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IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

RALPH COLEMAN, et al., Plaintiffs, **v.** **GAVIN NEWSOM, et al.,** Defendants.	2:90-cv-00520 KJM-DB (PC) **DECLARATION J. BICK, M.D. IN SUPPORT OF DEFENDANTS' RESPONSE TO ORDER TO SHOW CAUSE**

I, J. Bick, M.D., declare:

1. I am currently the Director of Health Care Services for the California Department of Corrections and Rehabilitation (CDCR). In this capacity, I oversee the mental health and dental programs providing services to CDCR's inmate patients. Before holding this position, I served as the Chief Medical Executive at CDCR's California Medical Facility from 2010-2020, the facility's Chief Deputy for Clinical Services from 2007-2010, and the facility's Chief Medical Officer from 1994-2007. I submit this declaration in support of Defendants' Response to Order

to Show Cause.

2. I received a Medical Doctorate from the University of Michigan Medical School in 1987, and am a board certified internist and infectious diseases specialist. I completed an infectious diseases fellowship at St. Luke's Medical Center in Chicago, Illinois in 1993, and am a Fellow in the Infectious Diseases Society of America. In addition to my work at CDCR, I have served as a Visiting Associate Professor for Infectious Diseases at the University of Malaya Medical Centre, Kuala Lumpur, Malaysia from 2012-2013; an International Technical Expert on Prisons with the United Nations Office for Project Services, Myanmar from 2013-2014; an Infectious Diseases Consultant for Kajang Prison in Kajang, Malaysia from 2012-2016; and a Court-Appointed Medical Monitor in *Leatherwood, et al. v. Campbell, et al.*, No. CV-02-BE-2812-W (W.D. Ala.), a class action concerning human immunodeficiency virus (HIV) infected prisoners in the Alabama Department of Corrections, from 2005-2007. I have contributed to various publications addressing infectious diseases in the correctional setting, and was the Assistant Editor of the "Infectious Diseases in Corrections Report" from 1997-2008, and have lectured on infectious diseases including Mycobacterium Tuberculosis, Hepatitis C, Methicillin Resistant Staphylococcus aureus, Coccidioidomycosis (Valley fever), and HIV.

3. Coronavirus disease 2019 (COVID-19) is a respiratory illness caused by a novel (new) coronavirus. According to the Centers for Disease Control and Prevention (CDC), the virus that causes COVID-19 is spread by both respiratory and person-to-person contact. (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html, last retrieved April 6, 2020.) Persons infected by the coronavirus have experienced symptoms including fever, cough, and shortness of breath, which can appear 2-14 days after exposure. (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html, last retrieved April 6, 2020.) Infected persons may feel a range of illness, from mild symptomology to more severe illness that can cause death. Other infected persons can also be asymptomatic after exposure. According to Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, the number of asymptomatic cases could be "somewhere between 25 and 50%." (https://www.health.com/condition/infectious-diseases/coronavirus/asymptomatic-

carriers-coronavirus, last retrieved April 6, 2020.) These viremic but asymptomatic individuals can transmit coronavirus to other persons even though they have no symptoms of infection, making it incredibly difficult for health care providers to screen them in the absence of instant testing, while posing high infections risk to populations with whom such asymptomatic individuals intermix.

4. COVID-19 poses a particular risk in confined settings, such as controlled patient facilities and correctional institutions, given the proximity of patients or inmates to one another and the ease with which the virus can be transmitted through a confined population. The CDC advises that some ways to prevent COVID-19 from entering a correctional facility from the community are to limit non-medical transfers in and out of the facility and screen all new entrants, staff, and visitors prior to entering the facility. (https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/index.html, last retrieved April 6, 2020.) Because the greatest danger of exposure to these enclosed communities is by introduction of the virus from external sources, I believe that, in addition to robust staff screening, it is paramount to limit the movement of patients and inmates between such facilities. Limitation of movement to that which is absolutely essential is key to limiting the spread of this virus.

5. Under a Memorandum of Understanding and related agreed-to procedures between CDCR and the Department of State Hospitals (DSH), certain CDCR inmate-patients in the Mental Health Services Delivery System who are both clinically and custodially eligible can be admitted to DSH facilities to receive intermediate-level mental health care. On March 16, 2020, to reduce the possible introduction of COVID-19 into its facilities, DSH temporarily suspended admissions of certain patient groups, including CDCR patients. Since the admission suspension commenced, I have been in regular contact with Dr. Katherine Warburton, DSH Medical Director, concerning DSH's response to the pandemic and potential availability of DSH inpatient resources for CDCR patients. I agree with Dr. Warburton's concerns regarding the importance of limiting patient admissions to prevent the introduction of COVID-19 into DSH facilities. Dr. Warburton and I have discussed conditions under which a CDCR patient who satisfied certain criteria could be evaluated for admission to DSH if absolutely necessary to provide mental health

treatment, and are jointly developing a COVID-19 screening protocol that would be one of the tools that can assist both Departments in evaluating the propriety of a transfer between our two systems. Such evaluations would take place on a case-by-case basis, and, if a transfer to DSH was deemed absolutely necessary from a clinical perspective, all movement should be accompanied by a thorough clinical screening to reduce the risk of COVID-19 introduction to a DSH facility.

6. Based on my conversations with Dr. Warburton, I understand that DSH has reduced movement throughout its facilities to prevent the introduction or spread of COVID-19. For similar reasons, CDCR officials have also taken actions to curtail all non-emergency movement. Recognizing the need to continue providing mental health services to its patients, CDCR mental health staff have worked with the *Coleman* Special Master and his experts to develop temporary transfer guidelines and processes for clinicians to refer patients for various levels of mental health inpatient care. Although still in development, these guidelines seek to minimize, where possible, patient movement outside of their present institution and are consistent with prevailing medical opinions concerning mitigation of COVID-19 introduction risk through reduced inter-institution transfers.

I declare under penalty of perjury that to the best of my knowledge the above is true and correct. Executed on this 8th day of April, 2020, at Davis, California.

/s/ J. Bick
J. Bick, M.D.
Original Signature Retained by Attorney

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