to treat at least the following dental conditions: odontogenic pain, dental caries, periodontal disease, gingivitis, pulpitis, lost fillings or crowns, fractured teeth, and chewing difficulty. Failure to diagnose and treat these conditions in a timely manner can have a serious effect on incarcerated people's overall health and wellbeing. Critically, dental conditions when untreated can result in gratuitous pain and tooth morbidity and mortality (*i.e.*, tooth loss). Each of these conditions and their means of diagnosis is explained in more detail in **Exhibit D** to this report.

74. In addition, nearly all dental conditions are progressive, *i.e.*, they get worse over time. For that reason, timely care is critical to ensure that dental conditions do not progress, resulting in otherwise preventable tooth loss. As part of

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Length of Stay (LOS) and Release Year January 1, 2021, to July 31, 2023." Note 2022 is the last year for which complete data are available. SD 105822.

[33] Shulman JD, Sauter DT. Treatment of odontogenic pain in a correctional setting. *Journal of Correctional Health Care* (2012) 18:1, 62-63 (*hereinafter* "Shulman and Sauter").

the standard of care, this report lays out specific timeframes for certain examinations and treatment, which are necessary to ensure that dental conditions do not progress.

75. Under the terms of the June 2022 NaphCare contract for provision of health care services at the Jail, NaphCare is "the prime provider for oral care services" at the Jail. County Contract No. 566117, SD 125534. NaphCare was instructed to "establish dental services in accordance with guidelines for dental evaluation and treatment," including with a "priority system," and include the following services: "[e]mergency and routine dental care," "[t]emporary fillings," "[i]ncision and drainge," "[c]ontrol of bleeding," "[n]ecessary emergency surgery," "[c]linically indicated extractions," "[r]eferral to dental specialist if needed," and "[m]edically necessary dental-related prescriptions." SD 125535.

76. As explained in more detail below, it is my opinion that the Sheriff's Department—through its contract with NaphCare and its failure to conduct appropriate direction and oversight of that contract—fails to provide adequate dental care to incarcerated people at the Jail. As a result of those failures, incarcerated people at the Jail face a risk of substantial harm, including gratuitous pain and loss of tooth structure and teeth in the long term.

A. Untimely Urgent Care

77. In my opinion, based on a reasonable degree of certainty, the Jail's treatment of incarcerated people with painful conditions is untimely—and therefore inadequate—as to both onsite care and offsite referrals.

78. Urgent care is treatment for painful conditions such as a toothache, a common complaint of incarcerated people. Because dental conditions can progress absent timely treatment, it is important that a dental program have appropriate policies, procedures, protocols, and enough treatment capacity to ensure that the treatment of painful conditions is sufficiently timely to prevent gratuitous pain. All incarcerated people should be provided timely urgent care.

79. As explained in more detail below, incarcerated people complaining of

a toothache should be **seen by a dentist within 3 business days**, unless they have been started on antibiotics, are experiencing severe pain, or their pain cannot be managed by analgesics, in which case they should be **seen by a dentist the next business day**. The dentist must then devise a treatment plan to remove the infection and manage the incarcerated person's pain and schedule the incarcerated person for treatment by date certain, as determined by reasonable exercise of the dentist's clinical judgment. Incarcerated people referred to an oral surgeon for the extraction of infected teeth should have the teeth extracted **within three weeks**.

80. Failure to meet these timelines for urgent care can negatively affect the health of incarcerated people in multiple ways. First and foremost, it results in gratuitous pain. Second, it can lead to the progression of dental conditions, possibly resulting in unnecessary tooth loss. And finally, it generally results in several otherwise unnecessary courses of antibiotics. Prescribing antibiotics unnecessarily is not a benign practice. Bacterial resistance to antibiotics has been clearly associated with exposure to antibiotics, the inappropriate and the increased volume of which has elevated bacterial resistance to a major public health concern and has made an increasing number of infectious diseases difficult to treat. Shulman and Sauter at p. 67.

81. Sheriff's Department's Policy MSD.D.2 purportedly lays out a priority system for dental care, with timeframes for different types of emergent and urgent care.[34] However, none of the charts I reviewed used the classification system to indicate the level of within the "urgent" category. In fact, there is no place on the dental chart for these levels to be recorded. Based on my chart reviews, the system

[34] San Diego Sheriff/s Department, Medical Services Division, Operations Manual. Dental Services: Emergency & Routine. Policy MSD.D., 11/4/2002. While the definition of Emergency care is standard among correctional institutions, the Jail's classification of Urgent Care parallels the Dental Priority Classifications ("DPC") used in CDCR. CDCR Health Care Operations Manual, 3.3.5.4 (Dental Priority Classifications), Appendix 1. Specifically, DPC 1A (treatment within 1 calendar day), DPC 1B (treatment within 30 days), and DPC 1C (treatment within 60 days).

described in MSD.D.D2 is at best theoretical. Indeed, the Sheriff's Department appears to be unaware of what the appropriate timeframe for dental care is. The March 4, 2024 Corrective Action Notice ("CAN") response includes this question: "What is the (correctional) industry standard for dental sick call wait times? What are NCCHC standards? NaphCare stated there are no standards or thresholds." SD 1572589.

82. As explained below, it is my opinion that, in practice, the Sheriff's Department fails to provide urgent care to incarcerated people in a timely fashion, both in its onsite dental clinics and via offsite referrals.

1. Untimely Onsite Treatment for Painful Conditions

83. In my opinion, based on a reasonable degree of certainty, the Jail's onsite treatment of incarcerated people who complain of painful dental conditions is inadequate because it is untimely.

84. Incarcerated people experiencing painful dental conditions should be examined by a nurse practitioner ("NP"), physician assistant ("PA"), or physician ("MD" or "DO") within 24 hours of the complaint being received by the facility staff. The NP, PA, or physician may prescribe antibiotics for dental abscesses at that preliminary examination, as appropriate. However, all incarcerated people complaining of dental pain must be scheduled to see a dentist, since only a dentist is qualified to make a definitive diagnosis on dental issues and determine the clinically appropriate sequence of care. Shulman and Sauter at p. 56.

85. Incarcerated people who (a) complain of severe dental pain (*i.e.*, pain that interferes with normal daily activities, such as eating and sleeping), (b) are prescribed antibiotics for dental pain, or (c) whose pain is not relieved by analgesics such as Tylenol should be seen by a dentist within one business day of their preliminary examination by a non-dentist.[35] Incarcerated people complaining of

[35] I use the term "business days" as opposed to "clinic days" because correctional

pain that is not severe, who have no signs of infection, and whose pain can be managed by analgesics such as Tylenol should be seen by a dentist within three business days.

86. At the dental appointment, the dentist should: diagnose the source of the problem; determine the appropriate course of treatment; and, if treatment cannot be provided the same day, schedule the incarcerated patient for follow-up treatment on a date certain, as dictated by a reasonable exercise of the dentist's clinical judgment. In the case of odontogenic infections where an antibiotic has been prescribed, the dentist should remove the source of the infection, *i.e.*, establishing drainage through the tooth or extracting the non-restorable tooth, while the patient has a therapeutic blood level of the effective antibiotic: typically, between seven and ten days after the patient began taking antibiotics. Shulman and Sauter, p. 66. Failing to schedule an appointment for treatment, or simply adding the incarcerated person to a waitlist for a follow-up appointment without reference to a specific follow-up date, does not meet the standard of care.

87. More detail on the appropriate treatment for various dental conditions is included in the section on Routine Care, *infra*. The same standards of care for those conditions apply regardless of whether the condition was diagnosed at an urgent care appointment or a routine care appointment. However, the need for dental care remains urgent—as opposed to routine—until the source of infection is removed or the pain is mitigated.

88. Under Sheriff's Department Policy M.17, incarcerated people complaining of dental pain are generally directed to write their request for dental

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institutions may not circumvent these timeliness requirements by limiting the number of days that the dental clinic is open. However, in institutions that have a dental clinic—staffed by a dentist—open at least four days per week, it may be appropriate to state this standard as "the next clinic day" as opposed to "within one business day." Note that the "three business day" timeliness standard for incarcerated people with pain that is not severe, who do not show signs of infection, and whose pain can be managed by Tylenol or other analgesics remains the same.

care on a sick call slip. SD 0115784. Those sick call slips are triaged, and incarcerated people are seen initially by "health staff." *Id*. If health staff determine that "a need exists, the incarcerated person will be scheduled for the earliest possible dental appointment." *Id.* In particular, based on my review of documents and conversations with staff during the inspection, I understand that the initial interactions, triage, and dental sick call scheduling are completed by nurses.

89. My review of the charts showed that timely treatment for urgent conditions was a rarity. Rather, in most instances documented in the dental records, both those provided by Defendants and those that I selected from interviews on the inspections, incarcerated people waited weeks—if not months—to be evaluated and treated by a dentist after complaining of pain, as described in more detail in Exhibit C. This falls well below the standard of care. And, because of the Jail's untimely treatment, incarcerated people experience gratuitous pain, tooth morbidity, preventable courses of antibiotics, and tooth mortality.

90. According to my review of the records, delays affected incarcerated people's access to dental care in two stages of the process: (1) the time between an incarcerated person's complaint of dental pain and their evaluation by a dentist, and (2) the time between being evaluated by a dentist and provided with treatment for that pain.

91. First, my review of the medical records provided shows that untimely dental evaluations—*i.e.*, evaluations *by a dentist*—of people reporting tooth pain to determine the source of that pain are the norm in the Jail. For example, [redacted] notified the Jail about "a painful tooth" that "need[ed] to be pulled" via sick call slip on [redacted], 2023, but had not seen a dentist as of [redacted], 2024—**75 days later**. SD 1008641. [redacted] again requested "teeth extractions" via sick call slip on [redacted], 2023, SD 1013567, but was not scheduled to see a dentist until [redacted], 2024—**38 days later**, SD 1013610- 14. These examples (and the many others documented in Exhibit C) fall far short of the three-day

waiting period that is the standard of care. Of the 199 urgent care appointments I reviewed, 176 (88.4%) fell **outside** the three-day standard of care.[36] As noted above, these calculations **understate** the extent of untimely care in the Jail, given that I stopped the clock as of the date a person awaiting care was released from the Jail, even if they did not receive any treatment, and that I have assumed for purposes of this report that all documented "refusals" are accurate.

92. Other documents produced by Defendants confirm that patients complaining of dental pain frequently wait far longer than three days to see a dentist. NaphCare's "Completed Dental Sick Calls Report" for December 2023, NAPHCARE034741, provides an example. Angela Nix, on behalf of NaphCare, explained that the "Appt Created" notation is the date that a dental appointment for a particular individual was "generated," *e.g.*, requested by a nurse after a sick call request was reviewed. Nix I Tr. 214:1-12.[37] The "Completed Date" notation is the date the patient was seen at the dental clinic. *Id.* at 214:22-24. Ms. Nix later testified that "Completed Date" could also be the date the appointment was cancelled automatically in TechCare if the patient was released from the jail. *Id*. at 218:12-219:4.

93. The December 2023 Completed Dental Sick Calls Report reveals numerous instances in which the "Appt Created" date is well over a week prior to the "Completed Date," for visits related to urgent care. For example:

- [redacted]

[36] According to the March 4, 2024 response to the CAN, the Sheriff's Department and NaphCare have been applying a seven-day waiting period. SD 1572589. Even under that waiting period—which in my opinion is too long and requires incarcerated people to suffer gratuitous pain—the charts I reviewed show that most urgent dental care is untimely.

[37] Several of the entries indicate that dental sick call appointments were generated when a person is booked at the Jail, for a potential routine care appointment. Those entries are not relevant to my analysis of urgent care. The flaws with the Jail's routine care program are discussed *infra*.

- [redacted]
- [redacted]
- [redacted]
- [redacted]

NAPHCARE034741. The list goes on. *See id.* Critically, the Completed Dental Sick Calls Report represents only part of the delay incarcerated people experience while waiting to receive urgent dental care. It does not reflect any delays between an incarcerated person first requesting care, *e.g.*, in a sick call request form, and a Jail staff member generating the appointment request in the system. For example, as explained above, [redacted] again submitted a sick call slip for a toothache dated [redacted] 2023, SD 1006882, but was not seen by a dentist until [redacted], 2023. The Dental Sick Calls Report for [redacted] 2023 reflects [redacted] "Completed" appointment on [redacted], but it reflects an "Appt Created" date of [redacted], 2023—16 days after [redacted] initially requested to see the dentist. In other words, the delays incarcerated people experienced in receiving care are likely even longer than the delays reflected in this spreadsheet.

94. Notably, the Sheriff's Department also relies on nurses (RNs) to "treat" dental pain without seeing a dentist every time—a practice that falls below the standard of care. Indeed, Ms. Nix, testifying on behalf of NaphCare, stated that some complaints of dental pain are not reviewed by a dentist. Nix II Tr. at 57:20-58:2 ("If it's just a general toothache, and Tylenol would help, that may not require a dentist."). Based on my review of the records, it appears that nurses in the Jail are instructed to conduct a preliminary evaluation of incarcerated people complaining of dental pain, which is documented on a Dental Complaint form in TechCare. *E.g.*, Dental Complaint form for [redacted], [redacted] 2023, SD 824889-91. The

Dental Complaint form itself lists multiple options for the nurse's course of action after the evaluation, one of which is "Refer to Dentist or Advanced Clinical Practitioner (ACP) for sick call if infection or severe pain present." *Id.* at SD 824890. That instruction suggests that nurses should *not* refer a patient to dental sick call *unless* there is an infection or "severe" pain. Several of the charts I reviewed contained Dental Complaint forms in which the "Refer to Dentist" option is not selected. **However, an evaluation by a nurse is not a substitute for one by a dentist, nor does it restart the three-day waiting period dictated by the standard of care.**

95. In the records I reviewed, there were numerous examples of incarcerated people complaining of dental pain, then being seen by a nurse following that complaint, but still not seeing a dentist in timely manner. For example, [redacted] notified the Jail that he had a toothache causing him pain when eating on [redacted] 2023. SD 825184. Nursing staff filled out two dental complaint forms for [redacted]: on [redacted] 2023, SD 824889-91, and on [redacted] 2023, SD 824892-93. However, [redacted] still had not been evaluated by a dentist as of [redacted] 2024—**82 days after** he initially notified the Jail of his toothache. Similarly, [redacted] notified the Jail that she was experiencing tooth pain via sick call request on [redacted], 2023. SD 1006583. A nurse filled out a dental complaint form regarding [redacted] on [redacted] 2023, SD 1006538-40, but there is no indication that [redacted] was seen by a dentist by the time she was released on [redacted] 2023 release—**32 days after** she notified the Jail of her toothache.

96. Relatedly, I found multiple instances of dental assistants filling out examination forms at dental sick call, without any indication that a dentist was present. *E.g.*, [redacted], SD 826071 – 826076. Completing an examination of a patient—or interpreting x-rays or diagnosing dental conditions—is beyond the scope of a dental assistant's practice. A dental assistant is not a replacement for a

dentist. Therefore, if dental assistants attempt to complete such an examination, they only succeed in further delaying an individual's care, because the person still needs to be seen by a dentist. To the extent that the Sheriff's Department is attempting to have dental assistants provide care to incarcerated people *instead of* dentists, that falls below the standard of care.

97. Second, even after a patient complaining of dental pain is evaluated by a dentist, the Jail routinely fails to timely provide the treatment recommended by the dentist and agreed to by the patient. Multiple examples in the records I reviewed show dentists (finally) seeing a patient in pain, diagnosing caries, marking the decayed tooth for extraction, noting that the patient agreed to the extraction, but neither extracting the tooth during that examination nor scheduling the patient for a timely follow up appointment.

98. The case of [redacted] decayed tooth #3 is illustrative. [redacted] reported a dental problem to the Jail via sick call slip on [redacted] 2021, SD 1005835, and was not seen by a dentist for 22 days, SD 1005874. During her [redacted] 2021 dental appointment, Dr. Polanco determined that tooth #3 was decayed, and [redacted] elected to have it extracted. SD 1005874-77. However, Dr. Polanco did not extract the tooth that day, nor did he schedule [redacted] for a follow-up appointment. SD 1005875-77. Despite [redacted] submission of additional sick call slips, she was not seen by a dentist, nor was tooth #3 extracted as of her [redacted] 2021 release—**80 days after Dr. Polanco determined that it should be extracted**. [redacted] was rebooked into the Jail in 2022 and submitted sick call request asking to "see dentist" for a "tooth pull[]" on [redacted] 2022. SD 1006227. On [redacted] 2022, Dr. Patel examined [redacted], prescribed antibiotics and analgesics, and marked tooth #3 for extraction.[38] SD 1006266-70. Because Dr. Patel diagnosed an abscess and prescribed an antibiotic, she should have

[38] Dr. Patel marked tooth #13 as being decayed and restorable. SD 1006267.

scheduled an extraction appointment within the therapeutic window of the antibiotic, *i.e.*, before [redacted] 2022. However, no such appointment was scheduled. *Id.* [redacted] submitted another sick call slip asking to have the tooth pulled on [redacted] 2022, SD 1006234, but was not seen by Dr. Patel again until [redacted] 2022, when she is documented as having declined an extraction of tooth #3. SD 1006305-09. Three days later, [redacted] asked via sick call request "[t]o see the Dentist" because she "need[ed] a tooth pulled." SD 1006243. However, there is no indication that [redacted] was seen by the dentist prior to her [redacted] 2022 release. *See* SD 1575334. [redacted] was rebooked in the Jail on [redacted] 2022 and again asked to see a dentist via sick request on [redacted] 2022. SD 1006440. [redacted] was seen by Dr. Polanco on [redacted] 2022, who finally extracted tooth #3 that day—**one year and 20 days after he first determined it should have been extracted**. SD 1006460-64. Had Dr. Polanco scheduled an appropriate follow-up appointed following his [redacted] 2021 evaluation determining that [redacted] tooth #3 should be extracted, it would have saved [redacted] from months of pain while incarcerated and unnecessary courses of antibiotics.

99. In my opinion, a principal cause of this consistent untimeliness is inadequate dentist staffing. Defendants' persistent staffing failures, including Defendants' failure to remedy these issues despite multiple contract amendments, are described in more detail *infra*. In short, having only two dentists (or the full time equivalent of at most two dentists) to support an average daily population of approximately 4,000 is woefully deficient. Director of Nursing Serina Rognlien-Hood testified that "there a lot of dental complaints" and that the Sheriff's Department recognizes there is a long wait list to see the dentist, in part due to insufficient dental staffing. Rognlien-Hood Tr. 35:11-37:25.

100. In addition, it is my opinion that Defendants' system requiring custody staff to escort patients to the dental clinic and limitations on the availability of

custody staff to do so attributes to the consistent untimeliness of urgent dental care. Ms. Nix, who testified on behalf of NaphCare, explained that, in order for incarcerated people to be seen in the dental clinic, NaphCare first "provide[s] the command staff [with] a list of patients" to be seen on a given day, then "coordinate[s] with [command staff] whether those patients can be brought to a clinic, [or] whether those patients have to be seen in a housing unit." Nix I Tr. 231:5-11. If "a patient is needed to be seen urgently that wasn't on the list when it was produced, then … we would communicate that with the custody staff." *Id.* at 231:14-17.

101. According to NaphCare, the coordination with custody staff is not always seamless. On May 24, 2023, NaphCare informed the Jail that they "continue to receive reports from our dental staff that they are unable to access the patients as needed." Response to Corrective Action Notice, May 24, 2023, NAPHCARE034658. An email from Dr. Patel provides an example of one such report on June 6, 2023 at George Bailey. Email from D. Patel to M. Farrier, June 6, 2023, SD 556249. Dr. Patel documented multiple attempts to obtain custody staff coverage, which would enable her to see patients on June 6, 2023, but was told that the facility was "short staffed." *Id.* As a result, she reported that she only had custody staff coverage for 2 hours and 15 minutes that day, limiting her ability to see any dental patients. *Id.*

102. Indeed, former Assistant Sheriff Theresa Adams-Hydar agreed that inadequate custody staffing could prevent incarcerated persons from attending dental appointments. Adams-Hylar Tr. 137:9-139: 4.

103. This coordination is even more critical for incarcerated people in a high security status who must be escorted or require other special security arrangements. Shulman et al., pp. 8-16, 8-17. In my experience monitoring prison and jail programs, incarcerated people in restricted housing have less access to care since they are dependent on custody escorts and subject to movement constraints.

104. The Jail needs to study how frequently custody staff unavailability leads to delayed access to dental care, including whether this is more common at certain facilities, and create a corrective action plan.

105. Finally, the documents I reviewed and my inspection of the Jail suggest that equipment malfunctions also contribute to delays in the provision of urgent care. On the day I visited Las Colinas on February 8, 2024, a handwritten sign indicated that the x-ray machine was broken. The medical records of [redacted] indicate that the x-ray machine at Las Colinas was similarly broken on January 25, 2024. SD 837496-501. Other records indicate equipment failures at other Jail facilities as well, *e.g.*, suction equipment broken on December 4, 2023, [redacted], SD 841562; equipment broken on June 20, 2023, preventing completion of prophy, [redacted] Medical Records, SD 825095-101. Each of these equipment failures contributed to delays in care for incarcerated people. While I did not review enough charts to determine the extent to which equipment downtime contributes materially to untimely care, these examples are troubling. This should be studied by the Sheriffs' Department and NaphCare and eventually be followed during monitoring.

2. Untimely and Denied Offsite Treatment for Painful Conditions

106. In my opinion, based on a reasonable degree of certainty, the Jail's referral process for providing incarcerated people with oral surgery treatment is inadequate and results in untimely care. While the Jail sends incarcerated people for offsite oral surgery, that surgery is generally untimely. This causes incarcerated people gratuitous pain and preventable courses of antibiotics.

107. Offsite treatment by an oral and maxillofacial surgeon is required for some dental conditions such as maxillofacial fractures, removal of skeletal fixation

hardware, severe infections, and complicated extractions.[39] Jails are responsible for arranging such referrals in a timely manner, as follows:

108. Incarcerated people with oral infections or fractures that interfere with breathing and swallowing should be referred to a hospital emergency department **immediately** upon the physician or dentist's diagnosis of the condition. These are potentially life-threatening conditions and must be treated by the emergency department's on-call surgeon. Shulman and Sauter, p. 67.

109. Incarcerated people with other maxillofacial fractures should be **referred** to an oral surgeon **the next business day**.

110. Incarcerated people who are admitted with intermaxillary fixation and cannot open their mouths or have pain related to the skeletal fixation hardware, should be **seen by an oral surgeon** to have the hardware removed **within a week of diagnosis**.

111. Incarcerated people with infections associated with teeth requiring extraction by an oral surgeon without such complications (progressing to cellulitis, spreading to facial spaces, difficulty breathing or swallowing) should be **seen** by a surgeon for the extraction **within three weeks**.[40]

112. For a patient to be referred to an oral surgeon, NaphCare must approve the request for a referral. According to Ms. Nix, who testified on behalf of NaphCare, the approval process for referrals to an oral surgeon is no different from the process for any other outside medical provider. Nix I Tr. at 222:20-25. Dr. Montgomery, on behalf of the Sheriffs' Department, testified that NaphCare's utilization management ("UM") team evaluates the appropriateness of referrals requested by their contracted providers. The UM team consists of nurses and is based in Birmingham, Alabama. Nix II Tr. at 75:9-14. If the UM team approves the

[39] I use the slightly abbreviated "oral surgeon" throughout this declaration.

[40] San Diego is a major metropolitan area, and there is no shortage of oral surgeons.

request, it is sent to the Sheriff's Department's for scheduling by its managed care team that has points of contact at various hospitals. The schedulers would coordinate the appointment with the Sheriff's transportation unit. Montgomery II Tr. 215:11-216:16.

113. In practice, my review of the records reflects that the Jail consistently fails to meet the timeliness standards outlined *supra*. Of the 21 charts produced by Defendants in the offsite referral group that I reviewed, 15 charts documented that the requested surgery was completed and 6 had an imputed endpoint (*i.e.*, when the person was released before receiving surgery). In those 15 completed surgeries, the median time from initiating a referral to the completion of surgery was 89 days compared to 94 days when the six patients with imputed endpoints were included. This is untimely and resulted in gratuitous pain and preventable courses of antibiotics. It is noteworthy that three wait times less than 10 days were referrals to a hospital emergency department, which I understand bypassed the typical NaphCare utilization management process.

114. It is my opinion that the outside referral approval process—which is governed by NaphCare—contributes to this delay. Director of Nursing Serina. Rognlien-Hood acknowledged in her deposition testimony that there may be lags in obtaining appointments for off-site services, and that the Sheriff's Department is required to "get approval from NaphCare for the outside [] referral, and then we're at the mercy of whoever NaphCare has contracted with to get that appointment." Rognlien-Hood Tr. at 35:20-36:6.

115. For example, [redacted] was evaluated in the Jail by Dr. Patel on [redacted] 2023, at which point Dr. Patel noted that she would refer [redacted] to see an oral surgeon. SD 863387. [redacted] was seen by an outside oral surgeon, Brian Mudd, on [redacted] 2023, at which point Dr. Mudd completed an "oral surgery evaluation/treatment plan," on which he indicated that [redacted] wisdom teeth should be extracted under sedation. SD 863598-600. Dr. Mudd also

noted that [redacted] had periodontal disease. *Id.* However, as of [redacted] 2024, [redacted] had yet to return to Dr. Mudd to receive the treatment he proposed—**113 days after Dr. Patel initiated the referral**.

116. In addition to the delays imposed by NaphCare's referral process, it is my opinion that incarcerated people are denied access to oral surgeons to treat painful conditions because the Jail's dentists fail to initiate appropriate referrals. The medical records I reviewed contain multiple examples of dentists evaluating a patient complaining of pain, determining that an extraction should be done by an oral surgeon, and merely informing the patient that they would need to seek an oral surgeon in the community. Unless an individual's discharge is imminent, a dentist's failure to refer the patient to an oral surgeon to treat a painful condition that is beyond the dentist's skill set is below accepted professional standards.

117. For example, [redacted] was evaluated by Dr. Patel in the Jail on [redacted]2022. SD 860735-39. During that appointment, Dr. Patel noted that he requested that his painful third molar be extracted under IV sedation, but she informed him that the Jail does not administer IV sedation. SD 860739. She prescribed an antibiotic and analgesic but did not schedule a follow-up appointment, nor did she request an oral surgery referral. *Id*. Her failure to make an oral surgery referral was below accepted professional standards.

118. As another example, [redacted] appears to have been advised that he should wait until he got to "state prison" to see an oral surgeon for extractions of four teeth. SD 853274. As with the preceding exemplars, a dentist's sloughing the patient to the "next" facility in this manner violated the standard of care.

119. Unless the dentist knew that the patient was scheduled to be discharged soon, it is a professional responsibility to make an appropriate referral—and not kick the can down the road by advising the patient to see an oral surgeon in the community. This behavior violates the standard of care.

B. Inadequate Routine Care

120. Routine dental care comprises the diagnosis and treatment of asymptomatic or non-painful dental conditions. Timely diagnosis and treatment of such conditions is important because it allows for treatment before the condition progresses to the point that it causes pain and preventable loss of tooth structure or results in a previously restorable tooth becoming non-restorable. As the NCCHC has explained:

> ***Delaying or deferring restorative care in a correctional setting simply leads to an increase of oral pain, infection, or tooth loss***. As a result, dental services become inundated with emergency dental sick-call requests and more procedures to replace lost teeth with removable prosthetics.

Adu-Tutu and Shields, p. 4 (emphasis added).[41]

121. In particular, routine care includes initial and annual dental examinations (a periodontal screening is performed, intraoral radiographs are taken as clinically appropriate, and a treatment plan is made); restoration of caries; diagnosis and treatment of periodontal diseases; oral prophylaxis (cleaning or prophy); and endodontic treatment.

122. Unlike urgent care, in a correctional setting, routine care may be limited to only the small proportion of admissions who will be incarcerated long enough to be examined and scheduled for such appointments, *i.e.*, incarcerated people who have been sentenced to local custody and those detainees awaiting trial for serious offenses and who have been denied or are unable to make bail.[42]

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[41] Adu-Tutu M, Shields TE (2008). Guidelines for a Correctional Dental Health Care System. National Commission on Correctional Health Care Guidelines. Note: this document was in Appendix G (at 167). It is not in the most recent (2018) Standards but is available on-line at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ncchc.org/wp-content/uploads/Dental-Health-Care-2014.pdf

[42] For example, less than 5 percent of those placed in the Jail will be in custody after 6 months. Moreover, incarcerated people who are awaiting trial for serious felonies and are unable to make bail are expected to have long stays until they go to trial.

123. It is my opinion that the Jail fails to provide routine care to people who are incarcerated in the Jail for an extended period.

124. Neither NaphCare nor the Sheriff's Department policy appears to specifically outline the scope of routine care services that are offered by the Jail. In fact, Sheriff's Department Policy MSD.D.2, which purports to describe "Emergency and Routine Dental Services," speaks at length about emergency and urgent care, but consigns routine care to "all other dental care." Section F. In particular: "All other dental care will be provided on a case by case basis. It will be determined based on the patient's symptoms, oral pathology, and treatment required to restore the patient's ability to function including but not limited to the patient's ability to chew and maintain adequate nutrition." *Id*. Similarly, the NaphCare Policy generally defines "Oral Care" as "[i]nclud[ing] instruction in oral hygiene (plaque control, proper brushing of teeth) and examination, and treatment of dental problems." NAPHCARE001023. It defines "Oral Treatment" as "[t]reatment provided according to a treatment plan based upon a system of established priorities for care, including a full range of services that in the supervising dentist's judgment are necessary for proper mastication and maintaining the inmate's health state, not limited to extractions." *Id*. Both policies are overly general.

125. In considering the Jail's provision of routine care, it is critical to note the distinction between scope of care—that is, the array of services provided—and quality of care. While the scope of care at the Jail is limited compared to a private practice and may be based on length of incarceration, it should include (at a minimum) *timely* examinations, extractions, pulpectomies, temporary and permanent restorations, limited endodontics, limited periodontal therapy, and removable prosthetics. Makrides et al., 2006 at p. 557. Yet, regardless of any limitation on the scope of care, ***the quality of the care provided is the community standard***.

126. In my opinion, based on a reasonable degree of certainty, the routine

care provided to incarcerated people is inadequate for the following reasons, and as explained in more detail below: (1) initial and annual examinations are not in conformance with accepted professional standards; (2) the Jail does not adequately diagnose or treat dental caries as required by accepted professional standards, including by failing to provide permanent restorations; (3) the Jail does not adequately diagnose or treat periodontal disease as required by accepted professional standards; (4) the Jail does not provide adequate preventative care, *i.e.*, cleanings; and (5) the Jail does not provide adequate endodontic treatment.

1. Inadequate Initial and Annual Examinations

127. In my opinion, based on a reasonable degree of certainty, the initial and annual examinations are inadequate both because they rarely occur within the required timeframe—if at all—and they are not informed by documented periodontal probing and bitewing x-rays. Consequently, caries and periodontal disease are underdiagnosed, allowing these conditions to progress to the point of gratuitous pain, loss of tooth structure, or tooth loss.

128. At the heart of routine care is an examination and treatment plan. Both in correctional facilities and in the community, new patients to a practice should receive an initial examination and follow-up examinations every year ("annual examinations"). The scope of the initial and annual examinations is the same. Such examinations include "taking or reviewing the patient's oral history, an extraoral head and neck examination, charting of teeth, periodontal assessment, and examination of the hard and soft tissues of the oral cavity with a mouth mirror and explorer." NCCHC, J-E-06, p. 98.[43] In addition, both initial and annual examinations must be informed by x-rays. For example, in CDCR, an initial examination includes adequate x-rays; a visual examination and charting to include

[43] *See also* Shulman et al, p.8-16; Information Gathering and Diagnosis Development Stefanac, p. 3 ("Accurate diagnostic information forms the foundation of any treatment plan. This information comes from the patient history, radiographs, and the clinical examination.").

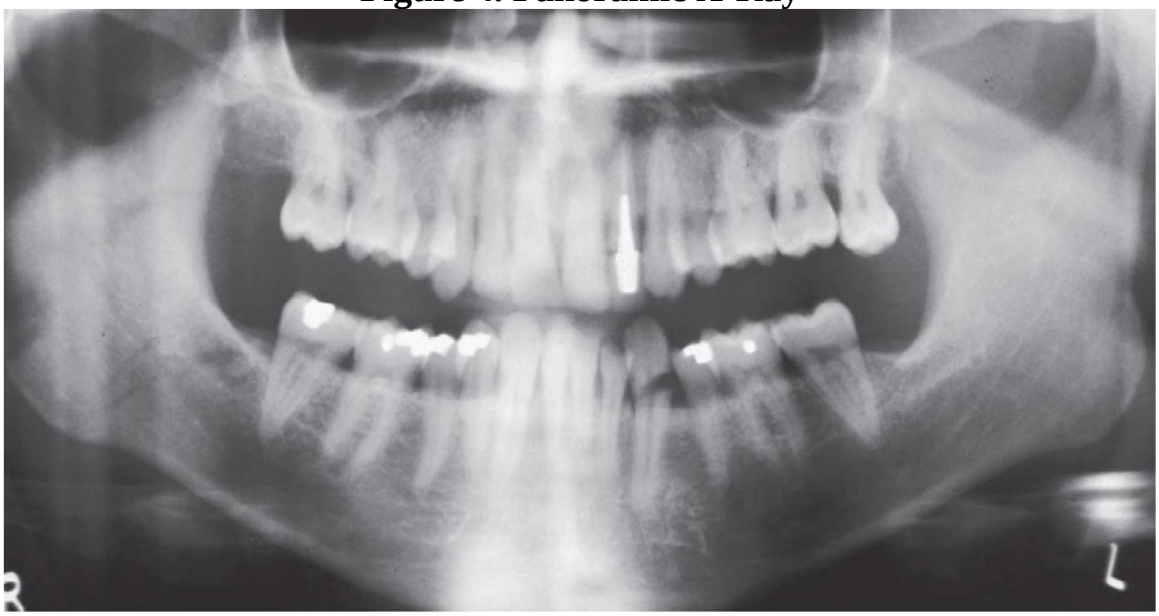
existing restorations, missing teeth, and dental decay; oral cancer screening; recording the plaque index; a comprehensive periodontal examination; a health history; and formulation of a sequenced treatment plan. Similarly, in the Federal Bureau of Prisons, an examination includes, among other things, a complete periodontal examination and necessary radiographs. Notably, these initial and annual examinations are different in scope from what a dentist would do at an urgent or sick call appointment, which is typically a more limited, problem-focused examination.

129. Two elements of the initial and annual examinations bear slightly more description: periodontal probing and x-rays. First, periodontal probing is the measurement of pocket depths to evaluate gum health. The screening standards for periodontal probing are described in the section on periodontal disease in **Exhibit D**.

130. Second, x-rays taken at initial and annual[44] examinations should include both panoramic and intraoral (either bitewing or periapical) x-rays. These different types of x-rays are important because they allow for different types of diagnoses. In particular, a panoramic x-ray (Fig. 4) displays a wide area of the jaws and helps detect developmental anomalies, pathologic lesions of the teeth and jaws, or other bone fractures.

[44] The frequency of different kinds of x-rays in follow-up annual examinations can vary based on a dentist's reasonable clinical judgment, considering the patient's risk of caries.

Figure 4. Panoramic X-Ray



131. But, because of the lower resolution and superimposition of structures on the film in a panoramic x-ray, it does not have the fine detail necessary to document periodontal bone loss or smaller lesions in between the teeth. Instead, intraoral x-rays more effectively show those conditions. There are two types of intraoral x-rays: periapical (Fig. 5) and bitewing (Fig. 6).

Figure 5. Periapical Radiograph

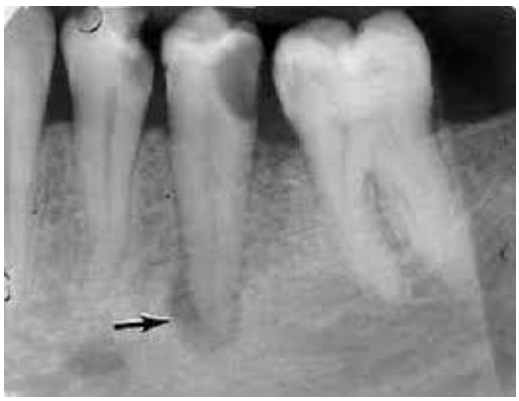
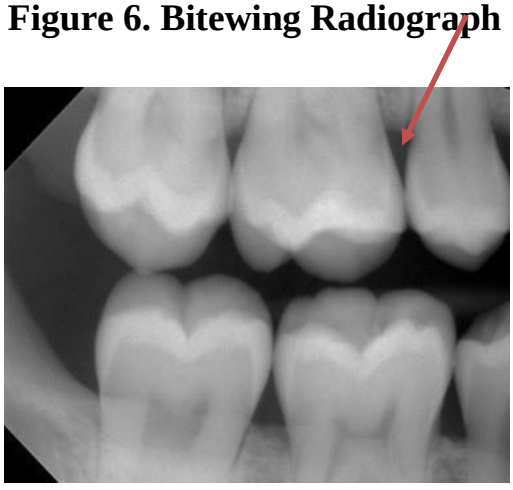


Figure 6. Bitewing Radiograph



132. Periapical x-rays show the entire tooth (including the root, see arrow in Fig. 5) and the surrounding bone, and bitewing x-rays show the crowns of the teeth in both arches and the alveolar crestal bone (the bone in between the teeth, see red

arrow in Fig. 6). These x-rays, unlike a panoramic x-ray, can show early caries in between the teeth and document signs of periodontal and periapical disease.

133. Correctional institutions have a responsibility to provide initial examinations consistent with these professional standards—*i.e.*, including both periodontal probing and both panoramic and intraoral (likely bitewing) x-rays—to incarcerated people. The NCCHC requires that jails provide an initial examination within 12 months of admission, though the timeframe for prisons is 30 days. J-E-06, Compliance Indicator 6, p. 98. However, that standard alone is insufficient for the Jail's population, which includes 1.6 percent of incarcerated persons whose Jail stays are 12 months or more, and incarcerated people who serving a prison sentence in the Jail. *See supra*. Therefore, waiting 12 months for an examination is inappropriate for both sentenced incarcerated persons in the Jail and those awaiting trial for serious felonies who cannot post bail. These incarcerated people should be examined within 30 days of admission and should be appointed for routine care if they request it.

134. Both in policy and in practice, the Sheriff's Department fails to meet these standards. Initial and annual examinations do not consistently occur in the required timeframes and, to the extent there are any such examinations, the examinations themselves are not consistent with professional standards.

135. By policy, NaphCare's Policy Manual defines "Oral Examination" as being "[p]erformed only by a licensed dental staff and completed within twelve (12) months of admission, including taking or reviewing the patient's oral history, an extraoral head and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral cavity with a mouth mirror, explorer, and adequate illumination." NAPHCARE001023. However, I have seen no policy documents describing the scheduling process for initial or annual oral examinations are scheduled in the Jail. However, deponents stated that the initial examination should be automatically scheduled after an incarcerated person completes the receiving

screening process, for some time within the first twelve months of their incarceration. Nix I Tr. 220-221.

136. In practice, it is not clear whether—and if so, how—incarcerated people are informed that they have been scheduled for an initial dental appointment. In fact, one of the issues raised by the Sheriff's Department in its Corrective Action Notices was that NaphCare did not have a process in place to effectively respond to annual/periodic cleanings. According to the Corrective Action Notices, many incarcerated patients have missed appointments and have been forgotten due to the inability of dental staff to schedule referrals or follow-up.

137. My review of the medical records produced indicates that initial and annual examinations are untimely if they occur at all. Several of the individuals whose records I reviewed had been incarcerated for over a year, but had not had an initial examination performed, nor any annual examinations. *E.g.*, [redacted] and [redacted], as discussed in **Exhibit C**.

138. Other people who were incarcerated in the Jail for over a year received untimely initial examinations. For example, [redacted] was first scheduled to see the dentist on [redacted] 2021—nearly fourteen months after he was booked into the Jail on [redacted] 2020. SD 825202 (sick call summary). He is documented as having refused the appointment. SD 825650; 826285. However, given the Jail's apparent lack of a system to notify incarcerated people that they can receive an initial dental examination, it is possible that [redacted] did not know what he was refusing (if he did in fact refuse—neither refusal form is signed by him). Dr. Montgomery testified that annual examinations should be scheduled as a matter of course during the booking process. Montgomery II Tr. 282:17-283:12; Nix I Tr. 220:3-221:6. However, Ms. Nix—testifying on behalf of NaphCare—did not know whether the annual exam date was communicated to the incarcerated person but instead said that Dr. Pandit, the NaphCare Dental Director "has oversight into compliance of the dental program in general." Nix I Tr. 221:3-22.

139. Notably, any initial "screening" conducted by a nurse does not satisfy the initial examination requirement. According to the Rule 30(b)(6) testimony of Dr. Montgomery, the Jail has recently begun conducting a "brief dental examination … for purposes of triage" of all incarcerated people within 14 days of each person's booking. *See* Montgomery II Tr. 145:15-23. The NaphCare Policy Manual similarly describes an "oral screening," to be "[c]ompleted within fourteen (14) days of admission to the facility," which "include[es] visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist." NAPHCARE001023. I assume, based on the 30(b)(6) deponent's description of this examination and the NaphCare Policy Manual's description, that this examination is conducted by a nurse or physician—not a dentist. As a result, this "brief dental examination" does not constitute an initial dental exam.[45]

140. Finally, based on my review of the records, it is my opinion that any examinations that do occur in the Jail are inadequate. The 55 charts I reviewed reported 25 initial[46] and two annual examinations.[47] My chart reviews found no documented, appropriate periodontal probing and use of intraoral x-rays to inform initial and annual examinations. Consequently, the examinations are below accepted professional standards.

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[45] This is important because until a dentist has (at a minimum) screened a patient, a dental hygienist or dental assistant may not take x-rays or perform an oral assessment under general supervision. (see discussion of dental hygienist scope of practice *infra*).

[46] SD 1005874, SD 827533, SD 829569, SD 832824, SD 842992, SD 843292, SD 846437, SD 853238, SD 858511, SD 860735, SD 863525, SD 865976, SD 873506, SD 913909, SD 937227, SD 941139, SD 992967, SD 1016654, [redacted] Records at pp. 74 – 78, [redacted] Records at pp. 274 – 279, [redacted] Records at pp. 341 – 345, J[redacted] Records at pp. 398 – 402, [redacted]s Records at pp. 366 – 371, SD 1009055, SD 828761.

[47] One chart checked both the initial and sick call boxes. SD 1006266. The two annual examinations were documented for [redacted] (SD 864177) and [redacted] (pdf 427).

2. Inadequate Diagnosis and Treatment of Dental Caries

141. In my opinion, based on a reasonable degree of certainty, the diagnosis of caries is inadequate because it is not informed by intraoral (primarily bitewing) x-rays. In addition, the Jail's treatment of caries is inadequate because permanent fillings are not routinely provided, instead, the Jail provides temporary fillings or, more likely, extractions only.

142. To appropriately identify and diagnose dental caries (*i.e.*, tooth decay or cavity), intraoral (bitewing) x-rays are required; a dentists should not rely exclusively on panoramic x-rays, as smaller lesions between teeth will likely be missed.

143. Once diagnosed, caries can generally be treated through either a restoration, *i.e.*, a filling, or—if the tooth is not restorable—an extraction. Correctional facilities may not limit their care to extractions and instead should restore incarcerated people's teeth to the extent possible. In other words, if an incarcerated person's tooth can be restored by providing a permanent filling, prisons and jails must provide a permanent filling. (Some teeth may be restorable only with endodontic care, *i.e.*, a root canal, which is discussed *infra*).

144. In some circumstances, a dentist may examine a tooth and, even using a reasonable exercise of their clinical judgment, be unsure whether the tooth can be restored or if it instead requires extraction. In that case, it is appropriate for the dentist to provide a temporary filling, then examine the tooth again after several weeks if the tooth is still causing problems. And, when a temporary filling has been placed, the dentist should evaluate that filling—along with the patient's other teeth and overall oral health—at an initial or annual examination, as part of standard routine care. Applying a temporary filling when the dentist is certain that a permanent filling is appropriate falls below the standard of care. Similarly, failing to document a treatment plan for a tooth that has received a temporary filling as part of an initial or annual examination also falls below the standard of care.

145. In the alternative, if a dentist is not sure based on an examination whether a tooth is vital, the dentist can "pulp test" the tooth, *i.e.*, determine whether the pulp within the tooth is alive, and either apply a permanent filling, begin endodontic treatment if appropriate, or extract the tooth on the same day as the examination.

146. The standard of care not only requires that restorations be provided when appropriate, but it also requires that treatment be timely and treatment plans be generated, so that teeth that could be filled will not deteriorate to the point that extraction is necessary. Systematic untimeliness in providing routine care is, in effect, a *de facto* extraction only policy and thus below the standard of care. Shulman and Sauter at p. 56.

147. In both policy and practice, it is my opinion that the Jail does not adequately diagnose or treat caries. Regarding diagnosis, as explained above, my review of the records shows that bitewing x-rays are not occurring. Neither the 25 initial examinations nor the two annual examinations I reviewed were informed by bitewing x-rays. In addition, my review of the dental charts suggests that the graphics used in the Jail's dental chart do not allow early decayed teeth to be recorded and followed. In other words, this inadequacy contributes to delayed diagnosis and treatment of decay. (This flaw in the Jail's dental charting tool is described in more detail *infra*).

148. The lack of appropriate diagnosis of dental caries (*i.e.*, failure to take bitewing x-rays) means that the Jail fails to identify decayed teeth that could be restored in the appropriate timeframe. As explained above, this delayed routine care resulting in extractions being required means that the Jail has a *de facto* extraction only policy.

149. The experience of [redacted] is a case in point. Mr. [redacted] was booked on [redacted] 2020, and was incarcerated until at least [redacted] 2024, when his medical records were pulled for production in this case. Mr. [redacted]

requested and received (untimely) urgent care in both 2021 and 2022. SD 1016654 – 1016657, SD 1016775-79. At each of those appointments, Dr. Polanco recorded that he had conducted an "initial" examination, but did not document a treatment plan, periodontal probing, or intraoral x-rays. *Id.* In addition, Dr. Polanco placed a temporary filling in one of Mr. [redacted]'s teeth at the first of those appointments on [redacted] 2021, but did not follow-up on that filling at Mr. [redacted] next so-called initial examination on [redacted] 2022. *Id.* Then, on [redacted] 2023, [redacted] was seen by a dentist (Dr. Farid) as part of an outside referral, who reported "active decay on teeth #20, #28, #29 close to the nerve that needs root canal, build[up] + crowns." SD 1016536. It is my opinion that the decay progression on those three teeth was due to the Jail's repeated inadequate examinations—even on tooth #20, which the Jail knew was decaying as of two years prior. Even more troublingly, the medical records suggest that no one at the Jail had even reviewed Dr. Farid's report as of [redacted] 2024, *see* SD 1015822-33, nor had Mr. [redacted] received any additional dental care. In my opinion, his is a textbook case of a *de facto* extraction only policy—and substandard care.

150. Similarly, Plaintiff Jesse Olivares, who was incarcerated at the Jail from 2021 to 2023, testified that, after he was transferred from the Jail's custody to CDCR, the CDCR dentists treated not only the broken tooth he complained of at the Jail, but also treated "cavities and gave [him] fillings." Olivares Tr. at 168:14-23. Notably, Mr. Olivares testified that CDCR ultimately extracted his broken tooth after determining that it could no longer be saved "because it just broke more from when I was in the county [Jail]." *Id.* at 169:18-22.

151. In my opinion, when the Jail does succeed in identifying dental caries, the treatment provided for caries falls below the professional standard. As explained above, to operate within accepted professional standards, correctional institutions may not limit their dental care to extractions, but must also provide fillings (temporary or permanent, as determined by the dentist's reasonable

judgment). It is my opinion that the Jail fails to meet this standard, and therefore has a *de facto* extraction only policy.

152. As an initial matter, the Jail does not appear to have any clear policy instructing dentists when or in what circumstances to provide fillings. Rather, the policy states only that dental care is "not limited to extractions." As of December 27, 2023, NaphCare's proposed additional guidance on this policy stated merely: "Remember that although the extraction may be warranted in most cases, there are opportunities for restorative dentistry such as fillings." NAPHCARE034731. That policy does not provide sufficient guidance to healthcare staff (both nurses and dental staff) and may lead to confusion.

153. For example, in response to an October 9, 2023 sick call request for a cleaning, the Jail responded: "No. Dental only does extractions." SD 843106. Similarly, Plaintiff Jesse Olivares, who was incarcerated at the Jail from 2021 to 2023, testified that he was told by people on the Jail's medical staff that "they don't do fillings." Olivares Tr. 167:14-24. In particular, he testified: "I informed [the Jail] that I had a broken tooth and they said all they do is pull them out." *Id.* at 168:4-5.

154. The Jail's policy also appears to be limited to temporary fillings—not permanent ones. The Sheriff's Department's contract with NaphCare lists a variety of services to be offered, which includes "Temporary fillings" but omits reference to permanent fillings. San Diego County Contract No. 566117, SD 122498. Similarly, the Jail's dental chart does not include an option for the dentist to select "permanent filling" as treatment, though there is an option for "temporary filling."

155. In my review of records, it was rare for a dentist to place a restoration (filling) and most of them were described as temporary. Furthermore, as indicated above, an initial examination (with intraoral x-rays) is not scheduled timely (or at all) so the dentist can follow-up on any temporary fillings that were placed. In addition to the case of Mr. [redacted] described *supra*, the example of [redacted],

who received multiple temporary fillings, is instructive. Dr. Polanco's decision to place a temporary filling rather than a permanent filling on tooth #11 on [redacted] 2023 and [redacted] 2023 more likely than not resulted in tooth #11 becoming abscessed and requiring extraction. *See* SD 828792-94 (dental sick call visit [redacted] 2024).

3. Inadequate Diagnosis and Treatment of Periodontal Disease

156. The diagnosis and treatment of periodontal disease, *i.e.*, gum disease, is an integral part of routine care. Untreated, periodontal disease can progress, possibly leading to the loss of teeth.

157. The standard of care requires both bitewing x-rays and periodontal probing to diagnose periodontal disease. Critically, the periodontal probing must be performed consistent with one of two professionally acceptable screening standards: the Community Periodontal Index of Treatment Needs ("CPITN"), which is used by the federal Bureau of Prisons, or the Periodontal Screening and Recording ("PSR"), which is used by many state departments of corrections, private practices, and the military.

158. "Spot" periodontal probing, also known as selective probing or partial probing, is insufficient. These terms refer to the practice of only probing specific areas of the gingiva rather than probing the entire mouth. While this approach may seem more efficient, it can miss pockets of infection or inflammation in other areas of the mouth, leading to an incomplete assessment of the patient's periodontal health. This can result in underdiagnosis of periodontal disease and inappropriate treatment planning. Substituting "spot" periodontal probing for a periodontal examination guided by the PSR or CPITN therefore falls below the standard of care.

159. Moreover, when periodontal screening indicates the presence of periodontal disease, the standard of care dictates that further diagnostic modalities should be used to identify the specific disease sites. This is especially important since periodontal disease is typically painless. Failure to diagnose dental conditions

timely is likely to result in tooth morbidity and tooth mortality.

160. In my opinion, based on a reasonable degree of certainty, the diagnosis of periodontal disease in the Jail is inadequate and below accepted professional standards, resulting in delayed (or no) diagnosis, gratuitous pain, and tooth loss.

161. As explained above, my review of the records suggests that bitewing x-rays are rare. In addition, my review of the documents suggests that periodontal probing is not happening.

162. As an initial matter, I am not aware of any Jail policy directing or outlining the procedure for diagnosis or treatment of periodontal disease. None of the Rule 30(b)(6) deponents could recall such a policy or confirm whether it was happening. Dr. Montgomery, testifying on behalf of the Sheriff's Department, testified that a periodontal assessment would be part of a regular dental evaluation but could not say whether it was happening in practice. Montgomery II Tr. 284:7-285:5. Similarly, while Ms. Nix, testifying on behalf of NaphCare, knew that NaphCare had an Oral Care Policy, she did not know whether it addressed periodontal disease. Nix I Tr. 221:23-222:4. A dental hygienist I spoke with at George Bailey during my tour informed me that she conducts only "spot" probing and does not document teeth that have clinically significant periodontal pockets.

163. My review of the records suggests that, in practice, periodontal disease is not screened for, diagnosed, or treated at the Jail. Of the charts I reviewed that were marked as having an initial or annual examination completed, none contained a documented periodontal assessment.

164. Moreover, none of the charts I reviewed had a diagnosis of periodontitis. This is surprising since the prevalence of periodontitis in the general population is high, and that of the incarcerated population is even higher. As an example, Dr. Patel examined [redacted] at a scheduled sick call appointment. She noted that he had 1) moderate generalized calculus, 2) moderate generalized bleeding, 3) moderate gingival inflammation, and 4) "spot probing 2-8mm." [redacted]

Dental Records, SD 825095-96. Her note did not identify which teeth had deep periodontal pockets so there was no baseline to assess disease progression. This failure to document periodontal probing is below accepted professional standards.

165. Finally, there was no periodontal treatment. My chart review did not find any instance of a treatment plan from an initial or annual examination that included a scaling and root planing procedure[48]—the standard non-surgical treatment for moderate to advanced periodontal disease.

166. Simply put, periodontal disease was ignored. Such a practice falls below accepted professional standards and places people incarcerated at the Jail at an unreasonable risk of harm.

4. Inadequate Preventative Care

167. Preventative care, which includes both making a treatment plan and providing treatment *e.g.*, dental cleanings, according to that plan is a standard part of routine dental care. Yet, there is a consistent lack of treatment planning and annual periodic dental prophylaxes across the Jail. It is my opinion that the Jail fails to provide adequate preventative care.

168. Sheriff's Department medical staff appear to agree. For example, Ms. Rognlien-Hood, Deputy Director of Inpatient Care Facilities (previously the Director of Nursing), testified that dental care was "one big thing" that the Jail can improve on, especially now that sentences are longer as the result of AB 109. Rognlien-Hood Tr. 24:8-25:7.

169. In addition, the Sheriff's Department raised the issue of inadequate cleanings in an April 28, 2023 Corrective Action Notice ("CAN") sent NaphCare. NAPHCARE034826. The Sheriff's Department amended its contract with NaphCare to add two dental hygienists in February 2024, who, according to

[48] See earlier discussion of periodontal treatment. Scaling and root planning can be performed by a dentist or dental hygienist. However, a dental hygienist may not perform it *sua sponte* – it must be prescribed by a dentist in a treatment plan.

NaphCare's March 4, 2024 response to the CAN, NaphCare estimates will complete 2,500 cleanings annually. SD 1572608. However, the March 4, 2024 CAN response does not include any further plan outlining how NaphCare and the Sheriff's Department will facilitate those cleanings—*e.g.*, how will the Sheriff's Department ensure sufficient custody staff are available to escort patients to those cleanings.

170. Despite the Sheriff's Department and NaphCare's awareness of this problem, my review of the records suggests that neither treatment plans nor dental cleanings are happening on a regular basis. My review of records included several individuals who had been incarcerated in the Jail for over a year as of the date their dental records were pulled for production to Plaintiffs. None of those individuals had received a treatment plan for routine care. In addition, multiple individuals who requested cleanings were told that the Jail does not provide that service. *E.g.*, [redacted] (SD 843106); [redacted] (SD 914307).

5. Inadequate Endodontic Treatment

171. Endodontic (root canal) therapy is an element of routine care, and it should be provided in the correctional setting for at least certain teeth. For example, in the Federal Bureau of Prisons, endodontic treatment may be completed when the dentist deems it clinically indicated, so long as the tooth is not a third molar, periodontally compromised, or requires extensive restoration such as a cast crown.[49]

172. CDCR allows endodontic treatment to be performed only on the maxillary (upper) and mandibular (lower) anterior teeth when (1) retention of the tooth is necessary to maintain the integrity of the dentition, (2) the tooth is not periodontally compromised, (3) the tooth does not require extensive restoration, and

[49] US Department of Justice, Federal Bureau of Prisons. Program Statement 6400.03, June 10, 2016, p. 15. Viewed at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.bop.gov/policy/progstat/6400_003.pdf. May 8, 2024.

(4) there is an adequate posterior occlusion, either from natural dentition or a dental prosthesis, to provide protection against traumatic occlusal forces.[50] Furthermore, posterior root canal therapy may be considered if the tooth in question is vital to the patient's masticatory ability and it is essential as an abutment for an existing removable cast partial denture or is necessary as an abutment on a proposed removable cast partial denture for that arch. *Id*.

173. In my opinion, the Jail's provision of endodontic treatment is inadequate. Given the amount of time people spend at the Jail post-realignment and the potential for severe negative consequences to their health, the Sheriff's Department should offer endodontic treatment to incarcerated people subject to CDCR's policy.

174. The Sheriff's Department appears to agree that root canals should be provided. On April 28, 2023, the Sheriff's Department sent a Corrective Action Notice ("CAN") to NaphCare identifying deficiencies in its health care program, including that there had been a failure to authorize root canals. NAPHCARE034826. Similarly, Theresa Adams-Hydar, until recently the Assistant Sheriff responsible for overseeing the entirety of the Detention Services Bureau testified that "[r]oot canals should be provided." Adams-Hydar Tr. 225:19-226:1.[51] A May 26, 2023 email from Dr. Montgomery makes the same point. He explained that NaphCare's repeated conclusion that root canals are "cosmetic services" was "unfortunate," given that "many Community insurance agencies actually cover root

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[50] California Department of Corrections and Rehabilitation Correctional Healthcare Services. Health Care Operations Manual.Article 3. Dental Care ¶3.3.2.9 c. Viewed at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://cchcs.ca.gov/wp-content/uploads/sites/60/HC/HCDOM-ch03-art3.2.9.pdf. 5/8/2024.

[51] As the Assistant Sheriff (now retired) explained: "If there was any work that needed to be done such as a root canal, rather than an extraction, we really pushed with NaphCare that we want them to be provided root canals, when appropriate, rather than an extraction, because we wanted them to have their teeth." Adams-Hylar Tr. 187:22-188:1.

canals." SD 227525. In addition, he explained:

> In the California detentions / corrections system, individuals could potentially serve their prison time in a jail setting. A generalized "blanket" refusal of services (in this case, a root canal) … just because they are in jail … is discrimination by geographic location,and would be considered "deliberate indifference."

Id. (ellipses in original). I agree with Dr. Montgomery in this regard.

175. In a December 18, 2023 letter to the Sheriff's Department, NaphCare proposed to [redacted] based on CDCR guidelines. NAPHCARE034725.

176. However, I have seen no indication that such a policy has been implemented. In the March 4, 2024 CAN—the most recent that I have reviewed—there does not appear to be any update in response to the Sheriff's Department's December 8, 2023 question: "Has there been a directive to Naphcare's dental staff of Dr. Pandit's improvement plan and root canal guidelines?" SD 1572589.

177. That this problem—which Dr. Montgomery himself stated "would be considered 'deliberate indifference'"—was still not resolved after nearly a year is concerning and means that the Jail's dental program falls below the standard of care. In addition, as explained in more detail above, the Sheriff's Department's outside referral system is woefully deficient. Absent substantial improvements to that system, it does not seem feasible that referrals to endodontists could occur in a timely fashion, as would be required to facilitate root canals.

C. Inadequate Dentist Staffing

178. In my opinion, based on a reasonable degree of certainty, the Jail has does not have enough dentists to treat painful dental conditions and provide routine care to longer-term incarcerated people. This subjects incarcerated people to gratuitous pain, tooth morbidity, and tooth mortality.

179. Inadequate dental staffing is typically a primary reason for untimely care in a correctional setting. The DOJ has recognized as much. A letter from the DOJ summarizing the findings of its investigation of the Lake County, Indiana Jail identified that "[i]nsufficient dentist time inappropriately limits dental care to prescription for antibiotics and extractions." Note 22, Lake County Letter, p. 15. With respect to waiting time for dental care, the letter stated: "[c]onsequently, this wait for medical care violates constitutional minimums, leaving significant inmate medical needs inadequately addressed or completely unmet." *Id.* Among the minimum remedial measures was "[e]nsure dental hours accommodate the need for dental care." *Id.*, p. 29.

180. The literature generally suggests that a ratio of 1,000 incarcerated people per dentists is appropriate for prisons, and an 850:1 ratio is appropriate for jails. Makrides et al., p. 557.[52] Notably, however, some correctional facilities have found that even lower ratios are appropriate. For example, in CDCR, the *Perez* settlement agreement mandated an incarcerated-person-to-dentist ratio of 515:1.[53]

181. In addition, it is important to note that, as a rule, jails require more dentists than prisons. This is because, unlike prisons, most of the jail population comes to the facility from the street/community, where they may not have been receiving any dental care and are therefore more likely to have a painful condition in need of urgent dentist attention. In contrast, the prison population is more likely to be transferred in from another institution, where they would have been receiving

[52] The Makrides et al. study reported that, based on data from 1996, prisons in various jurisdictions had incarcerated-person-to-dentist ratios varying from 428:1 to 2,375:1. Makrides et al., p. 557. However, the prison health care environment has changed in the past 28 years, partly due to litigation or the threat of litigation resulting in an expansion of health care services. In addition, the study noted that the prisons at issue likely varied in the scope of services provided, which would account for much of the variation.

[53] Shulman JD. Structural Reform Litigation in Prison Dental Care: The Perez Case. Correctional Law Reporter August/September 2013, p. 28. During the monitoring process, the ratio was changed to 600:1 with the addition of dental hygienists. The current ratio is 600:1.

dental care already.

182. Based on my review of documents, the Jail appears to fall woefully short of the recommended incarcerated-person-to-dentist ratio. Table 3 below shows the Jail's dental staffing as currently specified in the NaphCare contract, which amended in February 2024. "DDS" refers to dentists, "DA" refers to dental assistants, and "RDH" refers to registered dental hygienists.

Table 3. Contract Dental Staffing Levels

	Mon	Tues	Wed	Thurs	Fri	Total
Central						
DDS			4			4
DA			4			4
RDH						0
Las Colinas						
DDS		8				8
DA		8				8
RDH						0
George Bailey						
DDS	8			8		16
DA	8			8		16
RDH	16	16	16	16	16	80
East Mesa						
DDS					8	8
DA					8	8
RDH						0
Vista						
DDS			4			4
DA			4			4
RDH						0

The contract does not provide for any dental staff at either the Rock Mountain Detention Facility or the South Bay Detention Facility, though there is a note that "[s]taff may float between facilities based on operational needs." County of San Diego Contract 566117, Modification 01, February 5, 2024, NAPHCARE040852-62.

183. Under this contract, the Jail is staffed with dentists 40 hours per week,

or 1.0 full-time equivalent ("FTE"). This staffing plan results in an incarcerated person-to-dentist ratio 3,936:1, using the most recently available statistics for the Jail's average daily population.[54] This is approximately 25 percent of the optimal staffing estimates for a prison and 21 percent of the optimal staffing estimate for a jail.

184. In practice, documents suggest that the Jail is staffed by somewhere between 1.0 FTE and 2.0 FTE dentists, though that number is still well below optimal staffing estimates. Angela Nix, testifying on behalf of NaphCare, explained that NaphCare employs two dentists for the San Diego Jail: Dr. Polanco, who is full-time, and Dr. Patel, who is part-time. Nix II Tr. at 52:5-17. Ms. Nix also explained that NaphCare has "been providing more dental hours above the contract" in order to accommodate "the volume of patients within San Diego County." *Id.* at 58:17-21. Given that Dr. Patel, according to Ms. Nix's testimony, works at the Jail only part-time, the Jail in practice has fewer than 2.0 FTE dentists working there. However, even if the Jail were staffed by two FTE dentists, that would result in an incarcerated person-to-dentist ratio of 1,968:1, which is approximately half of the optimal prison staffing estimate discussed *supra*. And, even setting aside the recommendations for what level of staffing is appropriate, it is clear from the untimely urgent care and the almost complete absence of routine care described *supra* that dentist staffing is grossly inadequate.

185. Ms. Nix also testified that NaphCare is still in discussion with the County and Sheriff's Department to increase the number of dentist FTEs at the Jail in a future contract amendment. *Id.* at 58:18-59:3. However, no such additions were made when the contract was amended in February 2024.

186. The dental staffing plan is also notable in that it indicates that both

[54] The June 2024 population statistics are the most recently available on the County's website, available at: https://www.sdsheriff.gov/home/showpublisheddocument/8306/638560308063070000.

Central Jail and the Vista Detention Facility—which in June 2024 housed 838 and 711 incarcerated people, respectively—are scheduled to have only 4 hours per week of dental clinic. In practice, my review suggests that each of these facilities is visited by a dentist only once every other week. During my February 2024 inspection of the Central Jail, a sign hanging in the medical clinic stated: "Effective February 1st Dental SC [sick call] for SDCJ [Central Jail] will be held on the **1st** and **3rd Wednesday** of every month. Please schedule patients for these dates only." SD 983516. Additionally, one person incarcerated at Vista, who submitted over a dozen requests to see a dentist for "agonizing" and "excruciating" pain in January 2024, wrote in one such sick call request: "i'm told time and time again the dentist comes every two weeks." SD 833482.

187. Notably, the Sheriff's Department has so far declined the opportunity to increase dentist staffing at the Jail, despite its awareness of this problem. When NaphCare's contract was amended in February 2024, the Sheriff's Department added only two FTE *hygienists* to its dental roster. *See* County of San Diego Contract 566117, Modification 01, February 5, 2024, NAPHCARE040852-62. It did not add any dentists, despite apparently discussing the need for additional dentist staffing. Nix II Tr. 58-59. When I was at George Bailey, I met Claudia Last Name Unknown, a dental hygienist who told me that she was a recent hire at the Jail. Although the February 2024 staffing plan suggests that dental hygienists are staffed only at George Bailey, Claudia informed me that she worked a total of 16 hours per week, each day at a different Jail facility.

188. The addition of hygienists will not materially improve incarcerated people's access to urgent care, because dental hygienists primarily provide oral prophylaxes (cleanings) that support a routine care program. The acute need in this system is for *dentist* FTEs, as they are the only professionals who can provide urgent care, which is sorely needed. Simply put, a staffing plan that has twice as many dental hygienists as dentists makes no sense. With an average daily

population of approximately 4,000 people, the Jail needs, at minimum, four full time dentists.

189. While inadequate dentist staffing is the primary reason for untimely care, the availability of other staff can also negatively impact the provision of care. In particular, the availability of dental assistants is an important factor because dentists working without an assistant are limited in the scope of treatment that they can provide and how productive they can be. For example, the day I visited Las Colinas, I was informed that the dental assistant was out sick. I viewed the clinic three times during the day and not see a patient in the dental chair. I was told that Dr. Patel was "doing examinations in the housing units." Any evaluation completed away from the dental clinic cannot be considered a full examination, as described above. While a dentist can interview a patient and look into the mouth with ambient light or a headlamp, that would only be triage.[55]

D. Inadequate Program Monitoring and Oversight

190. In my opinion, based on a reasonable degree of certainty, the Jail's dental program is inadequately monitored. Consequently, critical program deficiencies are not identified and remedied timely, redounding to the detriment of incarcerated persons, who continue to be at risk of gratuitous pain and harm.

191. An adequate dental program must have: a dental chart that facilitates consistent recording of patient diagnosis, treatment planning, and productivity; a peer-review program; a dental director; and a continuous quality improvement ("CQI") process. As explained below, the Sheriff's Department is inadequate in each of these respects. As a result, the many areas of substandard care identified above have been allowed to persist.

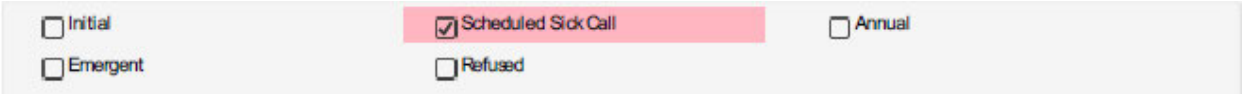
[55] While adequate dental staffing is necessary for timely dental care, it is not sufficient since even an adequately staffed dental program (which the Jail is not) has inadequate access to care if patients are unable to get to the clinic. As explained *supra,* there is some documentary evidence that the insufficient custody staff to escort patients to the dental clinic contributes to the delays in provision of care—a problem the Jail should also study.

1. Dental Charting

192. Since incarcerated people are likely to be treated at several institutions or facilities during the course of their confinement, it is important that entries in the dental chart be legible and the terminology be standardized so dentists and dental hygienists will know what treatment has been provided.[56] Where procedure definitions are inadequate or there is insufficient oversight to ensure that clinical entries are unambiguous, dentists and dental hygienists may obtain an inadequate understanding of past treatment which can redound to a patient's detriment. The accepted professional standard for procedure definitions is the Code on Dental Procedures and Nomenclature published by the ADA.[57]

193. In my opinion, dental charting at the Jail is inadequate because the dental chart tool is itself flawed, staff do not receive sufficient guidance to complete the chart, and, in practice, staff do not fill out the chart consistently.

194. As an initial matter, the electronic dental chart tool used throughout the records I reviewed lacks places for critical information to be documented. For example, the image below is a screenshot of the "Appointment Type" menu in one of the Jail's dental chart:



[56] "The format, basic content of the dental records, and charting in the dental records should be standardized across the correctional system." NCCHC Guidelines at 6.

[57] The purpose of the CDT Code is to achieve ***uniformity, consistency, and specificity in accurately documenting dental treatment***. One use of the CDT Code is to provide for the efficient processing of dental claims, and another is to populate an Electronic Health [Dental] Record.

On August 17, 2000, the CDT Code was named as a HIPAA standard code set. Any claim submitted on a HIPAA standard electronic dental claim must use dental procedure codes from the version of the CDT Code in effect on the date of service. The CDT Code is also used on paper dental claims, and the ADA's paper claim form data content reflects the HIPAA electronic standard. American Dental Association: http://www.ada.org/en/publications/cdt/ (visited January 23, 2021) (emphasis added.).

195. A dentist filling out the chart may select any (including multiple or none) of the following options: "initial," "emergent," "scheduled sick call," "refused," and "annual." Critically, as indicated *supra*, there is no box to indicate the level of urgent care, *i.e.*, treatment within one or 30 calendar days—despite the nominal inclusion of those priority levels in the Jail's policies.

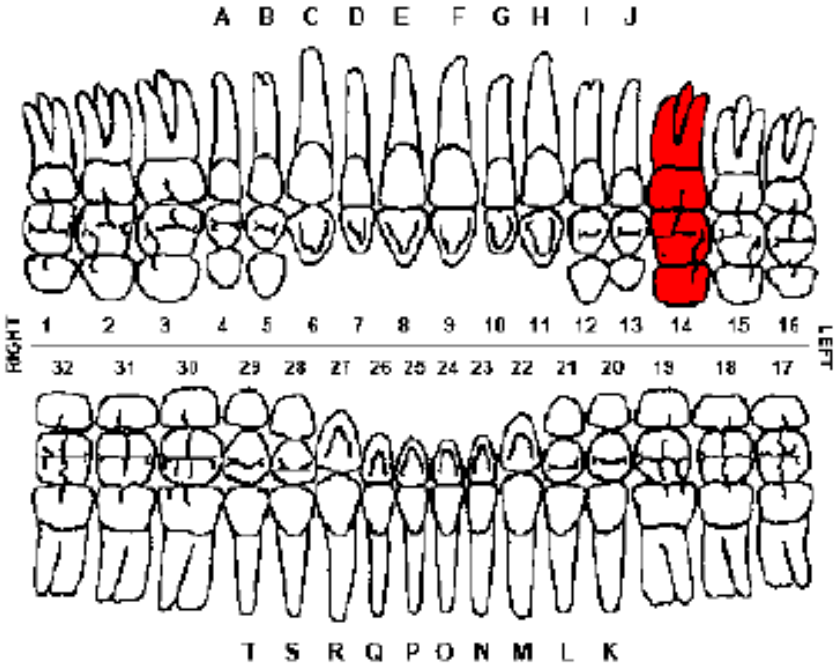
196. The diagnosis section of the Jail's dental chart (screenshot below) is also flawed.

197. A dentist filling out the chart may select any (including multiple or none) of the following options: "restorable," "non-restorable," "gingivitis," "periodontitis", "perio[dontitis] hopeless," "pericoronitis," and "other." Problematically, the chart does not allow dentists to record information on more than one tooth. For example, if a patient has two teeth with caries, one of which is restorable and one of which is not, this "diagnosis" tool cannot capture the dentist's notes on both teeth. Even if a dentist also used the notes function to describe both teeth, this checklist would be a confusing summary of the visit. This a major limitation which limits the usefulness of the chart and suggests that the menu is designed for a sick call, *i.e.*, limited focus, examination rather than for routine care.

198. In addition, there is no definition of the diagnosis "restorable" versus "non-restorable" in any of the policy guidance I have reviewed. It could mean, for example, that a tooth requiring advanced endodontic treatment available in the community is marked "non-restorable" on this chart because the dentist understands that the Jail's policy/practice is to deny such advanced treatment. Alternatively, such teeth might be marked "restorable" on the Jail's charts, leaving the "non-restorable" diagnosis only for teeth that cannot be restored under any circumstance. However, if Jail dentists are using that private practice standard to determine

whether a tooth is restorable, I anticipate the records would reflect fewer extractions and more fillings. Absent any policy setting out the usage of these terms, it may be that the Jail's dentists are not using these terms consistently, leading to confusion a patient's records are reviewed by a new dentist for the first time.

199. The Jail's dental chart then contains a standard tooth diagram (screenshot below), like those used in other large institutions, *e.g.*, in the military.



200. The charts I reviewed suggest that a dentist can color-code individual teeth to indicate, *e.g.*, whether the tooth is impacted or designated for extraction. However, I have not seen any indication that a dentist can color-code only *part* of a tooth, *e.g.*, to indicate where on a tooth the decay is or where an existing restoration was placed; a standard electronic dental chart would have this partial color-coding feature. Because it lacks the ability to mark locations on an individual tooth, the Jail's chart is insufficient for routine care.

201. The next section of the Jail's chart (screenshot below) allows the dentist to input a line-by-line description of individual teeth, including a description of the existing conditions, the date of the exam, the planned treatment, the date treatment was completed, and the periodontal probing depth ("Perio B" and "Perio L").

Tooth #	Existing Conditions	Surface	Perio B	Perio L	Exam Date	Treatment Plan	Treatment Date Completed
14	Decay, Root				3/18/2024	extraction	3/18/2024

202. Again, this portion of the chart is overly limited. Like the tooth diagram, it does not allow a dentist to denote any detail about what portion of a tooth was affected. In addition, none of the charts I reviewed had probing depth recorded for an individual tooth. (In any event, as noted above, a proper dental examination would include periodontal probing of more than just an individual tooth, and there is no location anywhere in the Jail's chart for a dentist to record such probing).

203. The Plan and Treatment section of the Jail's dental chart (screenshot below) is similarly flawed.

PLAN AND TREATMENT:

Treatment Options:

☑ No Treatment	☐ Antibiotics	☑ Analgesics
☐ Temporary Filling	☑ Extraction	☐ Private Dentist or Surgeon
☐ Other		

204. A dentist filling out the chart may select any (including multiple or none) of the following options: "no treatment," "antibiotics," "analgesics," "temporary filling", "extraction," "private dentist or surgeon," and "other." As noted above, there is no option for a permanent filling. Like the sections described above, this menu—which again does not have options to distinguish between different teeth—does not support a dental program that provides routine care.

205. Not only is the dental charting tool overly limited, but the guidance provided to dentists about how to fill out the chart is insufficient. In particular, I reviewed a December 2023 document prepared by Dr. Pandit, the NaphCare Corporate Dental Director, which describes guidelines to assist dental providers in standardizing the documentation of dental encounters in charts. Though the guidelines provide some useful information, they do not address all issues related to

the dental chart. NAPHCARE034729. For example, the guidelines do not discuss or define the elements of an initial or annual examination, nor do they provide guidance as to when a tooth should be diagnosed as "restorable".

206. Additional guidance is clearly necessary. Over the course of this assignment, I reviewed 55 dental charts as identified in Exhibit C. Some of these charts were part of a selection from Defendants; others were requested based on interviews with incarcerated people during the inspections. The charting throughout that sample was inconsistent. For example, several charts I reviewed had the initial examination box checked, but lacked any information indicating that the examinations did not comport with NCCHC J-E-06 or accepted professional standards (*e.g.*, documented periodontal probing or intraoral x-rays). It is therefore my opinion that the Jail's dental charting is inadequate.

207. To summarize, the Jails' dental chart as currently configured is inadequate to enable a dentist to follow a patient's dental health. While the chart tool might be useful for patients that receive only urgent care on a single tooth at a time, it is below the accepted professional standard for providing routine care. It is also difficult to use for patients who require urgent care on multiple teeth at the same time. I strongly recommend that the Jail adopt the electronic dental chart used by CDCR which is based on a commercial dental system.[58]

2. Peer Review

208. Peer review is an important element of a quality management program. This entails having dentists assess and provide feedback to each other, as well as to program management. Feedback from a peer review will include an assessment of clinical competency to include adequacy of documentation, adequacy of the clinical examination and treatment plan, and treatment outcome. A peer review can range

[58] Several years ago, the CDCR Dental Director told me that he would be willing to assist any California jail with implementing the system since this would provide a near seamless transfer of dental records between jails and CDCR.

from a random chart review to an examination of patient care by examining patients. In all instances, reviews are performed by a dentist (peer) and not by a non-dentist member of the staff. All peer reviews should be forwarded to the privileging authority for review prior to the (re) issuance of privileges.[59]

209. Peer review is part of NCCHC[60] and ACA standards,[61] and it is an essential component of institutional health care programs in corrections, the military, and large civilian organizations. The NCCHC guidelines state:

> Correctional systems should develop clinical performance review policies with the goal of enhancing patient care. ***A clinical performance review should be performed annually on all dentists who provide clinical care to inmates***. The review should be performed by a dentist who can be objective in the review. When only one dentist is practicing in the correctional system or the number of dentists could lead to biases in the process, the correctional system should seek the services of an outside dentist, preferably one with correctional experience.

NCCHC Guidelines at 6-7 (emphasis added).

210. For example, CDCR requires that all dentists evaluate the dental care provided by peers "using generic screening criteria and methodologies such as health record reviews and patient outcome data as well as other logs and reports"[62] to determine for example, appropriateness of care (timeliness and appropriateness of

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[59] Shulman *et al*. at 8-22.

[60] *See also* National Commission on Correctional Health Care Standards for Health Services in Jails, 2018. Standard J-C-02 (Clinical Performance Enhancement), p. 52; NCCHC Standards for Health Services in Prisons, 2018. Standard P-C-02 (Clinical Performance Enhancement) at 53.

[61] ACA (2018) Standard 5-6D-4411 (Peer Review) at 208 ("[a] documented peer review program for all health care practitioners/providers and a documented external peer review program will be utilized for all physicians, psychologists, and dentists every two years.").

[62] California Department of Corrections and Rehabilitation. California Correctional Health Care Services. Health Care Operations Manual. Chapter 3, Article 3, §3.3.4.3 (Dental Peer Review) at 2, ¶C. See for example, dental peer review audit tool evaluation criteria matrix (California Department of Corrections "Evaluation Criteria for Determining a Rating during a Dental Peer Review).

diagnosis, accuracy, and legibility of documentation; whether diagnoses and treatment plans were supported by clinical data. *Id*.

211. Based on my review of the documents, it is my opinion that the Jail's dentists are not subject to adequate peer review. The documents I reviewed contained one peer review form for Dr. Patel and Dr. Polanco, filled out by each other in October 2022. NAPHCARE034851-52; NAPHCARE034853-54. I have not seen any peer reviews from 2023, suggesting these reviews may not in fact be completed annually.

212. Even if these forms were completed annually, there are several inadequacies in the peer review form. First, it is unclear how the charts to be reviewed are selected and how many charts reflecting a certain type of examination should be reviewed. For example, are only scheduled sick call appointments reviewed, or are initial examinations also supposed to be reviewed?

213. Second, the criteria for evaluation are overly vague, *e.g.*, "Ordered diagnostics, procedures and/or referrals are appropriate based on national standards of care." *Id.* There is no indication of which "national standards" are used, nor do the evaluation criteria include any specifics, *e.g.*, whether periodontal probing was conducted and documented. It is therefore no surprise that these peer reviews did not identify the consistent problems noted in this report, *e.g.*, failure to document periodontal probing and failure to use intraoral x-rays to diagnose caries.

214. Critically, neither of the peer reviews I did review for Dr. Patel and Dr. Polanco identified that the other dentist's failure to document periodontal probing and use intraoral x-rays at initial examinations were below accepted professional standards. Clearly, it is implicit in the peer review concept that the reviewers were familiar with accepted professional standards.[63]

[63] It is striking that, in the case of [redacted] discussed *supra*, an outside dentist appears to have noted the failure in routine care by the Jail's dentists. In some ways, this might be considered a peer review—which found the Jail's dental care lacking.

215. I have been subject to peer review, been a peer reviewer, and have written peer review policies as part of settlement agreements in Ohio and California prison systems. In my opinion, this form is simply inadequate. It is not a true peer review program, but a fig leaf.

3. Dental Director

216. The Dental Director should be a part-time or full-time dentist working for the Sheriff—not NaphCare. The Dental Director's job is to ensure that care within the institution is consistent with the standard of care, representing the dental program within the facility and coordinating with other departments such as custody and medical. Moreover, the Dental Director should be responsible for evaluating the productivity of the dentists and dental hygienists employed by NaphCare.

217. While a non-dentist can assess dentist productivity such as the number of patients seen each day, specific clinical issues such as excessive use of antibiotics for urgent care patients, inadequate periodontal diagnosis and treatment, failing to provide permanent restorations when clinically appropriate, inadequate x-rays for routine examinations, extracting teeth that are salvageable, failing to schedule follow-up appointments for patients for whom they prescribed an antibiotic for a dental infection, require an experienced (**and disinterested**) dentist.

218. As far as I am aware, the Sheriff's Department does not have its own Dental Director. Indeed, the person identified by the Sheriff's Department as the person most knowledgeable with respect to dental care in this case is Dr. Montgomery, an MD and the Sheriff's Department's chief medical officer, who is not a dentist. This is inadequate.

4. Continuous Quality Improvement ("CQI")

219. Health care delivery systems, including prison health care systems, must have a program for evaluating the delivery of services and monitoring the quality of care for patients. The elements of such a program include the assessment or evaluation of the quality of care; identification of problems or shortcomings in

the delivery of care; designing activities to overcome these deficiencies; and follow-up monitoring to ensure effectiveness of corrective steps. Essential to the monitoring process is internal auditing (self-inspection) and external reviews.[64]

220. According to the NCCHC, a continuous quality assurance ("CQI") program identifies health care elements to be monitored, implements, and monitors corrective action when necessary, and studies the effectiveness of the corrective action plan. NCCHC 2018 at J-A-06 ¶ 1. Similarly, "a system of documented internal review will be developed and implemented by the health authority." ACA 2018 at 5-6D-4410. The review should include, *inter alia*, evaluating defined data, onsite monitoring of health service outcomes on a regular basis through chart reviews, review of prescribing practices, systematic investigation of complaints and grievances. *Id*.

221. Based on my review of the documents, I understand that the Sheriff's Department has essentially outsourced its CQI of the dental program to NaphCare, yet—to the extent that NaphCare does any auditing of dental care—those audits are inadequate.

222. The Sheriff's Department's internal medical Quality Improvement Committee Meeting Minutes indicate that dental care is not substantively discussed as part of the Sheriff's Department's own CQI process. In some of the Committee's minutes, the word "dental" does not appear at all. *E.g.*, Quality Improvement Committee (QIC) Meeting Minutes, January 25, 2023, SD 108227-28; *see also* Quality Improvement Committee (QIC) Meeting Minutes July 18, 2023, SD 114398 (stating that dental would be part of NaphCare quarterly report).

223. Instead, "actual administrative oversight" of the dental program is "conducted by NaphCare," according to Dr. Montgomery's testimony on behalf of

[64] American Public Health Association. Standards for Health Services in Correctional Institutions. Washington, DC 2003 at 153. ("APHA Standards").

the Sheriff's Department. Montgomery II Tr. at 115:18-21. Ms. Nix, testifying on behalf of NaphCare, similarly stated that Dr. Pandit, the NaphCare Dental Director, "has oversight into compliance of the dental program in general." Nix I Tr. 221:16-20.

224. Yet, Sheriff's Department staff seem unclear about what—if any—oversight NaphCare is even doing of the dental program. In a May 26, 2023, email about NaphCare's performance, Dr. Montgomery stated that, with respect to the dental program, there had been "[n]o mention about how oversight will occur." Email & Attachment from J. Montgomery to C. Miedico et al., May 26, 2023, SD 227524. And, in response to the Sheriff's Department's questions about dental program monitoring, NaphCare had "denie[d] any form of responsibility"—"guidelines are not presented/discussed or established." *Id.* This uncertainty apparently remained as of Dr. Montgomery's deposition in this case nearly a year later. When asked about the Department's oversight of the dental program, he stated that he was "[u]nclear about the processes for dental," though he described some non-substantive issues he thought were covered by NaphCare's audits, including dentist productivity. Montgomery II Tr. at 115:7-116:18.

225. Although NaphCare has purportedly conducted some auditing of the Jail's dental care, that oversight program is deficient. For one thing, the quarterly presentations regarding quality assurance and quality improvement run by NaphCare do not appear to contain any information or analysis about the *quality* of dental care provided, or even about the type of issues being diagnosed and treated. *See, e.g.*, NaphCare 3rd Quarter 2023, QA/QI Statistics Presentation, SD 114363-74. Rather, these presentations include only the numbers of prophys, fillings, extractions, and "exam/meds" conducted—without specifying what kind of examination; the number of x-rays taken; and the number of dental sick call appointments. SD 114369-70. There is, again, no discussion of periodontal diagnosis and treatment. Nor is there any discussion of outside referrals for serious

dental conditions. And, most damningly, there are no statistics regarding the average wait times for dental care.

226. In its various responses to the CANs, NaphCare stated that it conducted some analysis and peer review of its dentists' work at the Jail. However, those reviews, conducted in March 2023 and December 2023, are still inadequate, because they again miss critical issues with dental care at the Jail.

227. In March 2023, a NaphCare corporate dental consultant, Dr. Scott Kane, conducted a review of dental provider encounters for the month of March 2023. NAPHCARE034657. Dr. Kane identified two areas for improvement: (1) "documentation" in patients' medical records and (2) "sick call management and triaging," including, "providing treatment on day of exam." *Id.* While those points of improvement may be important, Dr. Kane's analysis omits obvious inadequacies in routine examinations, treatment plans, and periodontal diagnosis and treatment. The failure to mention those problems—and instead to conclude that overall treatment provided to patients was within established NaphCare guidelines[65]—is inexplicable. *See id*.

228. In December 2023, NaphCare reported the results of a purported "audit" performed by Dr. Kuntal Pandit, its Corporate Dental Director. NAPHCARE034729. However, this audit again appears to focus only on documentation. The result of the audit was a set of guidelines about documentation, *e.g.*, [redacted] NAPHCARE034730. While the guidelines are unexceptionable, it is again striking that NaphCare's "audit" of dental care fails to mention key flaws in the Jail's dental

[65] Similarly, NaphCare stated that it follows community standards and NCCHC policies for general dentistry. NCCHC standards notwithstanding, NAPHCARE034658. **However, the community standard for general dentistry requires documented periodontal probing and treatment, adequate x-rays for routine examinations, and timely urgent and routine care**.

program, including periodontal probing.

229. Given that the Sheriff's Department does not appear to conduct its own substantive auditing of the dental program, it is unsurprising that it failed to raise several critical issues with the dental program to NaphCare as part of its April 28, 2023 Corrective Action Notice. NAPHCARE034826. Though the Sheriff's Department did identify some problematic issues with the dental program—*e.g.*, timely responses to requests for annual cleanings, an inability of staff to schedule referrals or follow-up appointments, and not authorizing root canals and additional services in accordance with the NCCHC Standards—the CAN failed to identify critical issues related to the quality of care. *Id.* For example, the CAN does not mention many of the issues raised in this report, such as inadequate examinations, inadequate periodontal diagnosis and treatment, and inadequate treatment for dental caries.

230. Due to this lackluster program monitoring, the quality of dental care at the Jail remains substandard. Despite almost a year of attempting to comply with the findings reported in the April 28, 2023, CAN letter and several iterations of responses, a March 4, 2024 letter to NaphCare, SD 1572585, identifies deficiencies in compliance with the Oral Care Services portion of the contract. Specifically, establishing productivity milestones for dentists and hygienists, documenting referrals in TechCare, and providing a written plan to ensure appropriate follow-up appointments with the appropriate professional. However, the monitoring overlooks the most important deficiency, systemwide inadequate care that places all incarcerated persons at risk of serious dental harm.

231. To summarize, the Jail's dental program is poorly managed by both the SDSD and NaphCare due to inadequate policies and procedures and management that is either ignorant of or indifferent to the dental program's clinical deficiencies. Since the Sheriff's Department does not have a Dental Director or even a dental consultant, it is not surprising that serious systemwide deficiencies in clinical care

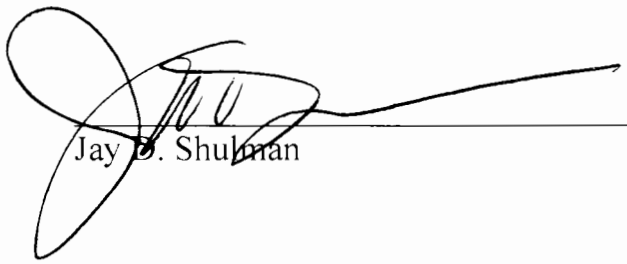
went unnoticed. NaphCare, on the other hand, has two dentists in its employ—a Corporate Dental Director (Dr. Pandit) and a Corporate Dental Consultant (Dr. Kane), neither of whom identified the systemwide inadequate clinical care at the Jail. It appears that the foxes are guarding the henhouse, and as a result systemic deficiencies remain, placing incarcerated people at risk of gratuitous pain and preventable tooth loss.

CONCLUSION

232. In summary, the Jail's dental program is woefully inadequate in both urgent and routine care. The systemwide deficiencies explained in this report place incarcerated people at a substantial risk of harm in the form of gratuitous pain and preventable tooth loss.

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 22, 2024



Jay D. Shulman