UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JEAN AZOR-EL, et al, Case No. 1:20-CV-03650-KPF
Plaintiffs,
v.

CITY OF NEW YORK, et al,
Defendants.

VIDEOTAPED DEPOSITION OF WITNESS, ROSS MACDONALD, MD, produced, sworn, and examined on May 24, 2021, between the hours of 2:10 p.m. and 4:56 p.m. of that day, via Zoom teleconference, before LIEBE STEVENSON, a Certified Court Reporter within and for the State of Missouri.

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EXAMINATION INDEX

EXHIBIT INDEX
(Exhibits described by PDF file name.)

ROSS MACDONALD, MD, having been duly sworn at approximately 2:10 p.m. on May 24, 2021, was examined and testified as follows:

EXAMINATION

BY MR. KEENAN:

Q. Good afternoon, Dr. MacDonald. How are you today?

A. I'm well. Thank you.

Q. Good. Could you go ahead and identify yourself for the record, please?

A. Sure. My name is Ross MacDonald, and I'm a chief medical officer for Correctional Health Services.

Q. Dr. MacDonald, Correctional Health Services is a unit of the New York City Health and Hospitals Corporation; is that correct?

A. Yes.

Q. Okay. And you are here today as a corporate representative of the Health and Hospital's Corporation and Correctional Health Services to give testimony on a list of topics that we have directed to Correctional Health Services and Health Hospitals, correct?

A. That's correct.

Q. Okay. So I'm going to -- first of all, the deposition notice for this deposition -- and I don't want to take too much time in background, but do you

feel prepared to testify and, again, physically and mentally able to testify today?

A. Yes, I do.

MR. KEENAN: Okay. So we'll go ahead and pull up the deposition notice. And my colleague, Julia Gokhberg, is going to be pulling up these documents, so you'll hear me speaking with her while we do that. And they're displaying on a Zoom screen share. Julia, which exhibit is this going to be in the sequence?

MS. GOKHBERG: I believe it'll be 112.

(Exhibit Number 112 was marked for identification.)

BY MR. KEENAN:

Q. Okay. Dr. MacDonald, you'll see in front of you displayed on the screen what will be marked as Exhibit 112 in this case. Are you able to see it, or is it displaying kind of oddly?

A. It's kind of odd on my screen at the moment.

Q. Okay. All right. Okay. Here we go. Are you able to see it now?

A. Yes.

Q. Okay. Dr. MacDonald, do you recognize Exhibit 112, the Notice of Deposition?

A. Yes.

Q. Okay. And let's just briefly go through that to

the topics. Okay. And do you see these four topics here? Are you prepared to testify as to all of those topics? We just lost it. There we go. Are you prepared to testify as to those four topics, Dr. MacDonald?

A. If I may just make one clarification.

Q. Yes, please.

A. So for Number 1, I can certainly speak to my experience of --

Q. Okay.

A. -- of that.

Q. Okay.

A. But it should be understood that New York City Health and Hospitals is not directly responsible for the sanitation supplies or the cleaning of the physical location.

Q. Okay. How about the remaining topics?

A. Number 2 as well, you know, I could speak to my personal experience with that topic, but you understand the division of labor between the Department of Correction and New York City Health and Hospitals in that regard. So just with those caveats, I'd be happy to talk about those items.

Q. Okay. And how about the Topics 3 and 4? Are you prepared to testify as to those?

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A. Yes.
Q. Okay. Dr. MacDonald, you were alluding to something which is the division of labor between Correctional Health Services and the Department, by which I mean the Department of Correction, New York City Department of Correction. Can you summarize what the division of labor is between Correctional Health Services and the Department?
A. Sure. Most basically, the Health and Hospitals Correctional Health Services, for which I'm the Chief medical officer, is responsible for the provision of health care. And that's a range of health care services from medical care, mental health, social work, pharmacy, and many others, but all in the realm of health care.
We're part of the City's public hospital system, so we're employed by a health care entity. And we operate within the New York City jail system, which itself is operated by the New York City Department of Corrections. So they would be responsible for what's often referred to as care custody and control of those people incarcerated in the New York City jails. They maintain the facility, and they manage all aspects of daily life for those persons incarcerated in New York City jail.

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Q. And just another terminology, kind of, shortcut here, I might vary between using the terms "detainee," "inmate" and "incarcerated person." Can we have an understanding that use of any one of those terms refers to all of the others and we're basically just talking about people who are confined in department facilities?
A. Yes. I prefer "incarcerated person," but we can agree on that, yes.
Q. Okay. All right. So how does -- the Correctional Health Services, which is part of Health and Hospitals Corporation is a separate legal entity from the City of New York. It's not an agency of the City of New York, correct?
A. Well, that gets a little beyond my expertise.
Q. Okay.
A. There's a complex distinction there that I must admit, I don't quite understand. Our colleagues in the law department might be able to describe that better than I can.
Q. Okay. The lawyers representing you here today are the lawyers from the law department in the City, correct?
A. Yes.
Q. And do you know how the working relationship is laid out between Correctional Health Services and

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department in terms of, is there a contract whereby the Department pays Correctional Health Services for the cost of providing care in department facilities, or is it done via direct appropriations to Correctional Health Services, or do you know?
A. No, there's not a contract and it's not a contractual arrangement. And the funding for Correctional Health Services is provided independently by the City of New York.
(Exhibit Number 113 was marked for identification.)
MR. KEENAN: Let's go ahead and pull up what will be Exhibit 113, which is from Correctional Health Services website, I believe.
BY MR. KEENAN:
Q. Doctor, you should have in front of you what's marked as Exhibit 113. I'll represent to you that this is a PDF printout of something from Health and Hospitals web page. Do you recognize this document?
A. I'm not familiar with this document specifically, but I -- it does seem consistent with something that we would put on our internal website -- or externally facing website.
Q. Okay. It's a fairly brief document. I just want to ask you to read the substance of the document and tell me if this is a correct description of

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Correctional Health Services.
A. Okay. Yes.
(Exhibit Number 114 was marked for identification.)
BY MR. KEENAN:
Q. Yes? Thank you so much, Doctor. And let's now go to what we'll mark as Exhibit 114. I'll represent to you that this is a printout of your public LinkedIn profile, just so maybe we can shortcut some of the normal biographical questions. Dr. MacDonald, do you recognize Exhibit 114 as your public LinkedIn profile?
A. Yes, that looks correct.
Q. And is the information in this profile true and correct?
A. I believe so. I'm not the most attentive to keeping this up-to-date, but what I'm seeing here looks correct.
Q. Okay.
A. Everything on the screen here is correct.
Q. Okay. Just curious, can you tell us about your career after medical school and what's brought you to where you're at now?
A. Sure. So I've been interested in mass incarceration as a social phenomenon in the U.S. since I was an undergraduate in college. And in part for that reason, I pursued training in social internal

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medicine, which is a field of medicine that really looks at the interface between social structures, socioeconomics and health. And I've been interested in medical care, in particular for incarcerated people, as well as the ways in which the criminal justice system, and particularly the phenomenon of mass incarceration in the U.S., has impacted health more broadly.

Q. After medical school, did you proceed on to internship and residency?

A. Yeah. So I completed a residency in internal medicine at Montefiore Medical Center in the Bronx. And after completing that residency, I became the deputy medical director for the Bureau of Correctional Health Services at the New York City Department of Health and Mental Hygiene, which at that time, oversaw a contract for the provision of health care services in the New York City jails, and then proceeded to become the medical director of that bureau.

And several years later, there was a change in the way that health care was provided in New York City, in the jail system, whereby the division of Correctional Health Services within New York City Health and Hospitals was created so that we could directly provide care and move away from that contracted model.

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I should also point out that I am a practicing physician as well, and I've maintained appointments previously at Albert Einstein College of Medicine and currently at New York University Medical School. And in conjunction with that, I serve as an attending physician at Bellevue Hospital in New York City.

Q. Is that a private practice, you have just a group of patients who are members of the general public, not specifically incarcerated persons whom you service?

A. It's not private in the sense of it's one of the City's public hospitals as well, but it's -- it is primarily with people who are not currently incarcerated.

Q. Okay.

A. So it's practice in the community that I maintain.

Q. Okay. All right. You talk about your background in social internal medicine, and particularly the challenges faced by incarcerated persons and medical issues in the mass incarceration setting. Can you give us an overview of, based on your expertise, are there any particular challenges or particular threats that COVID-19 has in a correctional setting that are above and beyond the level of threat in the general population?

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A. Yes. So correctional setting, as you know, is a congregate living setting where there are particular risks for the transmission of communicable disease. You know, the field of correctional health has focused a great deal over its existence on minimizing transmission of communicable disease within jails and prisons, whether it's, you know -- management of tuberculosis is probably the most classic example. So absolutely, there is an elevated risk of contracting communicable diseases because of the congregate living setting that exists in jail settings.

Q. Is the fact of a congregate living setting even more threat due to the nature of COVID-19 and the way it's transmitted?

A. Yeah, I mean, COVID-19 is a respiratory virus transmitted by close contact, so certainly that's among the diseases that -- that -- where the risk of spread is potentially greater in a congregate living setting of any sort like a jail.

Q. Are there also challenges in a correctional setting even once there are vaccines in play related to the level of vaccine use among incarcerated persons and staff?

A. Yeah, I mean, there are various mechanisms of control of COVID transmission that we've developed, you

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know, since the first wave of COVID in April -- March and April of 2020. Vaccination has -- and I should point out that for periods of time, at least, those were able to control COVID transmission within the jail really completely, for example, a long -- a long period of time last summer. But we were able to achieve that without the advantage of vaccination. Vaccination is here, thankfully, as a critical means to protect our staff, our colleagues and the Department of Correction and our patients.

But yes, I mean, as you've heard throughout society, you know, there are various levels of hesitancy versus willingness to be among the first to receive the vaccine. And so part of our job as health care professionals is to work with our patients and with our staff to promote the vaccination, and to address any concerns people might have to try to get as many people protected as possible.

Q. Doctor, you mentioned "mechanisms of control" regarding COVID-19. Can you expound more on what you mean by mechanisms of control?

A. Sure. So there are many strategies to try to prevent transmission within congregate settings despite that risk that I mentioned in response to your other question. And perhaps one of the most important with

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regard to COVID-19 is testing and prompt isolation of individuals who are identified to have active COVID, as well as different quarantine mechanisms to reduce movement and mixing among people who might have been exposed to any identified cases, and so along with downstream asymptomatic testing of those populations. And those are really the key strategies to prevent ongoing transmission once a case is identified.

A similar model is important for new admissions who might be coming from the community to maintain low levels of COVID transmission in these facilities, once control has been achieved across the majority of the facility. So a primary root of introduction might then be people coming into jail from a community. And so testing of that population along with cohorting and separation from the general population during a period of incubation is important, as well.

So those are kind of key strategies on the part of Correctional Health Services that pertain to health care, along with, you know, all the things related to personal protection that we see from our departments of health, you know, most critically among those being mask wearing.

Q. So mask wearing is one of the mechanisms of control for COVID-19, right?

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A. Absolutely, yes.

Q. Is it one of the most important mechanisms?

A. It's a very important mechanism.

Q. How about sanitation of high-touched surfaces, is that also a mechanism of control of COVID-19?

A. It is a mechanism of control. I think as the pandemic has evolved, our understanding of the transmission of COVID has led us away from that as a primary mechanism of control. But it is still an important strategy.

(Exhibit Number 115 was marked for identification.)

MR. KEENAN: I think this is going to be Exhibit 115, is that correct, Julia? This will be the New York Times article on lower vaccination rates.

MS. GOKHBERG: Yes, 115.

BY MR. KEENAN:

Q. Dr. MacDonald, we're marking this as Exhibit 115. It is -- I don't know if you saw this in the Times recently. I think it was from couple days ago. But on -- you'll see on page -- starting on page 2, you'll see a header that says, "Vaccinations are lagging at many U.S. prisons, where major virus outbreaks have been common." First off, have you seen this article before?

A. I just skimmed it over the weekend.

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Q. Okay. Do you have any impressions of the information in this article, whether you think it reflects what's going on in correctional settings, etc.?

A. I didn't read it very carefully, I have to say, but I do think that vaccine hesitancy is prevalent in criminal justice settings. So it was broadly consistent with -- with my experience, and the experience of colleagues that we've talked to across the country who are also responsible for health care in these facilities.

Q. Is Correctional Health Services encountering vaccine hesitancy among incarcerated persons in the Department of Corrections?

A. Yes, I don't know of any clinical setting where one would be doing large volumes of vaccinations where one would not experience vaccine hesitancy, but we do -- we do encounter that, yes.

Q. Let me ask you -- put it this way, Doctor, is the rate of vaccination inside the Department among incarcerated persons lower than, the same as, or higher than the general population in New York City?

A. Well, that's a complicated question, in part, because we have not been able to vaccinate the entire population throughout the entire course of the

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pandemic. So what we have seen is increasing -- an increasing percentage of the population vaccinated each week in the last many months since we've been able to vaccinate in the early days that was limited by the groups within the population that we were able to vaccinate.

These days, it is limited by the need to really engage with our patients to talk through the risks and the benefits of the scientific basis for why one would want to protect themselves using a vaccine, and so we see it creeping up week by week. I think the overall rate if you look at just the population compared to the city is lower. But I do believe if you match that for age that it would be comparable or possibly higher than the equivalent population of the city.

Q. And when you say "match that for age," tell me what you mean.

A. By that, I mean the criminal justice population, the incarcerated people in New York City tend to skew younger than the general population, certainly than the general population at a primary risk for COVID. And so the primary focus, as you know, in our society for vaccination has been to start with the -- the elderly populations and most at risk. And there are relatively few people of advanced age within the jail population,

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so the median age is younger in the jail. So if you compare the rates of vaccination to those groups in the city, I think -- I don't know exactly what -- how that shakes out, but I think it would be comparable or perhaps higher.
Q. Do you know, or is that just kind of a --
A. I haven't looked in a few weeks, so I don't -- I wouldn't -- I would hesitate to say. But I believe, you know, if you look among populations say, in the range of 30 or younger, those vaccination rates are not very high in Kansas City as well. And there are many people in the jail system who are of that age group.
Q. So in other words, if we isolate looking at people say, 30 years of age or younger, if you're 30 or younger, it's -- and an incarcerated person in the custody of the Department, there might be an equal or higher chance that you're vaccinated than 30 and under people in New York City, generally? Is that basically what you're saying?
A. I think that's plausible. I haven't -- you know, we'd have to look at the New York City Department of Health website to answer that question today, but yes, that's what I'm alluding to.
Q. Let's talk about people 50 and older. Are you aware or familiar with the idea that say, the Board of

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Correction had been tracking particularly people 50 and older when looking at what's going on in terms of COVID?
A. Yes. You know, there are different -- obviously the risk increases with age, and there are different cutoffs that are used, 55 or 50, but certainly 50 is a common cutoff to look at a higher risk population.
Q. People 50 and older in the custody of the Department what, if anything, can you tell us about vaccination rates of people 50 or older in department custody vis-à-vis vaccination rates of people 50 or older in the general population of New York City?
A. I have not done that direct comparison. What I do know is that vaccination rates among people 50 or older within the jail population are higher than in the younger age groups. I don't know how that compares to the City rate, though.
Q. Okay. Another thing to ask you about regarding vaccine use is correction officers. Have -- has Correctional Health Services encountered resistance to vaccine use among correction officers?
A. Well, correctional office is not today responsible for vaccination for the officers. We did have a brief period of time earlier when we offered. And the offer was accepted by the Department of

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Corrections to vaccinate officers really in the early first few days after they had been authorized as a risk group by the State.
And we did that because we shared a commitment to the importance of vaccinations among the leadership of DOC and -- I'm sorry, the Department of Corrections and the Correctional Health Services. So there was a period of, I think, a week or two when we vaccinated officers while the City was making arrangements for a contracted provider to take over that service. And so it's been several months since we've been engaged with vaccinating officers.
Q. Doctor, would you agree that COVID-19 is still a major threat to life and health at this present time and in the future?
A. Yes.
Q. And would you agree that the fact that there are now vaccines available does not eliminate that threat?
A. Yes.
Q. Dr. MacDonald, does Correctional Health Services do anything to -- whether formally or informally to monitor the level of mask usage inside department facilities?
A. We don't formally monitor the level of mask usage within the facilities. We have very clear policies for

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our health staff regarding the importance of masks. And really, masks are mandatory for our health care staff. We also talk with our patients about the importance of wearing masks, you know, as part of our general counseling about health, and particularly around COVID transmission in the jails. But we don't formally monitor the use of those.
Q. Has Correctional Health Services made any informal observations or are you aware of any impressions that had been made by Correctional Health Services in terms of the wearing of masks particularly by correction officers?
A. So I think that there has been -- there was a period of time -- and I apologize that these many months have sort of blurred together in my recollection. There was a period of time where there were a lot concerns around DOC staff mask adherence that was being raised to me by my staff. I would say that, you know, that led to a lot of conversation with the Department of Corrections, some public -- it was also raised in public by, I believe, the Board of Correction -- I apologize.
Q. Do you need a moment, Doctor?
A. No, no. My screen just went to sleep, but it's back.

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Q. Okay.
A. So I believe there was some public discussion with the Board of Correction around that issue. And then my general impression was that there was a more concerted effort to make that mandatory for DOC staff and some degree of enforcement on a disciplinary level. And in general, my personal sense of that was that things improved quite a bit. And I would say today, you know, I don't really get many concerns from my staff around that issue.
Q. And when you're talking about the conversations that were going on, concerns by DOC, what time frame are you talking about in terms of what you were just referencing a moment ago?
A. That's what's a little hard for me to remember exactly. I think it was -- I mean, it was certainly many months ago. And I think it may have been -- so, you know, if you look at the epidemiology of COVID in the New York City jail system, we have the first wave, which was really March to about mid May in 2020. And then we had a very -- a period of really no transmission within the jail during those summer months from May really to probably about late October or early November. And I think it was during that time period that the COVID cases were very low, both in the jail

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and in the city, where there started to be some laxity among mask use.
And then we kind of entered into a period of a much more attenuated, but still present, second wave within the jail system. This started about November or so, and is just now starting to come back to baseline. And I think it was early -- my best recollection is that it was kind of towards the end of those summer months when the cases were starting to go back up. And that's where there was a lot of concerns, and maybe people had become complacent because of the low rates of transmission. And as I mentioned, you know, seemed like the mask adherence really improved after that, and those types of complaints and concerns abated from my staff.
Q. You personally have not been monitoring footage from inside the Department or touring the Department to check levels of mask compliance, correct?
A. That's correct.
Q. Okay. And so your conclusions about whether it's been getting better are based more on the anecdotal absence of as many complaints being filtered under you, correct?
A. Yes, primarily.
Q. You mentioned a moment ago, Doctor, Correctional

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Health Services' policy on mask usage. Can you summarize what that policy is?
A. You must wear a mask.
Q. What type of mask?
A. So in general care settings, a surgical mask is fine. So in most settings in our clinics inside the jail, our expectation would be for a surgical mask to be worn by our clinical staff.
Q. And is there a difference in terms of the efficacy of a surgical mask versus a cloth mask?
A. Yes, I believe there is.
Q. What is that difference?
A. So, I mean, masks of all types are shades of protection against this respiratory virus.
So, you know, the highest level of protection would be an N95 mask. And that level of protection, which is not perfect for any mask, would decline depending on the particular nature of the mask, the way the mask fit, the number of layers for cloth-based coverings, for example. So I don't know the exact scientific consensus around the decrement of efficacy for each step, but I would say that there's well-defined hierarchy where N95s are the most protective, followed by surgical masks, followed by cloth face covering.

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Q. Are Correctional Health Services staff expected to wear a mask, meaning a surgical mask or an N95, even when they are more than six feet in distance from other people?
A. Yes, they are. You know, as you -- so exceptions to that might be people, as I am right now, in a closed office, you know, where I have, as well, distance from any of my colleagues. But in general, they should wear a mask at all times when they're around others. You know, as we know, we are all human, and so perfect adherence to that is challenging. And there are times when people are not in areas of patient care where they may remove the mask from time to time. But the policy and expectation would be that it's always -- always in place.
Q. Why have that policy and expectation that you need to wear a mask at all times, even if you're going to be more than six feet from people?
A. Well, I mean, I think it's often hard to parse the six-foot question. So it's really just for, you know, simplicity's sake, you know. In general policy, the more nuanced a policy is, the harder it is to follow. So I think that's the primary reason.
Just as there's no magical 100 percent protection from wearing a mask, there's no magical 100 percent

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protection from six feet. You know, there's a continuum of risk, you know, very close face-to-face contact is much higher risk than six feet of distance, but there's not zero risk at six feet or at ten feet probably or 12 feet. So it's really just balancing practicality and, you know, trying to understand human behavior, but also express the importance of this strategy to better health care staff.

Q. And that risk of transmission is especially present when you have an indoor setting that's a congregate setting, correct?

A. Yes.

Q. Okay. We talked a moment ago about correction officers and their level of vaccine use. Are you in any position to give us a sense of what the percentage is of correction officers who have taken a vaccine?

A. No, I don't have access to that information.

Q. I also want to ask you about sanitation, Doctor. I think you said earlier when we were going through the topics in the deposition notice that you can talk about kind of what you personally observed, but don't really know the broader policies and what is actually being done, correct?

A. Yes.

Q. Do you have an understanding just from your

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personal experience and knowledge of what type of sanitation is actually occurring of high-touch surfaces inside department facilities that you actually know is happening?

A. Well, that I actually know is happening is challenging. Again, I'm not there observing the enforcement of these practices or policies. I certainly know from talking with our colleagues in the Department of Correction that their primary strategy has been to use a virucidal agent, which goes by the name of Virex as the primary means for sanitation of high-touch surfaces in the jails.

You know, we collaborated with them just in the extent of understanding that that's consistent with sort of CDC recommendations for these settings, and understand their sort of practices as far as making these items available to staff and incarcerated people in the facilities. I couldn't say, you know, to what -- I can't confirm sort of the schedule or how frequently those things are performed just because I'm not there in the facilities enough to monitor that.

Q. What does Correctional Health Services use to sanitize high-touch surfaces?

A. We do use Virex in the -- in certain clinic settings. Virex is one of CDC approved -- it's not an

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approval process, but it's one of listed agents that could be used for this purpose. We also, though, have access to different types of wipes, which are used for clinical surfaces or equipment.

Q. Can you tell us what those wipes are?

A. I actually don't know the exact chemical formulation of those wipes. I just know that they would also be consistent with, you know, the CDC recommended agent that can be used that would be effectively virucidal against COVID-19.

Q. Would -- why use wipes as opposed to a Virex and a spray bottle or bucket?

A. I think for clinical equipment, you know, there's -- for -- we have a lot of electronic surfaces, keyboards and the like, as well as equipment, EKG machines, things like that where, you know, it's just oftentimes more convenient to use a wipe than to use a free liquid, which could get into the electronic device.

(Court reporter interrupts for clarification.)

BY MR. KEENAN:

Q. Would you agree, Doctor, that ease of use is an important consideration in determining, you know, what mechanisms of control you're going to use?

A. Yes.

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Q. As a practical matter, if you've got an electronic device, whether it's an EKG or a phone handset, having a free liquid that could get in there and everything, it's kind of disruptive and thus makes it less likely that you're going to use it, right?

A. Well, I mean, I suppose it depends on the device, but in general, yes.

Q. But does Correctional Health Services ever give out wipes or alcohol prep pads to incarcerated persons for them to use in cleaning high-touch surfaces?

A. We should not. That would not be part of our policy or practice, though, I do believe that that may occur from time to time.

Q. I think we've gotten some testimony in this case, if I'm not misremembering that and I think I am remembering this correctly, that at the Vernon C. Bain Center, also known as "The Boat," CHS has been a little more regularly handing out alcohol prep pads or something like that, or maybe they're being given to department staff who have been handing them out. But at any rate at some point, alcohol prep pads have been given to incarcerated persons to say, clean phones. Are you familiar with anything like that happening?

A. I don't believe that I've heard that that's happening systematically, no.

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Q. Okay. Let me ask you this: It sounds like to your knowledge, even though it's not official policy, Correctional Health Services staff are or have, at some level, handed out some sanitizing wipes or alcohol pads to incarcerated persons, correct?
A. Yeah. I mean, it hasn't been raised to me as an issue. I know that, you know, just in the practice of correctional health care, there's a constant pressure for various supplies that patients want from us, you know, our clinical staff, our health care staff. And they empathize with people and they will build a clinical relationship, and so there's some level of provision of those items, so it's not a really a recommended practice. And, you know, there might be -- there hasn't recently been an instance where DOC has come to us and said, Hey, this is a problem. But I do see them doing that if we were -- if we were truly distributing those items on a large scale.
Q. Let me ask you this: During the course of the pandemic, are you aware of any incarcerated person misusing an alcohol prep pad or some other sanitary wipe in a way that was disruptive or dangerous in the facility?
A. I haven't heard of that.
Q. Okay. Would you agree with me that alcohol prep

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pads and sanitary wipes, the types we've been talking about, are relatively available and relatively inexpensive to purchase?
A. When you say "available," you mean in the jail facility, or in -- for procurement?
Q. To procure. To procure.
A. Yes, absolutely.
Q. Do you know why Correctional Health Services has an official policy of not giving out wipes to incarcerated persons?
A. Well, with regard to alcohol wipes, there are particular risks in the secure environment that alcohol can pose, most notably flammability is of concern. You know, I think with regard to other wipes, it's really that division of labor that we discussed where it is the responsibility of the Department of Corrections to provide for those items that are required for the physical environment of the jail.
Q. So with respect to wipes, nonalcohol wipes, the reason for not giving them it's not a safety and security issues. It's just kind of a, It's not our job and not our scope of work type of issue, right?
A. Well, I mean, inherent there may be a safety and security issue, so we tend to -- the division of labor and it's not our job, you know, we also are not expert

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in what is most appropriate for the jail setting. So we tend to defer to our partners on that.
Q. And on alcohol wipes and alcohol pads, are you aware of during the pandemic of anybody ever setting them on fire or using them for flammable reasons inside the Department?
A. Not with regard to alcohol wipes specifically. Certainly fires are a concern, and they have occurred sporadically throughout the pandemic. But I don't know that those were started with alcohol, per se.
Q. And fires occurred before the pandemic, too. It just happens from time to time in a correctional facility, right?
A. Yes.
(Exhibit Number 116 was marked for identification.)
MR. KEENAN: Let's bring up what is going to be, I think, Exhibit 116. And this is a testimony, for the record, with the New York City counsel.
BY MR. KEENAN:
Q. While we pull that up, Dr. MacDonald, can you describe what your position is in the -- basically the Correctional Health Services and Health and Hospitals work chart, if you will, like, who you report to, who reports to you?

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A. So I report to the senior vice president for Correctional Health Services, Patsy Yang, and my -- I oversee the clinical services. So my direct reports are in charge of the major divisions of clinical services, so that would be the chief of medicine the cochiefs of mental health, the chief nursing officer, the director of pharmacy operations. So I basically oversee all the clinical staff.
Q. And to whom does Dr. Patsy Yang report?
A. To the CEO Of Health and Hospitals, Dr. Mitch Katz.
Q. And Dr. Yang, it's my understanding, she holds a doctorate in public health, correct?
A. That's my understanding as well.
Q. Okay. But she is not a physician, correct?
A. That is correct.
Q. And have you seen this testimony which appears to be from Dr. Yang to the city council from this past March?
A. Yes, I believe I have seen that.
Q. Okay. Dr. MacDonald, would you agree that the greatest risk of introducing COVID-19 into Department facilities comes from staff and officers bringing COVID in with them when they come into the facility from outside of the community?

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A. That's an interesting question, and I'm just taking a moment to think through whether I would say that's the greatest risk. Certainly, you know, there are several vectors or ways in which COVID-19 can enter a facility. Staff is an important one. You know, early on in the pandemic, we had visitation as well, and I think our first case of COVID we traced to visitation.

And then also new admissions who are coming directly from the community, these are all, you know, potential risk factors. Staff is certainly a prominent one. You know, I would hesitate to rank them, though.

(Exhibit Number 117 was marked for identification.)

BY MR. KEENAN:

Q. Let's look at what's going to be Exhibit 117. It is an Excel sheet showing officers testing positive for COVID. I think this is Bates stamped as NYC 1365. Dr. MacDonald, do you recognize this document?

A. No, I don't.

Q. Okay. Is it part of Correctional Health Services' job to test officers?

A. No, it is not.

MR. KEENAN: Okay. Let's now look at a document titled COVID-19 in the New York City Jail System: Epidemiology and Health Care Response,

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March-April 2020. If we could bring that up, Julia, will that be Exhibit 118?

MS. GOKHBERG: Yes, it'll be 118. Just give me a moment.

(Exhibit Number 118 was marked for identification.)

BY MR. KEENAN:

Q. Dr. MacDonald, you should be able to see in front of you on the screen share Exhibit 118. Can you tell us what this document is, please?

A. This is the description of our early response to COVID in the first wave that we published in the Journal of Public Health Reports.

Q. And you were coauthor of this article, correct?

A. Yes.

Q. One of the things that this article discusses is the difference between symptomatic and asymptomatic testing, correct?

A. Yes.

Q. Can you summarize what the importance is of asymptomatic testing and why asymptomatic testing is important?

A. Yes, so I think early on when COVID came to the U.S., there were fairly restrictive guidelines regarding who would be appropriated to be tested. And so the early recommendation -- well, as a

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parenthetical, testing was not widely available, as well.

I believe we were the first correctional facility in the nation to test onsite. So testing was not widely available. There were sometimes limitations in the total throughput of testing and localities, which we experienced during the first wave. And the recommendations were primarily for testing people with symptoms.

We realized as the pandemic went on that unlike many respiratory viruses, the period of communicability for COVID-19 included several days in a presymptomatic phase of infection, as well as the fact that really the majority of cases, especially in the younger population like ours, were completely asymptomatic. So what we're referring to there is the importance of broad based symptomatic -- asymptomatic testing to compliment, of course, the testing of patients with compatible symptoms as a mechanism to reduce transmission with the facilities like these.

Q. Do you know whether the Department has been conducting asymptomatic testing of correctional officers?

A. I do know that the Department has made testing available on Rikers Island, and encouraged officers to

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get tested regularly and not solely when they have symptoms. That's the extent of what I know about officer testing.

Q. But it's voluntary, correct?

A. Yes.

Q. Do you know if correctional --

A. That's my understanding.

Q. Do you know of correctional facilities and systems in the United States that have mandated asymptomatic testing?

A. Yes, I am aware of facilities that have done that.

Q. Okay. What's your professional opinion on whether that's a good idea?

A. I think it's a complex question and it has -- you know, it bears on so many factors. And what we -- what we've noticed most about COVID is, you know, the situation on the ground changes with great fluidity. The technology changes with great fluidity. And, you know, there was -- so it's a hard question to answer for a system in isolation.

Certainly, I do think that a regimen of mandatory testing could help prevent introduction of COVID into the facilities. But it would require, because of the transmission dynamics that I described earlier, very

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frequent testing, which would be logistically challenging and may take away from other strategies even of COVID control.

So I think it's certainly true that, you know, a very frequent regimen of mandated testing would help keep COVID out of the facility. Is that the best use of resources? And would there be collateral consequences that might outweigh the benefits of that, of an effort like that? Possibly.

Q. Are you aware of any actual instances in which there have been collateral consequences in a correctional system that have outweighed the benefits of a mandatory testing regime for staff?

A. Well, I wouldn't know enough about the systems that have implemented that to know, you know, what the costs were. You know, health staff during many phases of the pandemic have been at a premium and, you know. So the resources they put into testing, especially if it's done by health care staff, you know, are probably health care staff who are not engaged in the treatment of patients, for example. And so, you know, those things need to be weighed very carefully.

(Exhibit Number 119 was marked for identification.)

BY MR. KEENAN:

Q. Doctor, let's look at what's going to be Exhibit

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119. This is an article that I believe you authored titled, "Clinical Care in COVID-19 Patients: Monitor Manage, and Move Out." Dr. MacDonald, this is -- this article that you're a coauthor of starts on page 16 of Exhibit 118 (sic). Can you tell us what this article is?

A. Yeah, this is an article for the bulletin of the National Commission on Correctional Health Care, I believe, which just speaks to some basics of COVID management and these studies.

Q. What is the National Commission on Correctional Health Care?

A. It's a non-profit organization, I believe, that is dedicated to improving health care delivery in jails and prisons around the country. And they do -- they issue standards for care in those settings, and then also do a lot of consulting and technical assistance for different systems.

Q. When was this article published?

A. I don't recall the exact date when this was published.

Q. I think this says this was a fall-winter 2020 issue?

A. That sounds right.

Q. Does the National Commission on Correctional

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Health Care do any type of accrediting or anything like that?

A. They do accredit jail health care, prison health care and opioid treatment programs.

Q. Is the New York City Department of Correction accredited by the National Commission on Correctional Health Care?

A. The healthcare delivery is not the opioid treatment program that Correctional Health Services maintains as accredited by NCCHC.

Q. Has CHS and the delivery of health care component attempted to gain accreditation from the National Commission?

A. We have not since the transition to Correctional Health Services as a division of New York City Health and Hospitals. The contractor to the Department of Health in the prior model that I described would pursue that accreditation for one of those facilities in the bureaus, historically.

Q. Are there some aspects of the delivery of health care that would possibly lead to Department or Correctional Health Services not being accredited if they were to seek accreditation?

A. No.

Q. How come accreditation has not been sought?

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A. Well, accreditation carries a cost, and we feel quite confident, having overseen the contractor that was obtaining that accreditation year after year, that we meet and exceed the standards associated with that. So it has not been a priority of ours since the transition.

We, you know -- but we work with NCC to be able to respect them and understand why accreditation would be important in systems that have, oftentimes, you know, a less robust investment of resources or track record with health care delivery in these settings.

Q. The first page of this article selected on page 16 of Exhibit 118 (sic) has under the header, "Pay Special Attention to High-Risk Populations," it says, "Incarcerated individuals should be considered at risk for serious disease at an earlier age than the general population due to premature aging and higher rates of mortality from COVID-19 in this population. People of color, significantly overrepresented in jails and prisons, are also generally at higher risk for hospitalization and death due to the disease."

Did I read that correctly?

A. Yeah.

Q. Okay. Are those observations true?

A. Yes.

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Q. Above that in this article, there's a mention that there are various challenges inherent in working with incarcerated persons, language barriers, serious mental illness or cognitive impairment, lack of trust, logical hurdles and more. Are those observations true?
A. Yes.
Q. Dr. MacDonald, back to the topic of masks, what is your understanding of what the department's current policy is on correction officers wearing masks?
A. My understanding is that masks are required for correction officers when on duty. I don't have a more sophisticated understanding than that.
Q. Do you think it's important for correction officers to wear masks at all times while on duty?
A. Yes.
Q. Okay. Even when they're -- when they believe they'll be more than six feet away from other people?
A. Well, I mean, as I mentioned, you know, there are shades of risk that the farther away people get, we understand that they're less at risk. If people are outside, we understand that they're less at risk. You know, when people are vaccinated, we know that they're less at risk.
Many of the policies in such places, you know, don't allow for those nuances and shouldn't just for

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ease of -- ease of implementation. But -- so, you know, as we talk through with regard to the Correctional Health Services policy, you know, obviously the farther away people are from others and if they're vaccinated, the risk of transmission goes way down.
Q. Doctor, you talked earlier, but you made the comment, "We're all human." And would you say it's a generally true observation of human behavior that if exceptions are in place to some mandate, it's kind of human nature to try and fit yourself into the exception?
A. Well, I would say human nature is very complex. And if, you know, regulations are overly rigid, sometimes they're wholesale rejected. So I think making policy is a balance between those two extremes.
Q. Why strike the balance at: It's important to wear a mask at all times?
A. You're asking me about Correctional Health Services policy or Department of Corrections policy?
Q. Both.
A. You know, I don't believe that's the -- the entirety of our policy. I think it's a little more complex than that. I may have summarized it in that way. I suppose I don't understand the question.

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Q. My understanding is that you believe -- and we have documents that may indicate otherwise that we can look at. But let's start with Correctional Health Services policy. Correctional Health Services policy is wear a mask at all times, right?
A. So, again, there's a policy document that is not fully summarized by that statement.
Q. Okay. Wear a mask at all times when -- when you are, dare say, chance that you're going to be interacting with people, correct?
A. I think that's absolutely the spirit of the policy.
Q. Okay. Why strike that balance, and say, you need to be wearing a mask if -- at all times when you're getting to be in places where other people are present?
A. As opposed to?
Q. You can take your mask off if you think you're going to be at least six feet away from another person.
A. So again, I think it's a -- it's a bit of a judgment call when writing a policy how you balance that. You know, I think that to make the policy as simple as possible, but to be clear about the spirit of policy and what you want people to do is generally the best strategy as opposed to having a very nuanced policy that weighs out many different situations, which

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most people from their day-to-day work are not going to be remembering and caring with them in their mind.
(Exhibit Number 34 was marked for identification.)
BY MR. KEENAN:
Q. Let's go ahead and pull up Exhibit 34, which has been previously marked in this case. Dr. MacDonald, have you seen Exhibit 34 before?
A. I don't believe so.
Q. Okay. All right. So I'll represent to you, based upon some prior to testimony we've had in this case, that this is the current iteration of the department's policy on masks and face coverings. Why don't you take a moment to review it and tell us when you're done, and we can page to the next page when you're ready.
A. Okay.
Q. Okay. So you've had an opportunity to read this policy now, right, Doctor?
A. Yes.
Q. Is it your reading of the policy that wearing a face covering or mask is only mandatory when you're going to be six feet or closer -- or closer than six feet to another person?
A. Seems to read that way, yes.
Q. Okay. And wearing a mask in other settings,

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including when you might be in a congregate or indoor setting but you are going to be more than six feet away from other people, it is strongly recommended that it's not mandatory, correct?
A. Seems that way.
Q. Okay. Do you think this is the best policy, or do you think a different policy would be a better policy?
A. I mean, I don't think that this is a bad policy. I think the key is that people wear masks when they're in the highest risk situations. And probably the details of what's written in this policy are much less important than what's actually happening in person.
Q. And we may talk about that in a minute, but let me ask you this, Doctor: This is not Correctional Health Services' policy, correct?
A. This is a Department of Correction policy.
Q. Right. And Correctional Health -- the substance of Correctional Health Services' policy is different as well, correct?
A. I mean, I believe so, but not -- I think the spirit of both are the same.
Q. And what's that spirit?
A. That it's important to wear masks when you're doing your job, when you're putting others at risk, and

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that you could be disciplined if you don't.
Q. Why is it important that you could be disciplined if you don't?
A. Well, again, this is a question of human nature and behavior, and I think it speaks to the seriousness with which an organization takes this mandate.
Q. You said that this is not a bad policy. Do you think it's the ideal policy?
A. I have yet to see the ideal policy in my ten years of administration.
Q. Let me ask you this way, Doctor: If you could rewrite anything about this policy, would you, if you had the power to do that?
A. I -- there's nothing glaring to me in this policy that needs to be changed. Would I write it differently if I had to start from scratch? You know, I'm not accustomed to writing policies for the Department of Corrections, so it's a hard question to answer. I think for the purposes of what COVID-19 requires, this policy is fine.
Q. And why do you think it's fine?
A. Because it gets across that basic message that you should wear a mask when you're interacting with people, when you're in high-risk situations, it's part of your job, and you could be disciplined if you don't.

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Q. But implicit in the idea that a policy is fine is that people are actually going to follow it, right?
A. Yes, I mean, policy is -- policy is -- policy is only what's written on the page for sure.
Q. A policy doesn't mean much if people aren't actually broadly following it, correct?
A. Yes.
Q. Do you know whether the Board of Correction has recommended that Department staff wear masks at all times?
A. I'm sure that they have.
Q. What do you think about that recommendation?
A. I'm sorry. Can I clarify a point?
Q. Sure, yeah.
A. That they wear a mask at all times in distinction to the policy that they have, which does allow for removal of a mask when people are more than six feet away.
Q. Right, that's what I'm asking.
A. So I've never heard the Board of Correction raise that particular issue. I know that they're supportive of mask wearing, but again, that would be in the spirit that I mentioned, which is that it's important to do when you're interacting with people in the jail, and it needs to be prioritized by the Department of

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Corrections and correctional officers.
MR. KEENAN: Kind of a natural transition point. Would everybody be okay with taking just a short five-minute break here? I think we're moving along well time-wise.
(A break was taken from 3:29 p.m. until 3:40 p.m.)
BY MR. KEENAN:
Q. Dr. MacDonald, we are back on the record after a short break. Does the Correctional Health Services track deaths of incarcerated persons in the Department, or is that someone else's job?
A. Yes, we do keep track of that.
Q. I want to understand the details of how those statistics are kept. Which deaths in custody count for these COVID-19 death statistics, and which deaths might not count either because it's not known what the cause of death is, or there are multiple causes of death, or somebody was recently discharged from department custody? Can you kind of give me the contours of what is defined as an in-custody COVID death and what is not?
A. Sure, so every death of a person who's in custody at the time of their death is reported. Those deaths that were reported and classified as COVID-related, you know, really was a broad brush if there was any

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indication that the hospitalization proceeding death required treatment for COVID or was in any way influenced by COVID. I think of the number of deaths in custody, which was three that were attributed to COVID, those were all very clear cases of a COVID-related mortality.

Q. Can COVID also be a contributing cause in combination with other underlying morbidities whether it's -- I don't know, I'll just come up with something, COPD, or cancer, or diabetes or something like that, and you can have multiple potential contributing factors to an in-custody death?

A. Yes.

Q. Okay. Is there any clear way of disaggregating that, or knowing -- I guess what -- what is done -- let me start by asking this: Do you know how many in-custody deaths period there have been of all causes during the COVID-19 pandemic?

A. The exact number is escaping me. I believe there were some mentioned, but I was aware of three COVID-related deaths in custody. And I think, you know, there were probably less than ten other deaths in custody during that time frame, but I don't remember the exact number.

Q. If we were to compare the period of the pandemic

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with a prior similar period, and what I'm going for is this term that you certainly know better than I do, being a health person, but I've seen this term "excess deaths." Can you explain from a medical and public health standpoint what the term "excess deaths" means, and why this is an important term in analyzing the effects of an epidemic in a population?

A. Yeah, so excess deaths really refers to sort of the deaths in excess of some expected baseline in a population. And so whether those are attributable to COVID or not, you may see an increase in the overall death rate in a population, which was certainly observed nationally during the COVID pandemic. And that could be from, you know, deaths that are among patients with undiagnosed COVID, or deaths related -- in patients who don't have COVID related to other changes in society, such as changes in the health care delivery system.

You know, if a hospital's overwhelmed and they have limited resources to identify and treat something else, if a person doesn't seek care because they're afraid of contracting COVID at the hospital for some other condition and end up dying of that, all those types of death would be wrapped up in that excess deaths for a population.

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Q. Has there been any analysis of excess deaths or attempt to arrive at an excess deaths figure for incarcerated persons in the Department during the pandemic vis-à-vis a prior similar period before the pandemic?

A. There hasn't been a formal analysis but, you know, I've been doing this for about a decade and, you know, in 20 -- the overall trajectory of deaths in custody has been markedly down. And so, you know, in 2012 or 2013, there were more than 20 deaths in custody in a single year. So there's not been a formal analysis, but even a back-of-the-envelope calculation would suggest that, you know, somewhat surprisingly, the number of deaths since the pandemic has not been greatly outside of the norm in New York City jails.

Q. And is part of that, the continuation of the general downward trend in the baseline number of deaths because of say, maybe greater measures to prevent violence in the facility, or things like that? Is part of that baseline just a continued downward trend?

A. It may be. Yeah, it may be.

Q. Say, in --

A. It's complex to see that, all the factors. And, you know, we should also point out that the annum deaths, the total number of deaths in a given year, is

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a relatively low number such that, you know, there might be a fair amount of random variation there.

You know, 2019 was, you know, by far the lowest number of deaths in custody that the New York City jail system had ever seen. And -- you know, and if you go back further than my time here, you know, there were years with more than 50 deaths in custody. So things have changed dramatically, and there's many different factors that go into that.

Q. In 2019, how many in-custody deaths were there for the entire department?

A. I believe in 2019, there were three.

Q. Okay. In 2020, how many in-custody deaths were there?

A. So that's the number I'm not remembering off the top of my head. But it was less than ten, if my recollection serves.

Q. Okay. And in 2021, so far how many in-custody deaths?

A. I don't have the exact number again, but it's -- it's in the single digits so far this year.

Q. I want to ask you another question about the in-custody deaths statistic. Does in-custody deaths include people who were recently incarcerated but died out of custody shortly after being discharged from

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custody?
A. No.
Q. And does the in-custody death statistic reflect deaths of people who were transferred to a hospital after being in a correctional facility?
A. People who are transferred to a hospital remain in custody unless they're released from custody. So, you know, it tracks 100 percent with the custody status, whether they're an incarcerated person in the New York City jail system, which, you know, many people are, even though they're hospitalized.
Q. Is anyone ever discharged from custody while they are in the hospital?
A. Yes.
Q. Okay.
A. It's a common occurrence.
Q. Okay. So could there be people who were in the hospital, were there with COVID-19 and were discharged while they were in the hospital with COVID-19?
A. Yes.
Q. Okay. And do you know whether, in fact, that has occurred?
A. Yes.
Q. Okay. Do you know how many discharges from custody there have been while somebody was in the

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hospital being treated with COVID-19?
A. I don't know the exact number, no.
Q. Do you know an approximate number?
A. So I would say less than ten.
Q. Okay. Do you know how many of those people are still living and how many are not?
A. Oh, I'm sorry, I misunderstood your previous question. I thought you were asking me how many people has been discharged from custody and subsequently died. That was the answer to less than ten.
Q. Okay. So there is a number of people who have been identified who have been discharged from custody and subsequently died of COVID-19 after being discharged in the hospital being treated for COVID-19, correct?
A. Yes. I'm aware of cases like that.
Q. Okay. And you believe that it is fewer than ten cases?
A. I do believe that, yeah.
Q. Is it more than five cases?
A. I don't know that I could say with that level of specificity.
Q. Okay. Where are these statistics kept? How is this information compiled?
A. So historically, it has not been kept. And

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really the rationale for that from Correctional Health Services' perspective is that these are -- once a person is no longer detained, they are not a patient of ours. So we don't track our health outcomes related to that.

There has -- you may be familiar with media reports locally about people in a situation. I don't know if you are. But there has been media reports of people in this situation in New York City, which prompted the City to do some inquiry into whether this could be tracked in a more systematic way.
Q. And so did someone end up tracking it in a more systematic way and trying to -- trying to track down how many people were discharged while in the hospital with COVID and subsequently died?
A. Yes.
Q. Okay. Describe for me the process of how that occurred, please.
A. So there's been discussions within Correctional Health Services and City of New York about how that could happen, and also, you know, the legal -- the legalities of how that could be reported. Again, you know, there's a question of patient confidentiality when a person's no longer in custody, you know. So I think there's still -- those questions are still

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actively being investigated by the City.
Q. Why would someone be discharged from Department custody while they're in the hospital with COVID?
A. There's a variety of reasons. People -- because of the jail setting, the length of stay is short in general. So, for example, a person could have their bail paid at any time.

It's also the case that when people are critically ill, Correctional Health Services will advocate often on their behalf with their defense attorneys for their release, specifically because there are, you know, benefits to the care of seriously ill patients that come from not being incarcerated. You know, most importantly it allows for much easier visitation from someone's family if they're not in custody when they're critically ill.
Q. Does Correctional Health Services keep a database or file or a document or anything that records what's been tracked down in terms of number of people discharged in the hospital with COVID-19 and who later died?
A. Well, that would not be maintained by Correctional Health Services solely. Again, we don't have access to the information about what happens to a person after they're released from custody because

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they're no longer under our care.
Q. So the number you're giving me of, you know, some number fewer than ten, but we don't know whether it's more than five or not, what -- what are you deriving that number from? Have you seen some documents, seen some information, heard something from somebody?
A. That's from this ongoing effort that I described to you to get to a number. And I'm not sure if that number has been identified yet.
Q. Who's involved in this ongoing effort?
A. Correctional Health Services along with the City government, the Mayor's office.
Q. But in terms of actual individuals who are involved in this process, who all is involved in that?
A. So I'm not privy to, you know, all the players involved in it, but, you know, there's been discussion between the law department and the -- the Correctional Health Services leadership and Health and Hospitals generally. I think, you know, it's a question that's been raised of sort of public health significance that people are actively engaged in investigating whether that could be answered or reported in some way that is, you know, compatible with the law, and, you know, the ethics, our duties to our patients.
Q. Do you know when the most recent death of this

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type occurred, somebody was in the hospital being treated for COVID and they were discharged from the Department custody, and subsequently died? Do you know when that most recently happened?
A. My understanding is that that only happened in the first wave, and there have been no subsequent cases that meet that description, that I'm aware of.
Q. Have there been other cases of people who died of COVID after being discharged from department custody who maybe weren't in the hospital or were in a different situation?
A. We would not have any way to know that.
Q. Does Correctional Health Services record as COVID deaths persons who die of COVID-like symptoms that haven't tested positive for COVID or haven't had a test?
A. I'm unaware of any such cases. Testing was available enough that any person in that situation would have been tested, even early on.
Q. Would you agree that it's fair to say that the -- the number of deaths of persons from COVID that can be traced to time in custody at the Department is greater than three?
A. Yes.
MR. KEENAN: I know we're getting

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towards 5:00 here. I don't have a whole lot left. I'm going to try and go quickly, but I just want to know if we need to go just a little bit after 5:00, does anybody have any hard conflicts going on? All right.
If we could, please, pull up Exhibit 66.
(Exhibit Number 66 was marked for identification.)
BY MR. KEENAN:
Q. Dr. MacDonald, this is document previously marked at Exhibit 66 in this case. It is a redacted version of a report compiled by the Board of Correction titled, The April 2020 COVID-19 Deaths of -- three redacted individuals' names. I will represent that based on information we got, we believe that these names are [redacted], [redacted], spelled [redacted], and [redacted]. Are you familiar with all of those names?
A. Yes.
Q. Okay. And are those, in fact, the names of three people who died in custody during COVID-19?
A. Yes.
Q. Okay. Have you seen this document, Dr. MacDonald?
A. Yes, I have.
Q. And you've read it before, correct?
A. Yes.
Q. Do you recall generally what the recommendations

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were that Board of Correction made to Correctional Health Services in this report? And I'm referencing page 4 of the document.
A. Yeah.
Q. Which is redacted.
A. There -- there was a recommendation regarding the timeliness of providing COVID testing results to patients, if I recall correctly, and a recommendation regarding use of some routine treatment modalities during a respiratory pandemic including CPAP, which is a continuous, positive airway pressure which is used to treat -- which is used to treat sleep apnea.
Q. Sorry, go ahead, Doctor.
THE WITNESS: Can I interrupt for a moment?
MR. KEENAN: Yes, sir.
THE WITNESS: Do you mind if I have a short break just to take a phone call?
MR. KEENAN: Of course not. When do you want me to come back?
THE WITNESS: It should be less than five minutes.
MR. KEENAN: Okay. All right. We'll plan to come back in five, but if it takes longer than that, that's fine. I'll pause the recording.

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(A break was taken from 4:02 p.m. until 4:09 p.m.)
BY MR. KEENAN:
Q. We are back on the record after a short break, Dr. MacDonald. Pardon me. Would you say that the deaths of [redacted], [redacted], and [redacted] were preventable if DOC, the Department, had implemented different measures in advance than they had at the time?
A. I don't believe so. You know, I think a respiratory pandemic like this, overwhelming activity like New York City is inevitably going to have a large degree of transmission within the correctional facility like the New York City jail. And I think DOC did everything they could to try to mitigate the harms that were inevitable from that.
In a crisis like that, is everything going to go perfectly in every single case? Certainly not, but I would not call these preventable deaths. You know, I think the most important thing that could have happened to prevent it would be if they had been released from custody, which would have given them potentially less risk to be exposed to COVID. But I think DOC did everything they could under the circumstances.
Q. Do you think DOC is doing everything it can now, or do you think there's some --

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A. Yes.
Q. -- that it has room for improvement?
A. I think -- I think they're doing everything they can. I mean, you know, is any agency or any correctional facility perfect? No. But they've been, you know, a model agency in responding to COVID from the beginning of that first wave, and, you know, suffered, sadly, losses themselves. You know, they continue to come to work as public servants and do their jobs. I have no major contentions with the way they're handling COVID at all.
(Exhibit Number 67 was marked for identification.)
BY MR. KEENAN:
Q. Let's look at Exhibit 67. So I just want to summarize, you know, before we look at this, Dr. MacDonald, there's nothing you'd change in terms of Department policy or its implementation of those policies?
A. As far as COVID control today?
Q. That's correct.
A. I -- I'm not -- I'm just trying to be thoughtful about the question. You know, is there -- the health people in a position like mine are never going to be 100 percent in agreement with the security people, but we each have our other priorities and needs.

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I think they're doing a fantastic job. There is no major liability or risk that they're imposing right now. There's no major policy flaw. There's nothing that they're doing that's presenting a critical risk for COVID.
So I would have to answer that question no. Are they perfect? No. I mean, it would be ridiculous to expect perfection from any large institution like that under the circumstances.
Q. Doctor, are you familiar with the term "long COVID"?
A. Yes.
Q. What is long COVID?
A. Long COVID is used to refer to the sequelae, to use a medical term, of COVID-19 infection whereby, a patient may have a constellation of symptoms that occurs just after the acute phase of infection has resolved. Or patients may have sustained damage to different organ systems, be it the cardiac function or kidney function, or may just be recovering from prolonged critical illness, for example, if they spent time in intensive care unit.
Q. Dr. MacDonald, has Correctional Health Services or the Department kept any statistics on the number of incarcerated persons with long COVID or formerly

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incarcerated persons with long COVID?
A. We have not systematically tracked long COVID in the jail system, no.
Q. Have there been any tracking of any sort?
A. Not sort of at a public health level, no. You know, patients will be -- who remain in custody continue to be treated by Correctional Health Services. And there may be patients who have lasting effects of COVID, you know, which could range from disordered olfactory sensation, to worsening of chronic disease, but, it has not been systematically tracked. Again, we provide care to individual patients based on their clinical presentation. We haven't done a study, per se, of long COVID in the jail system.
Q. And when we talk about long COVID, we're using that term to -- and you're using that term to include people who say, you know, they might have impaired kidney function or something like that. You would include that in long COVID, correct?
A. I would, yeah.
Q. Okay. Basically, any long-term damage as a result of COVID-19, correct?
A. Yeah, I think as a general term, that's all included in that generally, yeah.
Q. Okay. Dr. MacDonald, can you see Exhibit 67

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here?
A. No.
Q. Does the -- does Correctional Health Services make any observations about crowding inside facilities or social distancing inside facilities?
A. What do you mean by observations?
Q. Like, do Correctional Health Services look at what's going on inside housing units and make an assessment of whether there's enough social distancing done?
A. Not typically. So we have argued as a health service for decarceration. One of the benefits of decarceration is that it allows for less density in housing. But we don't make recommendations, you know, on a case-by-case, housing-area-by-housing-area basis for the density of the setting. We do track housing areas that have been exposed, and collaborate with the Department in quarantine of those housing areas.
Q. It's your understanding that in many of the housing areas and facilities inside the Department, the population is at or near the pre-pandemic capacity, correct?
A. Yes. The population is roughly the -- the system as a whole is roughly the same or higher than it was before the pandemic.

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Q. Okay. And it stands to reason that that creates challenges in terms of social distancing, right?
A. Yes.
Q. Would you agree with me that as things stand right now, there are not at least six feet of distance between every inmate in department custody in housing units?
A. Yeah, I mean, social distancing is never going to be completely possible in congregate housing.
Q. It was being done better earlier on in the pandemic than it's being done now, right?
A. When there were fewer people, it was easier to do social distancing. Many more people have immunity today than they did at that time.
Q. Have you done studies on that, like, to verify that many more people have immunity?
A. Well, we've vaccinated thousands of people along with having data about prior infection and antibody status for large numbers of people in the jail population.
Q. But many of the people in a given jail setting will be new admits, right?
A. Yes, there's a -- a constant introduction of new people into the jail system, so it's important the community efforts to vaccinate continue, as well.

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Q. And so with facilities at their preCOVID capacity, many of the people in those facilities are going to be relatively new admits and you can't really know whether they are immune or not, right?
A. Well, as you know, we -- we have implemented Systems to cohort new admissions together, and to ensure that they have negative testing before they're sent to general population. And we also do offer vaccine in those settings.
Q. How are new admits housed? Are they in individual cells or in congregate cells?
A. Well, they're housed together in cohorts and that, up until last week, was primarily done in a facility that was majority cells. But more recently, I think the majority of those people are housed in -- I'm sorry, up until last week in a facility that was majority dorms. And as of last week, I believe most of those people are housed in housing areas that are cells.
Q. Do you know what share of them are in cells now and what share are in dorms?
A. Not exactly, but the majority would be in cells.
Q. Okay. And if you're in a cell, is it with a cell mate, or is it on your own?
A. No, there's no double celling in my experience in

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the New York City jails.
Q. So these would be single cells, correct?
A. Yes.
Q. Okay. All right. But if you're in a congregate setting and you're basically unlucky enough to be in a cohort with someone who's got COVID-19, good chance you're going to get exposed to COVID-19, right?
A. Well, we consider everyone in that housing unit to be potentially exposed, yes. The majority of people in those units do not develop COVID-19. But certainly there's an increased risk of developing COVID-19 among those patients who are exposed to a case that's identified in their housing unit.
Q. Are you able to determine at this point in time what percentage of the Department population in custody is fully vaccinated?
A. Yes, I believe we're reporting that publicly.
Q. Okay.
A. On a daily basis.
Q. What percentage is that today?
A. I don't have the fully vaccinated number off the top of my head. I believe it's 35 percent or so that have at least one -- one vaccine.
Q. Okay. But that would be either just one vaccine, or both if you're taking a two-shot regimen, right?

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A. The 35 percent number is -- is all vaccinated people, so some of those may not have gotten their second shot if they're having a two-dose regimen.
Q. Okay. When -- what's the balance of use of the various types of vaccines between the Johnson & Johnson vaccine and Pfizer vaccine and Moderna vaccine inside the Department?
A. We have used primarily Pfizer from the beginning. We had some use of Johnson & Johnson during the brief window from its approval and availability to the pause. And since that time, we've had much less uptake of Johnson & Johnson than we had before that. But we still do make those two options available, depending on the particular jail location. But Pfizer has been really the mainstay of our efforts.
Q. Do you use the Moderna vaccine at all?
A. No. For logistical reasons, you know, it's generally preferable to distribution efforts that a health care operation be focused on one or the other. It helps us because second shots have a different schedule, and those types of things.
It's important to have Johnson & Johnson available because many patients prefer the one-shot regimen, although the reputational damage from the pause has been significant, we've found.

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Q. Is there a reason the Department went with Pfizer over Moderna?
A. No, it was the first -- well, first of all, let me clarify that I'm discussing Correctional Health Services, not the Department of Corrections --
Q. I'm sorry.
A. -- that would handle or administer those vaccines. But really, the first one available to us. We had also positioned ourselves early on with an ultra cold freezer, which is required for storage of Pfizer; it fit in that way.
MR. KEENAN: Okay. I'm going to quickly go through some documents just to really just mark them for identification more than anything else. Can we bring up what I think will be 119, Julia or 120? There we go, 120.
MS. GOKHBERG: 120. 120.
MR. KEENAN: All right. Exhibit 120 will be Bates stamped NYC 464.
(Exhibit Number 120 was marked for identification.)
BY MR. KEENAN:
Q. Dr. MacDonald, do you recognize this document?
A. Yes.
Q. Okay. And can you identify what it is?
A. So this is a Correctional Health Services

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document that is patient-facing or directed towards patients describing mechanisms by which they can receive care after they're released from incarceration.
MR. KEENAN: And let's go ahead and bring up NYC 465. It will be Exhibit 121, please.
(Exhibit Number 121 was marked for identification.)
BY MR. KEENAN:
Q. Can you identify this document for us, please, Doctor?
A. So this is a patient-facing document informing a patient in our care about the COVID-19 vaccine and their eligibility to receive it and the reasons why they should.
MR. KEENAN: And Julia, could we please bring up what will be Exhibit 122, Bates stamped NYC 466?
(Exhibit Number 122 was marked for identification.)
BY MR. KEENAN:
Q. Dr. MacDonald, can you please identify Exhibit 122?
A. This is a Department of Corrections-distributed flyer with information about COVID-19 for people incarcerated in the New York City jail, and correctional officers have been put into these flyers, as well.

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MR. KEENAN: Julia, could you please bring up a document Bates stamped NYC 468? It will be Exhibit 123.
(Exhibit Number 123 was marked for identification.)
BY MR. KEENAN:
Q. Can you identify Exhibit 123 for us, please, Doctor?
A. This is an information pamphlet for patients. Seems to be primarily about the health triage line, which is a line that's available for them to contact Correctional Health Services to request care or raise a concern.
Q. And when you said, "for them to contact," you're referring to incarcerated persons or someone else?
A. Incarcerated persons.
(Court reporter interrupts for clarification.)
BY MR. KEENAN:
Q. As a practical matter, how would an incarcerated person call the triage health line?
A. Through the phone in the housing area.
(Exhibit Number 124 was marked for identification.)
BY MR. KEENAN:
Q. Next, let's take a look at document NYC 470. This will be Exhibit 124. Can you identify what Exhibit 124 is please, Doctor?

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A. This is a patient-facing flyer describing a dedicated phone line that we set up to -- for people to raise concerns about mental health during the pandemic.
Q. Is that line still operational?
A. No, the mental health requests have been incorporated into the health triage line, the general number for the health triage line.
Q. And how are these flyers distributed?
A. In collaborating with the Department of Corrections. We have division of operations within Correctional Health Services that coordinates with the Department on distributing materials.
(Exhibit Number 125 was marked for identification.)
BY MR. KEENAN:
Q. Next, let's look at CHS Access Report from January 2021. This will be Exhibit 125.
Dr. MacDonald, you'll see here Exhibit 125, it's a 54-page document. It's for -- it's titled CHS Access Report January 2021, but it says under that "Version 4/15/2021," correct?
A. Yes.
Q. Can you identify for us what this document is, please?
A. This is a document that is publicly reported to the Board of Correction regarding access to services

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within the jail system.
Q. And when was this document issued? Because it says January 2021, and then it says April 15, 2021? Help me understand that, please.
A. I don't know the answer to that question. This is developed by our monitoring and evaluation department. And that's not -- I'm not certain when exactly it was issued or which time period it covers.
(Exhibit Number 126 was marked for identification.)
BY MR. KEENAN:
Q. Okay. Next, can we go to what's going on Exhibit 126, which is CHS Local Law 58 report, Quarter 1, 2021. So this will be Exhibit 126. It says Version 4/27/2021, Local Law 58, looks like CY for calendar year 2021, Quarter 1, January through March. Dr. MacDonald, can you identify Exhibit 126 for the record, please?
A. Appears it's a public reporting. It was --
Q. What is -- oh, sorry. Go ahead.
A. Responsive to the local law that's cited there.
Q. What is Local Law 58?
A. I don't remember the details of that law, but it's a reporting law that requires Correctional Health Services to report certain metrics about care and access, I believe.

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Q. And this, as with previous documents we saw, 120 through 125, this is a Correctional Health Services document, correct?
A. Yes, it appears to be.
(Exhibit Number 127 was marked for identification.)
BY MR. KEENAN:
Q. Let's now look at a report for May 3rd to May 9, 2021 under Local Law 59. This would be marked as Exhibit 127. Dr. MacDonald, can you identify Exhibit 127 for the record for us, please?
A. It reads, "Local Law 59 Report for week of May 3, 2021 to May 9, 2021."
Q. And what is this? Tell us what it is, please.
A. I'm not familiar with what this is. If you show me more pages of it, I might be able to give you more information. But we do a great deal of reporting responses to local laws or to oversight, which is managed by our monitoring and evaluation department.
Q. And this is a Correctional Health Services document, correct?
A. Appears to be, yes.
Q. Do you know what Local Law 59 is?
A. So you'll have to excuse me for not keeping them all straight. But I think it's one of the reporting laws that requires us to report certain things

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publicly.
Q. Dr. MacDonald, has Correctional Health Services made any recommendations to the Department regarding the response to the COVID-19 pandemic?
A. We've been in constant collaboration with the Department of Corrections at the highest levels since March of 2020.
Q. So really, you've been working together on this, right?
A. Yes.
Q. Okay. Have there been any recommendations from Correctional Health Services that the Department has not implemented?
A. There have.
Q. Can you tell us what those are, please?
A. You know, I don't know that I can give an accounting of them. I think the response for this pandemic required a constant collaboration and a balance between health interests, COVID control interests and the interest of maintaining the safety and security at functional operational of the jails, and that's what we've been engaged in.
You know, there are things that they want to do that we say we can't do. There are things that we want to do that they say we can't do. That's the nature of

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responding to a crisis together, and balancing our different perspectives.
Q. I appreciate that, Doctor. My question was a little different. Are there any measures that Correctional -- what are the measures Correctional Health Services recommended to the Department that the Department has not implemented?
A. So early on, we encouraged them to make hand sanitizer available, and we engaged in a discussion around that. And they described the potential security risk of an alcohol-based hand sanitizer, including -- you know, which was very important to me, the risk of flammability and the risk of injury to patients through scalds or actual fires in a facility. So, you know, we talked through that recommendation and they made their case for why that would not be the safest path forward, and described how there were viable alternatives, which is what they implemented, as I understand.
Q. What other recommendations has Correctional Health Services made that the Department has not implemented?
A. I think we made a similar recommendation around bleach.
Q. Okay. What was that recommendation?
A. Well, again, you know, early on in the

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pandemic -- and I would say this was not a formal -- this was not a formal recommendation from us to them, but really, things that come up in the context of collaboration and preparation for a crisis, you know.
And so we talked through bleach as an alternative, and they really were able to describe to us the -- the mechanisms of dispensing and the relative safety benefits of the Virex solution, which became the preferred method of sanitizing surfaces, and so we moved forward with that.
I don't know that I would characterize it as a formal recommendation, again, because, you know, these are two entities with different areas of expertise collaborating together to come to, you know, the best the way to care for the patients. We call them patients, they call them detainees, who are -- who are responsible for them.
Q. What other recommendations has Correctional Health Services made that the Department did not implement?
A. I can't really think of another recommendation. And I'm not even sure that those were recommendations, so much to think that we advocated for in the course of collaboration --
Q. Proposal, why don't we use the word "proposal"?

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A. I can't think of another proposal that Correctional Health Services put forth with regard to COVID control that was rejected by the Department of Corrections.
Q. Anything involving sanitization or sanitation?
A. No. Like I said, we discussed hand sanitizer, we discussed bleach early on, and they were able to make their case. And, you know, I understood them to be making those decisions in good faith based on what they thought was best for the situation, so we moved on.
Q. How about mask wearing? Any recommendations or proposals by Correctional Health Services regarding mask wearing that the Department did not fully implement?
A. No. As I said, you know, there was a period of time where there was a general feeling that mask adherence had dipped and was too low. It would raise concerns around that time to the Board of Corrections publicly and, you know, the Department worked hard to address those. And the general sense among my staff was that mask adherence went up and those types of complaints abated.
Q. How about recommendations or proposals involving social distancing?
A. No.

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Q. How about decarceration or population control?
A. Decarceration is a complicated issue because it's very much out of the hands of the Department of Correction who's actually incarcerated. There was a smaller population of cities and individuals that they -- which I would never have known before the crisis occurred, but they actually had the legal authority to release from custody -- from jail incarceration with some form of community level supervision, which they did as an emergency measure.
And that was an important component of the overall decarceration that Correctional Health Services advocated for, but most of that was outside of their control.
Q. What is currently going on to try and persuade people to take vaccines and overcome objections to taking vaccines?
A. Yeah. So we are -- health staff are engaged in conversations. I mean, really conversation is the key tool that we have to try to get our patients to understand the tremendous health benefit of vaccination. We have tried every method of making vaccine available, including big points of vaccination within facilities where people from all corners of the jail can be escorted to receive a vaccination in a

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central location, to calling people down to the clinic setting, to discussing in almost every almost clinical encounter the importance of vaccination, inviting patients using our electronic health record for follow-up for vaccine appointments, to roving teams of pharmacists, nurses, and office PAs, physician assistants or doctors who will go from housing area to housing area with vaccines, which is a logistically effective effort, but we found that it's important to minimize the barriers. It's often most effective to bring vaccine directly to where people are housed within the jails.

So we pursued all of that, for instance, as we will continue to for months and years to come.

Q. What are the biggest objections that you're hearing to vaccines, or barriers?

A. You hear every objection that has been raised in the media that has been talked about on social media. You know, we've -- we had a population of patients who were ready to be first in line, and we have patients at the other end of the spectrum who are absolutely convinced that the vaccine will harm them, and that it's part of a conspiracy to do harm to them, and every part of the spectrum in between.

So we -- our most important strategy is to be

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there week after week to demonstrate that we believe in this vaccine, that we've taken it ourselves and that care about our patients, and that we want them to take it because we care about their health and want them to do well in life, and particularly in the vulnerable situation they're in, being incarcerated during a pandemic.

Q. What are you doing to get information out there regarding some of the myths about vaccines and dispelling some of the myths?

A. Yeah, so we've done patient information flyers. But as I said, a lot of that is the work of our clinical staff on the unit engaging in these discussions with groups of patients together, and often leveraging their peers to participate in the discussion.

The more people we get to take the vaccine, the more advocates we have for vaccination. That's an important strategy, as well.

So it's really, you know, trying to build trust, trying to demonstrate consistency, trying to demonstrate caring as really the driver, the driving force of why we keep offering over and over and over.

And we do run into situations where people tell us to go away because we've been there so much with

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this same message. So it's really just going to take time, and we're going to keep working at it for as long as it takes.

Q. Is the vaccine currently available to every detained person?

A. Yes.

Q. Incarcerated person?

A. Yes.

Q. I want to quickly ask you about the actual availability of soap and cleaning supplies inside housing areas. I think you told me at the beginning of the deposition, you could, you know, give me some of your personal observations. Have you been in a position to have any systematic sense of how widely soap is available, actually available, and how widely cleaning supplies actually are available in housing areas?

A. I wouldn't say in a systematic sense, no. You know, in housing areas from time to time, supporting staff, I've been in housing areas talking to patients about vaccines, but I wouldn't call it a systematic surveillance.

You know, I -- there is absolutely no contention about the provision of soap, and so I think the Department has ample resources and makes soap extremely

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widely available. So I do believe soap is broadly available.

And, you know, I think there's been so much attention and importance on the other forms of cleaning, you know, the Virex and other things that we've talked about, you know, I think it's -- my sense is that it's widely available. And this is not one of the concerns that people raise to me when I go around the facility.

Q. Some of the testimony we've heard in this case from some of the incarcerated persons is that Virex is not systematically available. Sometimes it's locked in a closet. Sometimes all they've got is mildew remover and not Virex. Would you have any reason to doubt that testimony?

A. Not specifically, no.

Q. I think we're finished here, but give me just a second.

Dr. MacDonald, just a couple more questions. In terms of mask wearing, proper wearing of masks, so over nose and mouth, I estimate that on average a number of the incarcerated persons we've heard from in the last couple weeks say on average that there's maybe about 40 percent compliance by correctional staff in terms of properly wearing a mask. Would you have any reason to

doubt that observation?
A. I mean, my personal experience would be higher than that.
Q. Okay. And what do you base that on?
A. Just from walking around the employees. I am wearing a suit when I walk around, so understanding that people may be putting them on when I'm coming by, but that seems quite low.
Q. Would you -- if that is, in fact, what is going on, would you find that problematic?
A. Well, I mean, I think it certainly -- the more mask wearing, the better. I think there are many different elements of control of this virus in these settings, and what we're seeing from the second wave is that it was much more mild than the first wave. And by that I mean, fewer cases, the vast majority of those cases being asymptomatic, which is a reflection of the broadness of our testing strategy, and increasing levels of immunity in the population.
So if that's the case, then things are moving in the right direction despite that. And I think they will continue to because, you know, immunity and vaccination are the clear pathways to really get to continue societal suppression of this virus. But like I said, I think that estimate is low.

Q. Have any Correctional Health Services staff been disciplined for noncompliance with mask mandates?
A. I'm not aware of any being disciplined specifically, but I know that we made it very clear to the staff in many different venues that that would be the expectation. And we've never had staff who resist wearing masks.
Like anything with human nature, you might get somebody who needs to be reminded about adherence, you know, here and there, but I would never -- I've never heard of a correctional staff person who, when asked to pull up their mask, refused to do so or anything like that.
Q. Correctional Health Services staff are medical professionals or health care professionals, right?
A. Correct.
Q. Okay. And one can predict that the level of compliance with a public health mandate among health professionals is probably going to be higher than in non-health professionals, correct?
A. Yes.
Q. Okay. And I was asking you earlier about soap. I know you said that you think soap is broadly available. We've heard some testimony at points in this case, about inavailability of soap in some

settings or soap being out. Would you have any reason to doubt that?
A. I don't have a specific reason to doubt it. I have no evidence either way.
MR. KEENAN: I think that is all I've got for you today, Dr. MacDonald. I really appreciate you taking this time today, and I thank you very much.
THE WITNESS: Thank you.
MR. THAYER: We have no questions.
(Deposition concluded at 4:56 p.m.)

CERTIFICATE OF REPORTER

I, Liebe Stevenson, a Certified Court Reporter, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me to the best of my ability and thereafter reduced to typewriting under my direction; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties thereto, nor financially or otherwise interested in the outcome of the action.

/s/ Liebe Stevenson
LIEBE STEVENSON, C.C.R. #1340

E R R A T A S H E E T

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IN RE: JEAN AZOR-EL, et al v. CITY OF NEW YORK

Page	Line	Correction	Reason

Under penalties of perjury, I declare that I have read my deposition in this matter taken on May 24, 2021, and that it is true and correct, subject to any changes in form or substance entered above.

_____ _____

DATE ROSS MACDONALD, MD