
SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF THE BRONX

Matter of JOSEPH AGNEW, ANTHONY GANG, TYRONE GREENE and KAMER REID,

On behalf of themselves and all others similarly situated,

Petitioners,

For a judgment under Article 78 of the Civil Practice Law and Rules

--against--

NEW YORK CITY DEPARTMENT OF CORRECTION,

Index No. 813431/2021E
(Taylor, J.)

Respondent.

AFFIRMATION OF PETITIONERS' COUNSEL IN SUR-REPLY TO THE DEPARTMENT OF CORRECTION COMPLIANCE AFFIDAVIT

Katherine Kelly Fell, an attorney admitted to practice before the Courts of the State of New York, affirms the following to be true upon information and belief, under penalty of perjury, pursuant to Rule 2106 of the Civil Practice Law and Rules:

1. I am special counsel with the law firm Milbank LLP, attorneys, alongside The Legal Aid Society and Brooklyn Defender Services, to Joseph Agnew, Anthony Gang, Tyrone Greene, Kamer Reid, and the class in the above-captioned matter (collectively, Petitioners). I am a member in good standing of the bar of the State of New York and this Court.

2. I am familiar with the facts and circumstances of this matter based upon the relevant documents attached hereto, my review of the records and files maintained by my office, and my conversations with counsel.

3. I submit this Affirmation in response to the affidavits of Kathleen Thomson, dated June 16, 2022 [NYSCEF Doc No. 129 ("Thomson Affidavit")] and Rabiah Gaynor, dated July 5, 2022 [NYSCEF Doc No. 140 ("Gaynor Affidavit")] submitted by the Department of Correction ("DOC") in support of its showing of substantial compliance. Petitioners respectfully submit that the Gaynor Affidavit and DOC's supplemental data purportedly demonstrating compliance in fact show the opposite: that DOC continues to be in contempt of this Court's December 3, 2022 Order [NYSCEF Doc No. 81 ("December Order")], as set forth in this Court's May 13, 2022 Order [NYSCEF Doc No. 126 ("May Contempt Order")]. Therefore, DOC has failed to meet its burden to show that it has purged itself of contempt.

4. Per this Court's guidance at the June 24, 2022 hearing, on June 28, 2022, DOC provided Petitioners with additional information about the reasons that people in custody were not produced to medical appointments in recent months. *See* Exhibit 1 (Medical Non-Production Report, December 2021 to June 2022), and Exhibit 2 (Medical Non-Production

Report, May 17 to June 12, 2022).

5. As the Gaynor Affidavit notes, DOC recently began tracking several new categories of reasons for non-production to medical appointments, including "Maximum Safe Capacity." [NYSCEF Doc No. 140 (the "Gaynor Affidavit" or "Gaynor Aff."), at ¶¶ 15, 18, 20. The Gaynor Affidavit explains that "Maximum Safe Capacity" refers to "the availability of safe space to wait for the scheduled appointment, when escort officers are available to bring individuals to the clinic." *Id.* at ¶ 20. Ms. Gaynor notes that "often there is inadequate space to safely hold more than a designated number of individuals while taking into consideration security concerns" and that "unless there is a steady flow of individuals in and out of the treatment areas, we have no choice but to return them to the housing area or not bring them down." *Id.*

6. In her affidavit, Deputy Chief Gaynor submits that "issues of physical space and related security considerations should not be deemed a 'failure to produce,' as DOC had ample escort staff, which was the focus of the Contempt Order." *Id.* at 22. But the data shows that DOC failed to produce people in its custody to necessary medical appointments due to "Maximum Safe Capacity" ***1,441 times in May 2022*** and ***469 times between June 1 and June 15, 2022***, which includes time following this Court's May Contempt Order in which DOC could purge itself of the contempt finding. *See* Exhibit 1 at 6, 7. These are almost 2,000 failures to produce that were not explained in the initial Thomson Affidavit and which Respondent, having been called upon to account for the shift in numbers, now argues should not be counted.

7. DOC's assertion that these non-productions should not be counted against compliance, like their claims that deaths in custody are disconnected from this case because it

is "unfair" to imply a "causal connection between a death in custody and a missed clinic appointment," is a disingenuous attempt to change the scope of DOC's duty and of this Court's Order.

8. The May Contempt Order finding that DOC is in contempt of this Court's December Order directed DOC to comply with its pre-existing legal obligations to:

> a. "Provide Petitioners' with access to sick call on weekdays, excluding holidays, and to make sick call available at each facility to all persons in DOC custody a minimum of five days per week within 24 hours of a request, or at the next regularly scheduled sick call, whichever is first"; and to
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> b. "Safely keep in the New York City jails each person lawfully committed to his custody by providing sufficient security for the movement of incarcerated persons to and from health services, and *by not prohibiting or delaying incarcerated persons' access to care, appropriate treatment, or medical or dental services*."

(December Order at 8-9 (emphasis added); *see also* May Contempt Order at 6.).

9. DOC's pre-existing, non-discretionary duty is to provide access, and to not prohibit or delay that access, to medical care. The December Order required DOC to comply with this duty. The December Order was not limited to escort staff or productions to clinic appointments. Similarly, the May Order set out a process by which DOC could purge its contempt by complying with the December Order but did not say that contempt could be purged simply by providing additional escort staff and increasing clinic productions.

10. To be sure, the parties have spent much time in this litigation discussing DOC's failure to provide escorts to bring people in custody to their medical appointments. That is

because the failure to provide escorts to bring people to medical appointments has been a clear contributor to the medical access crisis at DOC facilities and was a visible data-point documented in DOC's own monthly reports of medical non-productions. But the goal of this litigation—and the focus of DOC's applicable statutory obligations and the Court's orders—has always been to achieve ***access*** to medical care for people in DOC custody. The new data shows that, in addition to failing to provide escorts to bring people to scheduled medical appointments, DOC is ***also*** denying access to care through its failure to provide adequate space and security in the waiting areas of the clinics, spaces under the control and management of DOC. "Maximum Safe Capacity" is simply another way in which pervasive mismanagement and dysfunction is contributing to the medical care access crisis in DOC's facilities.

11. Surely, DOC would not claim substantial compliance if it provided escorts for every person in custody with a medical appointment but then chained the doors to the clinic so that people could not enter. But denying access to medical care ***nearly 2,000 times*** in a six-week period due to "Maximum Safe Capacity," and then claiming compliance with the law because the lack of escort number was reduced to 186, is effectively the same thing. *See* Exhibits 1, 2.

12. To achieve substantial compliance with this Court's December Order, DOC ***must not be the cause of the denial of access to medical care.*** *See Matter of Benson Realty Corp. v. Wash*, 73 Misc 2d 889, 893 [Sup Ct 1973] (finding "inability to obey the court's mandate is no defense where such default was occasioned by the acts of the party charged" and holding respondent in contempt where "failure to comply [was] attributable to administrative failure"). Whether that means providing additional escorts to bring people to the clinic, making additional space or security available in the clinic areas so that people are safe while waiting

for their scheduled medical appointments, or taking any other action, it is incumbent on DOC to provide this access.

13. DOC outlines several proposed measures to address and remediate the "Maximum Safe Capacity" issue. Gaynor Aff. ¶ 25. But DOC offers no explanation for why it did not address this issue immediately following this Court's December Order, in the 18 months prior to that Order when DOC was not meeting its obligations under the law, or in the months since the December Order when DOC has been in contempt of that Order.

14. DOC similarly claims that non-productions that occur because of a "Medical Priority" or "Mental Health Priority" (in which a medical or mental health emergency displaces another person's scheduled clinic appointment, or a patient "becomes eligible for release" and "require[s] a discharge plan appointment") should not be held against it. Gaynor Aff. ¶¶ 18, 23-24; *see also* Exhibit 1 at 7. But DOC is required to have the capacity to deliver both scheduled appointments and emergency medical and mental health care as part of its duty to provide care for its patients. Non-productions in these new categories are clearly attributable to DOC's administrative failures.

15. Petitioners also note that DOC's data from June 1st to 15th indicate that a bus departed early on one occasion, without three patients. *Id.* The implication is that those appointments should not count against DOC. DOC failed to satisfy its obligation to provide medical care to those people by failing to produce them to their scheduled appointments, and the decision to recategorize those missed appointments both presents another attempt by DOC to shift responsibility for its failures and reflects DOC's mindset in confronting those failures: rather than taking responsibility, DOC continues to make excuses.

16. Ms. Gaynor's contention that it is unfair and inflammatory to suggest a

relationship between the almost unprecedented number of recent deaths in DOC custody and DOC's failures to provide appropriate access to medical care is similarly unpersuasive. Gaynor Aff. ¶¶ 7-8. Again, the duty and obligation at issue here is to provide access to medical care, which includes, but is not limited to, access to medical appointments.

17. Although Petitioner's access to information on the causes of the recent deaths is limited, there is persuasive authority that many of the recent deaths are tied to deficiencies in DOC's provision of access to medical care, and that these deficiencies are a direct result of its own mismanagement. In its recent report on the three deaths in custody in February and March 2022, the Board of Correction found that DOC failed to adequately staff its housing units, including the "dangerous practice" of not ensuring the presence of "B" post staff, did not possess a functional system for providing emergency medical care to people in its custody, and neglected to timely bring patients to medical appointments and provide medication. *See* Exhibit 3 at 4-8 (Deaths in Custody Report). The Deaths in Custody report notes that, in each of the three deaths discussed in this report, there were issues relating to failures of DOC to adequately staff its housing units resulting in delayed access to medical care, a history of not transporting the individual to medical appointments or medication, or both, as was the case of Mr. George Pagan, who "missed nine scheduled medical appointments . . . over a six-day period." *Id.* at 4-5. "According to the CHS record, DOC failed to produce him in all nine instances." *Id.* Mr. Pagan did not receive critical medication for almost 48 hours before he was transported to the clinic for emergency care on March 16; "at that point, he was hallucinating and unable to walk." *Id.* Mr. Pagan died on March 17.

18. Petitioners respectfully submit that DOC should focus on resolving the extreme disorder in its facilities rather than hiding behind red tape and careful language to avoid

responsibility for the humanitarian crisis unfolding before its eyes.

* * *

19. For the foregoing reasons and those set forth in Petitioners' prior submissions on contempt, Petitioners respectfully request that the Court find that DOC has not purged itself of this Court's contempt finding and direct DOC to pay the compensatory fine of $100.00 for each missed escort to the infirmary from December 11, 2021 through January 2022, as set forth in the May Contempt Order.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 8th day of July 2022.

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