



# Disability Law Center

Massachusetts Protection and Advocacy

## **INVESTIGATION REPORT:**

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Experiencing the Pandemic Inside Department of  
Correction Facilities – MCI-Shirley and MCI-Norfolk

**March 28, 2022**

## Executive Summary & Addendum

### Executive Summary:

The Disability Law Center (DLC) releases findings and recommendations for corrective action from our investigation of COVID-19-related lockdown conditions, infection control measures, and access to health care at two Department of Correction (DOC) facilities – MCI-Norfolk and MCI-Shirley. DLC’s findings and corrective action recommendations issued on November 19, 2021 (Attachment A) and DOC’s January 7, 2022 response (Attachment B) are attached hereto with necessary redactions. DLC thanks DOC for its participation in this process.

Both MCI-Shirley and MCI-Norfolk house large numbers of individuals who are at greater risk of complications from COVID-19 due to disability/medical condition, age, or a combination thereof, and who have chronic conditions and medical needs that require continuity of care. (Attach. A at 1) The average daily population in 2021 at MCI-Shirley was 805 and 1,149 at MCI-Norfolk.<sup>1</sup> MCI-Shirley has two specialized units that house prisoners with disabilities and significant medical issues, many of whom are elderly; these units are known as the Nursing Care Unit (NCU)<sup>2</sup> and the Clinical Stabilization Unit (CSU).<sup>3</sup> MCI-Norfolk holds DOC’s other CSU. The CSUs are large dormitory-style rooms that generally hold between 15 and 20 prisoners with disabilities.<sup>4</sup>

DLC commenced its investigation on April 27, 2020<sup>5</sup> in its role as the Commonwealth’s designated Protection and Advocacy (P&A) agency for persons with disabilities. On November 20, 2020, while MCI-Shirley and MCI-Norfolk faced a resurgence of COVID-19 infections, DLC shared preliminary findings and recommendations for corrective action<sup>6</sup> with DOC. Among its preliminary findings, DLC found: delays in testing and inadequate symptom screening for medically vulnerable prisoners; prisoners being quarantined in restrictive housing units in harsh conditions; disruptions in medical and mental health care across the prison population; disruptions in assistance with activities of daily living for vulnerable prisoners in the NCU; and inconsistent and unenforced use of face masks and other personal protective equipment by DOC staff.<sup>7</sup> DLC recommended that corrective action be taken to stem the further spread of infection within DOC facilities, provide adequate quarantine and treatment conditions, and ensure continuity of medical and mental health care. (Attach. A at 2)

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<sup>1</sup> DOC, *January 2022 MA DOC Institutional Fact Cards*, <https://www.mass.gov/doc/institutional-fact-cards-january-2022/download>.

<sup>2</sup> The NCU is the DOC’s only unit intended to provide a nursing home level of care to prisoners who are elderly and/or significantly disabled. As of March 2020, the NCU had 31 total beds – 28 medical and 3 utilized for mental health watch. Plaintiffs’ Memorandum in Support of their Motion for Preliminary Injunction, Ex. 3 (Declaration of Victor Lewis, M.D.) at para. 6, *Foster v. Mici*, SJC2020-1235 (2020) (“Lewis Declaration”).

<sup>3</sup> Prisoners in the CSU are generally individuals who may need help performing activities of daily living, but do not require a nursing home level of care. *See id.*

<sup>4</sup> *See id.*

<sup>5</sup> The letter initiating DLC’s investigation is available for review at <https://www.dlc-ma.org/wp-content/uploads/2021/01/DLC-MCI-S-and-MCI-N-Investigation-Letter-4.27.2020.pdf>.

<sup>6</sup> DLC’s preliminary findings and recommendations are available at <https://www.dlc-ma.org/wp-content/uploads/2021/01/DLC-DOC-Inv.-Preliminary-Findings-Letter-11.20.2020.pdf>.

<sup>7</sup> *Id.*

After DLC released its preliminary findings and recommendations in November 2020, DOC and DLC continued to exchange correspondence while DLC continued its investigation. On April 29, 2021, DLC met with DOC Commissioner Carol Mici and other key DOC administrators. (Attach. A at 2-4)

Over the course of the investigation, DOC made many improvements that addressed issues raised in DLC's preliminary findings and subsequent correspondence,<sup>8</sup> including increasing testing opportunities for prisoners and staff, improving quarantine conditions, educating prisoners, and improving its monitoring of staff wearing face masks. (Attach. A at 4) In January 2021, ahead of most correctional systems in the country, DOC began a vaccination program for prisoners that led to 60% to 70% of prisoners being vaccinated. (Attach. A at 4)

On November 19, 2021, DLC provided its findings upon completion of our investigation of the two facilities, inviting DOC to provide a response. (*See* Attach. A) The letter emphasized the continuing need for DOC to: provide increased targeted testing and screening for medically vulnerable prisoners; maintain adequate infection control measures in the NCU and CSUs; and ensure continuity of necessary medical care during periods of lockdown or restricted movement. (*See* Attach. A at 9-17) While DLC recognizes the unprecedented situation with which DOC was confronted and its extensive efforts throughout the pandemic, we ultimately found that DOC's actions and omissions with respect to two issues constituted neglect of prisoners with disabilities.<sup>9</sup>

First, DLC found that DOC failed to institute appropriately intensive infection control measures to protect MCI-Norfolk CSU residents from COVID-19 in late 2020, resulting in every one of the 16 elderly and/or medically vulnerable individuals living in the dormitory contracting the virus in December 2020. (Attach. A at 3-4) This failure constituted neglect. (Attach. A at 4)

Second, DLC found that DOC sanctioned the policy and practice of its contractor, Wellpath, that delayed and strictly limited access to vital health care services and resulted in widespread neglect of DOC prisoners with disabilities. (Attach. A at 9-16) Wellpath restricted access to medical, dental, and mental health care far beyond contemporary community restrictions on health care in place in Massachusetts. (Attach. A at 9-12) Even when lockdown conditions eased and community hospitals began reopening in late May and June of 2020, records indicate that Wellpath continued to cancel off-site specialist appointments and failed to timely schedule and reschedule them, giving rise to considerable, growing backlogs well into the fall of 2021. (Attach. A at 6, 10-12) Below, DLC presents brief descriptions regarding five prisoners from MCI-Norfolk and MCI-Shirley to exemplify the experiences of many DOC prisoners who have endured unnecessary delays in essential health care services throughout the pandemic. (Attach. A at 13-16.)

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<sup>8</sup> DOC maintains that certain improvements began prior to receiving DLC's November 2020 recommendations. *See, e.g.,* Attach. B at 1.

<sup>9</sup> Applicable federal authority defines neglect. 45 C.F.R. § 1326.19; 29 U.S.C. § 794e(f)(2); *see* 42 C.F.R. § 51.2.

On January 7, 2022, DOC provided its response to DLC's November 19, 2021 findings and corrective action recommendations. (See Attach. B) DLC made no further documentation requests from DOC after completing our investigation and, as a result, have not had the opportunity to review any developments in DOC policy or practice since early November 2021.

**Addendum:**

DLC notified DOC of its final findings before the spread of the Omicron variant at both MCI-Shirley and MCI-Norfolk in January 2022. Sadly, once again, aged and medically vulnerable prisoners in the CSU at MCI-Norfolk were infected with COVID-19. In November 2021, DLC had found that DOC's failure to dedicate separate staff to the CSU and to conduct frequent symptom checks, testing, and screening of both prisoners and staff during a period of rising community transmission constituted neglect prior to the previous CSU COVID outbreak in December 2020. (Attach. A at 3-4) Again, transmission rates were increasing in Norfolk County through January 8, 2022<sup>10</sup> before the first new cases were reported in the CSU.

With respect to the Office of the Ombudsman, the current director was hired November 21, 2022; before then, the director was fulfilling those duties on an interim basis following the first director's termination.<sup>11</sup> (Attach. B at 1-2) With the appointment now permanent, DLC urges the Ombudsman to reinforce DLC's recommendations detailed below in Attachment A that DOC follow not only correctional standards with respect to mitigation of COVID-19, but the State's standards governing COVID-19 infection control in all congregate settings, as cited in the Ombudsman's own SARS-COV-2 Public Health Compliance and Mitigation Standards.<sup>12</sup> (Attach. A at 7, 16)

There is a troubling discrepancy between the positive test data information posted by DOC, the report of new Ombudsman, and CSU prisoners' reports to DLC of the number of people who were quarantined together on the unit as of January 13, 2022. DOC reported no cases at all at MCI-Norfolk until January 17, 2022<sup>13</sup> and the Office of the Ombudsman reported two active cases as of January 13, identifying positive cases as occurring in the CSU.<sup>14</sup> However, CSU prisoners have reported that six out of 14 prisoners in the CSU dormitory were quarantined together as of January 13, 2022, separated from COVID-negative prisoners in the same CSU dormitory by only a tarp hung from the ceiling.<sup>15</sup>

<sup>10</sup> Massachusetts Department of Public Health, COVID-19 Dashboard – Wednesday, January 12, 2022: *Count and Rate of Confirmed COVID-19 Cases and Tests Performed in MA by County, January 1, 2020 – January 11, 2022*, <https://www.mass.gov/doc/county-level-positivity-rates-january-12-2022/download>.

<sup>11</sup> See Deborah Becker, *Ombudsman Overseeing Mass. Prisons' COVID Mitigation Efforts Is Fired* (September 27, 2021), <https://www.wbur.org/news/2021/09/27/ombudsman-overseeing-mass-prisons-covid-mitigation-efforts-is-fired>.

<sup>12</sup> The Office of the Ombudsman published these standards under the Interim Director October 21, 2021. [https://live-ombudsman-umms.pantheon.io/wp-content/uploads/2021/10/Ombudsman-Standards-MA\\_DOC-Final-10.28.2021.pdf](https://live-ombudsman-umms.pantheon.io/wp-content/uploads/2021/10/Ombudsman-Standards-MA_DOC-Final-10.28.2021.pdf).

<sup>13</sup> DOC, *DOC COVID-19 Inmate Dashboard*, <https://www.mass.gov/info-details/doc-covid-19-inmate-dashboard>.

<sup>14</sup> DOC, *Report 10 – Independent COVID-19 Update & Mitigation Compliance Report*, 7-8 (January 19, 2022), <https://covidombudsman-madoc.org/view-reports/>.

<sup>15</sup> CSU prisoners reported that four prisoners tested positive and were isolated in the CSU dayroom as of January 11, 2022; when two more prisoners tested positive on January 13, 2022, all six were moved to the CSU dormitory and separated from the COVID-negative prisoners by a tarp.

In addition, MCI-Norfolk CSU prisoners reported serious concerns about the unsanitary conditions and poor treatment they received while quarantining in January 2022, including lack of access to assistance with activities of daily living. DLC received multiple reports that, during the outbreak, DOC isolated four CSU prisoners who initially tested positive in the CSU dayroom without running water, including toilets, for several days. Those four prisoners were forced to use urinal bottles and commodes that were emptied infrequently, including a prisoner who uses a wheelchair and requires assistance for safe transfers to the toilet but received no such assistance. When two more prisoners became infected, the four men were moved out of the dayroom and all six placed together in the dorm where the aforementioned tarp separated them from the other prisoners with chronic medical issues and disabilities who had tested negative. According to reports, neither prisoner workers nor staff provided the COVID-positive CSU prisoners with needed assistance while they were in quarantine. Notably, although there are both medical and correctional staff stationed in the CSU to protect and assist residents, because the tarp was opaque, staff sitting at their station were not able to observe the prisoners on one side of the tarp; the COVID-positive prisoners were on the side of the tarp farthest from the staff station. Prisoner workers were not permitted into the dormitory to clean the bathrooms for at least the first week; COVID-positive and -negative prisoners had to share a shower, which was not disinfected between uses. Fortunately, no further infections were reported. CSU prisoners reported conveying concerns about these circumstance to the Ombudsman. Based on the foregoing, DLC adds to its recommendations in Attachment A a call for the Ombudsman to fully investigate the discrepancy in the January 2022 data and all allegations of neglect.

Finally, addressing DOC's January 7, 2022 response, DLC takes the opportunity in this Addendum to point out that DOC misplaces reliance on the Supreme Judicial Court's June 2, 2020 and November 18, 2021 decisions in *Foster v. Mici*.<sup>16</sup> (See Attach. B at 2-4) Unlike in *Foster*, DLC need not establish deliberate indifference to substantial risk of serious harm to prisoners' health or safety in order to substantiate that neglect of persons with disabilities is taking place or has occurred at MCI-Shirley and MCI-Norfolk. The applicable definition of neglect comes from federal regulations concerning DLC's authority as Massachusetts' P&A agency.<sup>17</sup> Moreover, the issue before the SJC in *Foster* was whether conditions of confinement and DOC's infection control measures at the time of the preliminary injunction determinations were constitutionally adequate; the adequacy of access to medical and mental health services unrelated to COVID-19 during the pandemic was not at issue. Nevertheless, the SJC did recognize in its June 2020 decision that, "while the pandemic continues, the lockdown conditions instituted by the DOC to prevent a serious risk of harm themselves risk becoming Eighth Amendment violations," expressing particular concern about the effects of lockdown on prisoners with serious mental illness as well as long term deprivation of exercise.<sup>18</sup> DLC's findings not only bear out the SJC's concerns about the health effects of prolonged lockdown, but also describe Wellpath's implementation of DOC-sanctioned policies and practices resulting in unjustifiable sustained restrictions on prisoners' access to health care.

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<sup>16</sup> *Foster v. Mici*, 484 Mass. 698 (2020); *Foster v. Mici*, 488 Mass. 643 (2021) (reviewing the Superior Court's February 17, 2021 denial of plaintiff's second motion for preliminary relief).

<sup>17</sup> See 29 U.S.C. § 794e(f)(2); 45 C.F.R. § 1326.19; see 42 C.F.R. § 51.2.

<sup>18</sup> *Foster*, 484 Mass. at 731-732.

## **Attachment A**

Disability Law Center's MCI-Shirley and MCI-Norfolk Investigation Findings and Recommendations for Corrective Action to the Department of Correction (November 19, 2021)



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November 19, 2021

**VIA EMAIL**

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**Re: Disability Law Center's Investigation of MCI-Shirley & MCI-Norfolk**

Dear Commissioner Mici and Attorney White:

Disability Law Center (“DLC”) writes to discuss its findings and remaining concerns arising out of the Protection and Advocacy investigations of MCI-Shirley and MCI-Norfolk. DLC opened this investigation in April 2020 under its Protection and Advocacy (“P&A”) authority in response to reports of neglect experienced by prisoners with disabilities during the COVID-19 pandemic relating to lockdown conditions and infection control at MCI-Shirley and MCI-Norfolk. Both of these Department of Correction (DOC) facilities house large numbers of prisoners who are particularly susceptible to grave complications from COVID-19 due to age, disability/medical condition, or both, and whose chronic conditions require continuity of care.<sup>1</sup>

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<sup>1</sup> Notable also, percentages of African American/Black and/or Latinx/Hispanic individuals in the populations of MCI-Shirley (33% African American/Black; 31% Hispanic/Latinx) and MCI-Norfolk (33% African American/Black; 24% Hispanic/Latinx) are higher than percentages across all DOC facilities (29% African American/Black; 26% Hispanic/Latinx), which is already grossly disproportionate to the demographic makeup of Massachusetts (9% African American/Black; 12.4% Latinx/Hispanic). DOC, *January 2021 MA DOC Institutional Fact Cards*, <https://www.mass.gov/doc/institutional-fact-cards-january-2021/download>; U.S. Census Bureau, *Quick Facts: Massachusetts – Population Estimates July 1, 2019*, <https://www.census.gov/quickfacts/fact/table/MA#>. Racial and ethnic disparities in COVID-19 outcomes persist, resulting in disproportionately high rates of infection and death among African American, Black, and Latinx community members. See, e.g., CDC, *Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity* (updated September 9, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>; <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0254809>. Thus, high infection rates and poor COVID-19 outcomes at MCI-Shirley and MCI-Norfolk can be expected to have a disparate impact on people of color.

The Protection and Advocacy System for Massachusetts

DLC found probable cause to invoke its statutory authority to conduct investigations of MCI-Shirley and MCI-Norfolk. DLC notified the DOC of its investigation, and in April 2020 and August 2020 requested policies, protocols and guidance utilized at MCI-Shirley and MCI-Norfolk by DOC and its medical contractor Wellpath. Topics of these policies and protocols included:

- Prevention and mitigation of the spread of COVID-19 infection, including protection of older and disabled prisoners;
- Screening & testing for individuals presenting COVID-19 symptoms, or who have been exposed to others who are symptomatic or have tested positive;
- Quarantine and treatment for individuals who are symptomatic or test positive;
- Cleaning and sterilization of living quarters, communal areas, and shared equipment;
- Supplies provided to prisoners, including PPE and cleaning supplies, to prevent infections; and staff usage of PPE;
- Information provided to prisoners and staff concerning COVID-19 and infection control;
- Provision of medical and mental health services, including documentation relating to suspension or regularity of appointments;
- Prisoners' access to recreation, telecommunications, and programming, and daily schedules;
- Written plan or timeline for easing COVID-19 related lockdown infection control procedures.

DLC also requested data concerning numbers of prisoners testing positive for COVID-19 infections, numbers of deaths related to COVID-19 and related documentation, and dates of facility-wide testing, and records related to COVID-19 deaths. DLC conducted interviews and corresponded with approximately forty (40) prisoners at MCI-Shirley and MCI-Norfolk in June and July 2021, and updated and added to these interviews from October 2020 through the present. DLC reviewed sworn affidavits from DOC, prisoners, and medical experts filed in the *Foster v. Mici* litigation. DLC further reviewed surveillance and prevention policies and other best practices applicable in long term care congregate settings and correctional settings alike.

Following a resurgence of COVID-19 infections at both facilities in the fall of 2020, DLC provided its preliminary findings on November 20, 2021, recommending corrective action to be taken to stem the further spread of infection within DOC facilities, provide adequate quarantine and treatment conditions, and ensure continuity of medical and mental health care.

Since issuing those preliminary findings on November 20, 2020, DLC reviewed additional documents, over thirty (30) prisoner medical records, and conducted additional prisoner interviews. On February 8, 2021, DOC replied to DLC's preliminary findings and provided further information concerning its testing & surveillance programs, infection control, and quarantine conditions on February 8, 2021. In the period between November 20, 2020 and



February 8, 2021, fourteen (14) prisoners died due to COVID-19, four (4) of whom came from MCI-Norfolk and one (1) from MCI-Shirley.<sup>2</sup>

DLC responded to DOC's reply on March 15, 2021, again recommending specific corrective actions. Among the most serious of DLC's concerns was DOC's failure to adequately protect its prisoners from the resurgence of COVID in the fall of 2020, at a time when community transmission rates were rising<sup>3</sup> – an essential factor in planning preventive measures in correctional facilities.<sup>4</sup> The Centers for Disease Control and Prevention ("CDC") recommended regular universal testing as the best means of identifying new infections in prisons.<sup>5</sup> Rather than employing regular universal testing and screening procedures as recommended, DOC was still only testing symptomatic prisoners and their close contacts "as needed."<sup>6</sup> Screening and testing measures should have included, in addition to daily symptom screening, at least targeted regular testing of older and medically vulnerable prisoners, improving quarantine and treatment conditions for COVID-19, and implementing effective education and communications to encourage reporting of COVID-19 symptoms. DOC failed to carry out these measures, and the rates of infection rose dramatically by the end of October at MCI-Norfolk and later at MCI-Shirley.

One of the most devastating consequences of DOC's failure to protect this vulnerable population, was the spread of COVID-19 in the MCI-Norfolk's Clinical Stabilization Care Unit ("CSU"). Each of the medically vulnerable prisoners living there contracted the virus in December 2020. Though, remarkably, no one died from complications related to COVID-19 in the CSU, prisoners interviewed by DLC reported that some were hospitalized, including one prisoner who was discharged on medical parole to a nursing home following hospitalization. As a dormitory setting, with sixteen beds situated in very close proximity to one another, the CSU poses a high risk for the spread of a communicable disease from one prisoner to another. At the same time, it is in a separate building from other general population housing units. Therefore,

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<sup>2</sup> ACLU of Massachusetts, *Tracking COVID-19 In Massachusetts Prison & Jails*, <https://data.aclum.org/sjc-12926-tracker/>; Deborah Becker, *Prisoners Hospitalized With COVID-19 Die A Day After Being Granted Medical Parole* (December 4, 2020), <https://www.wbur.org/news/2020/11/30/massachusetts-prisoners-coronavirus-medical-parole-deaths>.

<sup>3</sup> Numbers of reported cases increased by 60% in the last two weeks of September in Massachusetts, and, by mid-October, case counts in both Middlesex and Norfolk counties had nearly doubled from the previous month, and positive testing rates had increased in both counties. See *Coronavirus Outbreak: Massachusetts Coronavirus and Case Count*, NY TIMES (updated March 20, 2021); DPH, *Weekly COVID-19 Dashboard September – October 2020*, at <https://www.mass.gov/info-details/archive-of-covid-19-weekly-public-health-reports>.

<sup>4</sup> The CDC emphasized the significance of the rise of infections in the surrounding community for planning preventive measures since its first guidance for correctional facilities issued March 23, 2020, and continues to do so through its most recent guidance updated June 9, 2021. CDC, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19)*, March 23, 2020 (produced by DOC on May 11, 2020, in response to DLC's first request for documents); CDC, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (updated as of June 9, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.

<sup>5</sup> Liesl Hagan, et al., *Mass Testing for SARS-CoV-2 in 16 Prisons and Jails — Six Jurisdictions, United States, April–May 2020*, CDC Morbidity Mortality Weekly Report, Vol. 69, No. 33: 1139-1143 (August 21, 2020), at <https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a3.htm>.

<sup>6</sup> Deborah Becker, *Medical Experts Raise Questions About COVID-19 Data from Massachusetts Jails and Prisons*, WBUR (August 31, 2020), <https://www.wbur.org/commonhealth/2020/08/31/massachusetts-coronavirus-jail-prison-data-discrepancies>.

DOC may have prevented the entry and spread of COVID-19 by dedicating separate staff to the CSU, screening CSU staff and prisoners frequently during the period of rising community transmission, and conduct daily symptom screening with bi-weekly testing during the COVID outbreak at MCI-Norfolk,<sup>7</sup> which began October 27, 2020.<sup>8</sup> DOC failed to adequately protect the CSU prisoners from COVID-19.<sup>9</sup> The failure to do so constituted neglect.<sup>10</sup>

Following the exchange of letters in February and March 2021, DLC met with Commissioner Mici, Deputy Commissioner Jennifer Gaffney, DOC counsel, and MCI-Shirley and MCI-Norfolk facility administrators on April 29, 2021.

At the April 29, 2021 meeting, DOC provided information and updates concerning increased surveillance testing. DLC reiterated requests to implement more frequent testing and screening of vulnerable prison populations throughout MCI-Norfolk and MCI-Shirley, broad public health educational approach encouraging dialogue, and improving access to medical and mental health treatment during periods of restricted movement. DLC requested updates on the evaluation and treatment of ten (10) prisoners with disabilities, and reviewed additional medical records provided by DOC. DOC has been responsive to DLC's requests for medical records and relevant policies, and has provided all requested updates.

DLC has addressed many of the issues that were the subject of DLC's preliminary findings and subsequent correspondence. DOC's policies and practices related to COVID-19 have evolved greatly throughout the course of the investigation. DOC has increased its surveillance and targeted testing of prisoners, using wastewater surveillance technology to target particular facilities for testing, and increasing its testing capacity. It has reportedly improved quarantine conditions in the Restrictive Housing Units to reduce the punitive impact on prisoners. Ahead of most correctional systems in the country, DOC began vaccinating prisoners in January 2021, accompanied by educational materials and videos. Vaccinations, particularly the full two doses of Moderna or Pfizer, sharply reduce the risk of serious illness or death even from the potentially more severe Delta variant. According to prisoner reports and DLC observations during monitoring, PPE usage greatly improved by the winter of 2020/2021.

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<sup>7</sup> Such frequency of screening and testing is recommended during outbreaks in nursing homes. Centers for Disease Control and Prevention, *Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes* (Updates as of September 10, 2021), [https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor\\_1631031062858](https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031062858)

<sup>8</sup> ACLU of Massachusetts, *Tracking COVID-19 in Massachusetts Prisons & Jails*, <https://data.aclum.org/sjc-12926-tracker/>.

<sup>9</sup> Centers for Disease Control and Prevention, *Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes* (Updates as of September 10, 2021), [https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor\\_1631031062858](https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031062858)

<sup>10</sup> Under applicable regulatory authority, 29 U.S.C. § 794e(f)(2) and 45 C.F.R. § 1326.19, the following definition applies to a finding of neglect:

Neglect means a negligent act or omission by an individual responsible for providing treatment or habilitation services which caused or may have caused injury or death to an individual with [ ] disabilities or which placed an individual with [ ] disabilities at risk of injury or death, and includes acts or omissions such as failure to: establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care to an individual with [ ] disabilities; provide a safe environment which also includes failure to maintain adequate numbers of trained staff.

However, DOC's efforts to prevent the spread of COVID-19 infections in its facilities have been hampered by the relatively low vaccination rates of its health care staff and corrections staff. As of August 10, 2021, 43% of corrections staff and 22% of the DOC population were unvaccinated.<sup>11</sup> According to vaccination rate data produced by DOC on September 16, 2021, at MCI-Shirley, 80.4% of prisoners were vaccinated, 41% of Wellpath medical and mental health staff were vaccinated, and merely 38.4% of DOC staff were vaccinated; at MCI-Norfolk, 69.9% of prisoners were vaccinated, 52% of Wellpath staff, and 43.2% of DOC staff were vaccinated. The risk of the virus entering MCI-Norfolk and MCI-Shirley rose in the summer and early fall of 2021 as community transmission rates increased.<sup>12</sup> DOC correctional and program officers at MCI-Shirley and MCI-Norfolk continued to report active cases of COVID-19 throughout August and September 2021.<sup>13</sup> Fortunately, the publicly available COVID-19 testing data shows no positive tests among DOC prisoners at MCI-Shirley and MCI-Norfolk resulted from targeted testing since June 1, 2021.<sup>14</sup> However, another correctional facility in the same complex as MCI-Shirley, Souza-Baranowski Correctional Center, did experience an outbreak of twenty nine (29) infections by August 10, 2021,<sup>15</sup> and over forty (40) more later that month.<sup>16</sup> MCI-Concord, also in Middlesex County where the COVID-19 risk level has remained high, had 29 infections in October 2021.<sup>17</sup>

On August 19, 2021, Governor Charlie Baker issued an executive order requiring all Executive Department employees to provide proof of COVID-19 vaccination on or before October 17, 2021.<sup>18</sup> DOC and Wellpath employees alike were included in this mandate: the order defines employee to include persons who perform services for any Commonwealth executive agency or department, including contract employees. The Massachusetts Correction Officers Federated Union (MCOFU) sued the state seeking an injunction against the Governor's order, arguing that the vaccination mandate violated their constitutional rights and the collective bargaining agreement; a federal judge denied MCOFU's motion for a preliminary injunction on October 15 and MCOFU is now appealing.<sup>19</sup> "Hundreds of the union's 3,300 members had applied for religious or medical exemptions from the vaccine," and at least fifty (50) have been

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<sup>11</sup> Deborah Becker, WBUR: *30 New COVID Cases Reported in Massachusetts Prisons*, August 10, 2021, <https://www.wbur.org/news/2021/08/10/souza-baranowski-prisoners-coronavirus-positive-cases>.

<sup>12</sup> Rates of positive cases in Middlesex and Norfolk counties are increasing, as well as hospitalization rates. COVID Vaccine & Risk Tracker – Covid Act Now, [https://covidactnow.org/us/massachusetts-ma/county/middlesex\\_county](https://covidactnow.org/us/massachusetts-ma/county/middlesex_county); [https://covidactnow.org/us/massachusetts-ma/county/norfolk\\_county](https://covidactnow.org/us/massachusetts-ma/county/norfolk_county).

<sup>13</sup> Massachusetts Department of Correction, *DOC COVID-19 Staff Testing Reports*, <https://www.mass.gov/lists/doc-covid-19-staff-testing-reports>.

<sup>14</sup> ACLU of Massachusetts, *Tracking COVID-19 In Massachusetts Prison & Jails*, at <https://data.aclum.org/sjc-12926-tracker/>; <https://www.mass.gov/info-details/doc-covid-19-inmate-dashboard>.

<sup>15</sup> Becker, n.10.

<sup>16</sup> DOC reported 40 more positive infections at Souza between August 12 and August 20, and smaller numbers of positive infections as recently as August 26, 2021. DOC, *DOC COVID-19 Inmate Dashboard*, <https://www.mass.gov/info-details/doc-covid-19-inmate-dashboard>.

<sup>17</sup> *Id.*

<sup>18</sup> *Press Release: Baker-Polito Administration Announces COVID-19 Vaccine Requirement for Executive Department Employees* (August 19, 2021), <https://www.mass.gov/news/baker-polito-administration-announces-covid-19-vaccine-requirement-for-executive-department-employees>.

<sup>19</sup> Deborah Becker, *Judge denies Mass. correction officers' injunction against vaccine mandate*, WBUR (October 15, 2021), <https://www.wbur.org/news/2021/10/15/massachusetts-prison-guards-vaccine-mandate-ruling>.

suspended to date, with some suspensions ultimately proceeding to termination.<sup>20</sup> Thus, while vaccination rates can be expected to increase due to the mandate, it is reasonable to assume that a significant number of DOC and Wellpath staff may remain unvaccinated based on approved objections.

The presence of the Delta variant in the community presents a serious risk, even with a high rate of vaccination. The Delta variant is highly contagious, twice as contagious as previous variants,<sup>21</sup> more likely to result in breakthrough infections among vaccinated individuals than earlier variants,<sup>22</sup> and risks more serious complications from infection for unvaccinated individuals.<sup>23</sup> Vaccinated individuals can also transmit the Delta variant, and may become seriously ill if they experience breakthrough infections, particularly if they are older.<sup>24</sup> Additional screening and testing measures targeted at unvaccinated as well as medically vulnerable prisoners are still needed.

In addition, DLC has been extremely concerned with the restrictions on medical and mental health care during the lengthy periods of restricted prisoner activity. The widespread suspensions of outside appointments included many urgent and essential appointments for prisoners, far exceeding the restrictions on care for the outside community. Moreover, the resulting backlogs have been difficult and slow to resolve. DOC's failure to provide appropriate and timely care neglected the health and mental health needs of prisoners with disabilities diagnosed with medical and psychiatric conditions.

DOC should consult and abide by all public health measures recommended for congregate settings discussed below, as well as guidance specifically designed for correctional settings. DLC urges DOC to select for the now vacant ombudsman position responsible for overseeing DOC's COVID-19 mitigation efforts, an individual with significant public health expertise who is knowledgeable about all relevant COVID-19 and infection control standards and guidelines, and provide that individual the authority to ensure their proper implementation. In addition, DLC calls upon DOC to undertake the corrective actions described below to maintain reduced risk of COVID-19 transmission and prevent disruptions in care should lockdown conditions be reintroduced, either due to COVID-19 or future threat of another contagious disease:

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<sup>20</sup> Deborah Becker, *About 50 correction officers are suspended over state's COVID vaccine mandate*, WBUR (October 27, 2021), <https://www.wbur.org/news/2021/10/27/correction-officers-suspensions-coronavirus>; Alison Kuznitz, *Unvaccinated Massachusetts prison guards fired over Gov. Baker's COVID mandate*, (November 17, 2021).

<sup>21</sup> CDC, *Delta Variant: What We Know About the Science*, (updated August 26, 2021), [https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html?s\\_cid=11559:%2Bdelta%20%2Bvariant:sem.b:p:RG:GM:gen:PTN:FY21](https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html?s_cid=11559:%2Bdelta%20%2Bvariant:sem.b:p:RG:GM:gen:PTN:FY21).

<sup>22</sup> JM Musser, PA Christensen, RJ Olsen, et al., *Delta variants of SARS-CoV-2 cause significantly increased vaccine breakthrough COVID-19 cases in Houston, Texas*, medRxiv (July 22, 2021), [https://www.medrxiv.org/content/10.1101/2021.07.19.21260808v1#disqus\\_thread](https://www.medrxiv.org/content/10.1101/2021.07.19.21260808v1#disqus_thread).

<sup>23</sup> *Id.*

<sup>24</sup> JB Griffin, M Haddix, et al., *SARS-CoV-2 Infections and Hospitalizations Among Persons Aged ≥16 Years, by Vaccination Status – Los Angeles County, May 1–July 25, 2021*, Centers for Disease Control & Prevention Morbidity and Mortality Weekly Report (MMWR) / August 27, 2021 / 70(34); 1170–1176, <https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e5.htm>.

## 1. Increase Targeted Testing & Screening For Medically Vulnerable Prisoners, and Implement Adequate Infection Control Measures in Clinical Stabilization Units (“CSU”) and Nursing Care Unit (“NCU”)

DLC urges DOC to target screening and testing measures for all unvaccinated prisoners as well as targeted regular testing of older and medically vulnerable prisoners, in keeping with CDC and Massachusetts screening guidance for congregate long-term care facilities as well as CDC’s guidance for correctional facilities. Screening and testing should be conducted more frequently during periods of rising community transmission.<sup>25</sup> The CDC’s *Interim Guidance for SARS-CoV-2 Testing in Correctional and Detention Facilities*, updates as of June 7, 2021 (“Interim Testing Guidance”), recommends that facilities implement at least selected routine screening testing to increase the likelihood of early case identification to prevent widespread transmission and protect especially vulnerable prisoners. To protect medically vulnerable and older prisoners from COVID-19 transmission, DLC calls upon DOC to evaluate such prisoners daily for the full range of possible COVID-19 symptoms, consistent with CDC guidance for screening residents of congregate long-term care facilities.<sup>26</sup> Further, DOC should require routine surveillance testing of all staff – corrections officers and health care staff – who work in the CSUs and NCU, regardless of vaccination status. Such testing would be consistent with the public health measures Massachusetts recommends for congregate care settings in all counties.<sup>27</sup> The frequency of such testing should be determined according to the positivity rate of the surrounding county.<sup>28</sup>

Data on facility and community transmission level and testing capacity should guide decisions about routine screening testing strategies.<sup>29</sup> The CDC recommends both facility-based and individual-based criteria. When selecting facilities or units for routine screening testing, CDC recommends choosing facilities where there are cases or outbreaks within the past month, dormitory housing units where physical distancing is less feasible, and units where the incarcerated population is at higher risk of severe illness from COVID-19.<sup>30</sup> Routine screening testing for staff and incarcerated/detained persons who are not fully vaccinated should be

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<sup>25</sup> The CDC recommends that correctional facilities monitor community data to be prepared for an outbreak. It is important to be aware of the level of community transmission both where the facility is located and in prisoners’ communities of origin (for recent transfers, presumably). CDC, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (updated as of June 9, 2021),

<https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>.

<sup>26</sup> CDC, *Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes* (updates as of September 10, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>.

The CDC recommends screening for the full range of possible symptoms because older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory issues. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. *Id.*

<sup>27</sup> DPH, *Residential and Congregate Care Programs: 2019 Novel Coronavirus (COVID-19) Surveillance Testing Guidance* (updated August 5, 2021), <https://www.mass.gov/info-details/covid-19-testing-guidance#guidance-for-congregate-care-surveillance-testing>.

<sup>28</sup> *Id.*

<sup>29</sup> CDC, *Interim Guidance for SARS-CoV-2 Testing in Correctional and Detention Facilities*, updates as of June 7, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/testing.html>.

<sup>30</sup> *Id.*

conducted regularly to allow for early identification and isolation of persons who are positive, and should be conducted in conjunction with symptom screening.<sup>31</sup> This is especially important in areas with moderate to high community transmission. As of November 8, 2021, Middlesex County has a high community transition rate, and Norfolk County's transmission rate is substantial. Nine of twelve Massachusetts counties are at high risk for COVID-19 transmission.<sup>32</sup>

The CDC recommends that facilities consider implementing routine screening testing among all incarcerated/detained persons and staff who are not fully vaccinated, who are at higher risk of several illness from COVID-19, i.e., individuals with medical conditions that increase or may increase risk of severe COVID-19. Identifying infections early can help ensure timely medical attention to prevent severe outcomes. The Interim Guidance includes numerous conditions, based on the CDC's evidence-based review. Many of these conditions are common among MCI-Norfolk and MCI-Shirley prisoners,<sup>33</sup> including those DLC interviewed: cancer, chronic kidney disease; chronic lung diseases; dementia or other neurological conditions; Type 1 or Type 2 diabetes; heart conditions; HIV infection; immunocompromised state; liver disease; overweight or obesity; hemoglobin blood disorders; current or former smoking; cerebrovascular disease, including stroke; and substance use disorders.

Several prisoners in MCI-Norfolk's CSU have reported to DLC monthly testing since April 2021, and that recently testing has been more frequent with the rise on community transmission. The CSU meets the recommended criteria for frequent routine testing both because the prisoners are both medically vulnerable and closely confined in dormitory quarters. It is important to regularly test in the units where medically vulnerable prisoners reside, such as the CSU. However, most older prisoners at MCI-Shirley and MCI-Norfolk, and many prisoners with chronic medical conditions, live outside the prisons' limited capacity specialized units for prisoners with medical needs and/or assistance with activities of daily living.<sup>34</sup> MCI-Norfolk houses the oldest prisoner population in DOC, with over 20% aged 60 and over.<sup>35</sup> More than half of its approximately 1400 prisoners are followed for chronic disease.<sup>36</sup> We continue to recommend targeted regular testing of this population consistent with the CDC's *Interim Testing Guidance*.

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<sup>31</sup> *Id.*

<sup>32</sup> CDC, *COVID Data Tracker, COVID-19 Integrated County View: Massachusetts*, [https://covid.cdc.gov/covid-data-tracker/#county-view|Risk|community\\_transmission\\_level](https://covid.cdc.gov/covid-data-tracker/#county-view|Risk|community_transmission_level).

<sup>33</sup> DOC released patient rosters listing chronic conditions for prisoners on the chronic care caseload.

<sup>34</sup> MCI-Shirley has two specialized units that serve prisoners with serious medical issues and disabilities. Its NCU, intended provide a nursing home level of care, has 28 beds for prisoners with medical needs. MCI-Shirley and MCI-Norfolk each have a CSU, which each have 15 to 16 dormitory-style beds for prisoners who need help with activities of daily living.

<sup>35</sup> DOC, *January 1 Snapshot Dashboard*, <https://www.mass.gov/info-details/january-1-snapshot-dashboard>.

<sup>36</sup> According to an audit conducted in May 2017 by the Department of Mental Health ("DMH"), MCI-Norfolk had 736 prisoners followed for chronic disease out of approximately 1400 prisoners at the time. Lewis Declaration at para. 8; DOC, *Quarterly Report on the Status of Prison Capacity, Fourth Quarter 2017*, <https://www.mass.gov/doc/prison-capacity-fourth-quarter-2017/download>. DLC assumes that a similar number of prisoners are followed three years later, out of a similar population, particularly since prisoners serving the longest sentences are housed at MCI-Norfolk. See DOC, *Weekly Count Sheets: November 9, 2020*, <https://www.mass.gov/lists/weekly-inmate-count-2020>.

We also strongly urge DOC to require Wellpath to screen for COVID-19 symptoms daily in the NCU and CSUs. MCI-Norfolk CSU prisoners reported to DLC that Wellpath nursing staff do not engage in regular symptom screening: after a few occasions following the December 2020 outbreak, the nurses simply did not have the time. The CSU has limited staffing in a unit with up to sixteen medically complex individuals: there is only one licensed practical nurse per shift. Improved infection control is essential in the specialized dormitory units, where tight dormitory quarters risk transmission of infection, as demonstrated in December 2020 when the entire CSU tested positive for COVID-19. Should another outbreak occur, it is essential that prisoners who may have had contact are screened daily for symptoms, whether or not they have been vaccinated, and that DOC ensure that Wellpath assigns sufficient medical staff to the CSU to complete those daily screenings.

The existing levels of Wellpath staff appear to be unable to ensure all infection prevention and control measures are implemented effectively, including the robust surveillance screening and testing DLC recommends. In addition to DLC's investigation, Prisoners' Legal Services reported a recent series of infections in the CSU, including one hospitalization from a bacterial infection serious enough to trigger a mandated report of risk to public health to the Department of Public Health ("DPH").<sup>37</sup> Accordingly, we urge DOC and Wellpath to hire additional infection control nursing staff to ensure effective infection control measures are implemented in the NCU, CSUs, and for medically vulnerable prisoners in general population at MCI-Norfolk and MCI-Shirley.

In addition, DOC must explore and implement measures to ensure greater social distancing between prisoners in the NCU and CSU units – particularly the cramped quarters of the MCI-Shirley CSU. DOC should install high-efficiency particulate air ("HEPA") fan/filtration systems to reduce the concentration of airborne particulates, including COVID-19 viral particles. The CDC recommends such units for higher risk indoor areas.<sup>38</sup>

Most concerning among Prisoners Legal Services' allegations implicating failure to protect against COVID-19 infection, are the allegations of insufficient disinfectant products, failures to fill open unit worker positions, and correctional officers' failure to wear masks while two units at MCI-Norfolk were under quarantine for infections during August 2021.<sup>39</sup> DLC urges DOC to investigate PLS' allegations of poor hygienic practices and corrections officers' failures to mask appropriately, and to implement all necessary corrective action.

## **2. Medical and Mental Health Care Must Not Be Suspended During Periods of Lockdown or Restricted Movement**

As DLC reported in its preliminary findings letter, during the spring of 2020, Wellpath restricted access to critical medical and mental health care far beyond contemporary community

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<sup>37</sup> Letter from Elizabeth Matos, Executive Director of Prisoners' Legal Services to Superintendent Nelson Alves and Dr. Chidi Achebe, MCI-Norfolk (September 28, 2021).

<sup>38</sup> CDC, *Ventilation in Buildings*, (updated June 2, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html>.

<sup>39</sup> Letter from Elizabeth Matos, Executive Director of Prisoners' Legal Services to Superintendent Nelson Alves and Dr. Chidi Achebe, MCI-Norfolk (September 28, 2021).

restrictions on health care in place in Massachusetts. By late October and November 2020, prisoners at MCI-Shirley and MCI-Norfolk reported once again that restrictions on in-person chronic care and 1:1 sessions with mental health clinicians had resumed, and off-site appointments were again being canceled, repeating the pattern of shutdowns of the previous spring.<sup>40</sup> DLC’s review of medical records, completed after issuing the November 20, 2020 letter, confirmed that cancellations of off-site appointments during both periods were blamed on the pandemic and that off-site visits were not scheduled because of the institutional lockdown – not because the outside hospitals refused to schedule appointments.<sup>41</sup> And, while outside hospitals did cancel or suspend appointments last spring, Wellpath failed to reschedule many of them in a timely manner.

DLC’s review of records and Wellpath documentation further demonstrates that telemedicine for off-site specialty care was only available when prisoners could access the Health Services Units (“HSU”). Telemedicine was not made available on the units during lockdown. Even worse, access problems persisted for telepsychiatry. Telepsychiatry was not available at all last spring at either MCI-Shirley or MCI-Norfolk. Additionally, without justification, Wellpath permitted only telepsychiatry, not in-person visits, when there were no lockdown restrictions during the summer and early fall months.

Wellpath’s restrictions are in stark contrast to Centers for Medicaid and Medicare Services (“CMS”) and DPH guidance in effect during this period. On March 18, 2020, and updated April 7, 2020, CMS, in order to prioritize limited resources, established a tiered framework of care to be followed in making clinical determinations concerning patient visits and procedures.<sup>42</sup> Under this framework, evaluations should have been conducted for patients exhibiting new symptoms, and for existing medical or behavioral or mental health conditions whenever delay in services could increase the potential for morbidity or mortality. Absent these urgent circumstances, follow-up should still have been done via telehealth or by virtual check-ins.<sup>43</sup> On March 15, 2020, the Commissioner of DPH issued an order pursuant to Governor Baker’s State of Emergency declaration, consistent with CMS recommendations.<sup>44</sup> Alarming, however, Wellpath defined serious medical conditions that would justify off-site appointments as

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<sup>40</sup> DOC produced Wellpath’s *COVID-19 MH Overview*, which indicates reliance on periodic rounds in units and provision of informational written materials for MCI-Shirley and MCI-Norfolk prisoners until on or around January 22, 2021. As of that date, the document reports that “modified operations discontinued” at MCI-Shirley and “patients seen for 1:1 sessions.” At MCI-Norfolk, mental health rounds were “continuing in quarantine units and RHU”; 1:1 sessions “re-started for patients who are COVID-recovered or cleared”; and “[e]mergency 1:1 sessions provided to patients who are COVID-positive or not cleared on housing units.”

<sup>41</sup> For example, ██████████ of MCI-Norfolk submitted a sick call request for an appointment at Lemuel Shattuck Hospital (LSH) for an ingrown toenail. The nurse practitioner responded on December 16, 2020, that only emergency procedures would be allowed at LSH “due to institutional restrictions lockdown.” For ██████████, the nurse practitioner responds on January 4, 2021 to a sick call slip concerning chronic abdominal pain, that a repeat colonoscopy at LSH was approved, but delayed due to “COVID-19 institutional lockdown.”

<sup>42</sup> CMS, *Non-Emergent, Elective Medical Services, and Treatment Recommendations*, March 18, 2020 (updated April 7, 2020), <https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf>.

<sup>43</sup> *Id.*

<sup>44</sup> Commissioner Monica Bharel, *Order of the Commissioner of Public Health*, March 15, 2020, <https://www.mass.gov/doc/march-15-2020-elective-procedures-order/download>; DPH, *Guidance: Reopen Approach for Health Care Providers*, May 18, 2020 (updated May 25, 2020), <https://www.mass.gov/doc/dph-phase-1-reopening-non-acute-care-hospital-health-care-provider-guidance/download> (noting consistency with CMS recommendations, as well as providers’ expansion of telehealth).



those “that may cause immediate loss of life or limb needing ongoing evaluation/treatment.”<sup>45</sup> Such an extreme definition prevented access to necessary off-site care.

Community hospitals reopened weeks before Wellpath began resuming off-site appointments in July 2020<sup>46</sup> and have not shut down services since that time. According to DPH, since May 2020, “hospitals and other health care facilities have provided the full spectrum of healthcare services, including preventive care.”<sup>47</sup> Many acute care hospitals and other providers began expanding available services in keeping with DPH guidance in May and June of 2020. For example, Boston Medical Center (“BMC”), which frequently serves MCI-Shirley and MCI-Norfolk prisoners, attested on May 31, 2020 that it would resume “high-priority preventative care and urgent procedures or services that cannot be delivered remotely and would lead to high risk or significant worsening of the patient’s condition if deferred.”<sup>48</sup> BMC filed further attestations to broaden its services for routine care on June 16, 2020 and again on September 21, 2020.<sup>49</sup> Another example, UMass Memorial Health Care, Inc, filed such attestations resuming care June 1 and June 12, 2020 at its multiple hospitals.<sup>50</sup> Lemuel Shattuck Hospital (LSH), operated by DPH and contracted with Wellpath to provide services for DOC prisoners, reopened for routine services June 22, 2020 and further on August 10, 2020.

With the resurgence of COVID-19 in the fall of 2020, reopened hospitals did not cut off all non-emergency services and outpatient procedures again. The Chief Medical Officer for BMC, interviewed December 2, 2020, stated that the shutdown of all but emergency care would not be repeated.<sup>51</sup> Only Lawrence General Hospital suspended elective inpatient surgeries and procedures, but continued to provide urgent and diagnostic care.<sup>52</sup> Clearly, DOC and Wellpath had many choices of outpatient providers available to provide specialist evaluations and care to prisoners, but failed to prioritize provision of that treatment.

<sup>45</sup> Wellpath, *Off-Site Guidance During COVID-19 Pandemic*.

<sup>46</sup> DPH, *Guidance: Reopen Approach for Acute Care Hospitals*, May 18, 2020 (updated May 25, 2020), <https://www.mass.gov/doc/dph-phase-1-reopening-guidance-acute-care-hospitals/download>; DPH, *Guidance: Reopen Approach for Health Care Providers (Providers that Are Not Acute Care Hospital)*, May 18, 2020 (updated May 25, 2020), <https://www.mass.gov/doc/dph-phase-1-reopening-non-acute-care-hospital-health-care-provider-guidance/download>; Mass General Brigham, <https://www.masseyeandear.org/assets/MEE/pdfs/covid19/mgb-acute-care-attestation.pdf>.

<sup>47</sup> DPH, *COVID-19 Hospital Capacity and Surge Response*, <https://www.mass.gov/info-details/covid-19-hospital-capacity-and-surge-response>.

<sup>48</sup> BMC, *Acute Care Hospital Phase 1 Reopen Attestation* (May 31, 2020), at <https://www.bmc.org/sites/default/files/documents/Boston-Medical-Center-Phase-1-Re-Open-Attestation-5-31-2020.pdf>.

<sup>49</sup> BMC, *Acute Care Hospital Reopen Attestation: Phase 3: Vigilant*, at <https://www.bmc.org/sites/default/files/documents/BMCphase3.pdf>.

<sup>50</sup> UMass Memorial Health Care, Inc., *Acute Care Hospital Phase 1 Reopen Attestation* (June 1, 2020), at [https://www.umassmemorialhealthcare.org/sites/umass-memorial-hospital/files/Documents/Emergency\\_Documents/Attestation.pdf](https://www.umassmemorialhealthcare.org/sites/umass-memorial-hospital/files/Documents/Emergency_Documents/Attestation.pdf); UMass Memorial Health Care, Inc., *Acute Care Hospital Reopen Attestation: Phase 2* (June 12, 2020), at <https://www.umassmemorialhealthcare.org/sites/umass-memorial-hospital/files/Images/Events/Hospitals%20Phase%20%20Reopening%20Attestation.pdf>.

<sup>51</sup> Rich Barlow, *Boston Medical Center is Well Prepared for COVID-19 Surge*, BU Today (December 2, 2020), at <http://www.bu.edu/articles/2020/bmc-is-well-prepared-for-covid-19-surge/>.

<sup>52</sup> Commissioner Monica Bharel, *Order of the Commissioner of Public Health Exempting Hospitals from the Requirements of M.G.L. c.111, §231*, May 18, 2020, <https://www.mass.gov/doc/dph-order-nurse-staffing-updated-may-18/download>; DPH, *Acute Care Hospital Attestation: Suspension of ICU Staffing Minimums and Elective Procedures*, <https://www.mass.gov/lists/hospital-submitted-attestations>. Lawrence Hospital suspended elective inpatient procedures on December 1, 2020. See <https://www.lawrencegeneral.org/about-us/monitoring-covid-19>.

Wellpath's summary of its DOC operations during the pandemic confirms that medical, dental, and mental health care were all dramatically cut back during lockdown periods.<sup>53</sup> Wellpath suspended routine in-person meetings for chronic disease management. Medical staff only saw patients in the HSU's who needed urgent care, and only urgent or emergent off-site and specialty appointments were scheduled. Doctors did not see patients on the units; only physician assistants and nurse practitioners (NP) performed most patient visits.<sup>54</sup> Consistent with the operations summary, prisoners at MCI-Shirley and MCI-Norfolk reported to DLC that evaluations and treatment were severely restricted from March through June 2020 while facilities were in various stages of lockdown. This included canceled outside surgeries and specialist evaluations as well as on-site care for chronic medical conditions, including conditions such as diabetes and asthma that place prisoners at higher risk of serious complications from COVID-19. DLC interviewed an additional 15 prisoners in the fall and winter of 2020-21, and their records confirmed that services had not taken place.

The National Commission on Correctional Health Care ("NCCHC") recommended in its COVID-19 Guidance to delay chronic care only for brief periods during restricted operations, and to implement telemedicine as much as possible to provide continuity of care.<sup>55</sup> DOC and Wellpath did not implement telemedicine on the units during this period of restricted care; the only access to telemedicine is on the Health Services Units (HSU). Long term cell confinement under lockdown also aggravated chronic conditions for which exercise is essential, as well as prisoners' mental wellbeing.

MCI-Shirley and MCI-Norfolk prisoners reported to DLC that they likewise experienced detrimental restrictions in mental health services. Prisoners no longer saw their assigned mental health clinicians and instead only had minimal access to rounding clinicians. Multiple prisoners reported feeling that their mental health was deteriorating during the isolation of lockdown. The lack of mental health counseling increased these difficulties. Prisoners who needed changes in their medications did not receive the necessary evaluations. Others reported that a correctional officer always accompanied nurses or mental health clinicians when they performed rounds or met with prisoners cell-side, eliminating altogether the confidentiality so important for mental health care.

These reports are consistent with Wellpath's COVID-19 and Mental Health Services guidelines and staffing announcement, whereby "routine mental health contacts" were eliminated until the conclusion of the COVID-19 event.<sup>56</sup> Wellpath provided only crisis coverage, twice weekly rounds in general population units, and rounds three times per week in RHUs.<sup>57</sup> Wellpath staff purportedly provided alternative means of service for patients whose services were suspended, such as homework and activity packets.<sup>58</sup> If written materials were provided, as Wellpath claims, they made no beneficial impact on the mental health difficulties experienced by

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<sup>53</sup> Wellpath, *MADOC Restart Template*.

<sup>54</sup> *Id.*

<sup>55</sup> *Id.*

<sup>56</sup> Memorandum from Mitzi Peterson, Director of Behavioral Health, to Superintendents, *Mental Health Staffing During COVID-19*, March 25, 2020.

<sup>57</sup> Wellpath, *MADOC Restart Template*.

<sup>58</sup> *Id.*

these prisoners. Tele-mental health services were not provided on the units to help compensate for the lack of in-person sessions.

DLC reviewed updated records and received reports on the resumption of off-site evaluations, treatment and surgeries. DOC has reported that they addressed the backlog as quickly as possible; however, many delays in care cannot be explained by a backlog alone. Below are just a few examples of unnecessary delays in services:

- [REDACTED] is an 87-year-old MCI-Norfolk CSU resident (since April 2020) with phimosis, a large abdominal hematoma, diabetes, and a cardiac condition. For two years, he has experienced difficulty urinating and painful burning sensations in his penis due to phimosis. Mr. [REDACTED] is hard of hearing, making telemedicine far less effective than in-person consultation. He had a telehealth appointment with LSH Urology in July 2020, where the doctor noted soft tissue bleeding and his buried penis. The doctor commented in the consult that telemedicine is ineffective because of his hearing loss and that he needed to be seen in the urology clinic. Wellpath informed Mr. [REDACTED] in January 2021 that due to COVID-19 restrictions, his in-person appointment with urology would be further delayed. Wellpath failed to schedule an in-person appointment until *ten months later* in May 2021, by which time he had begun bleeding from his penis. In the meantime, Mr. [REDACTED] filed increasingly urgent sick call slips of continued pain and difficulty urinating. The May 2021 urology consult recommended a topical cream, and that if this did not resolve Mr. [REDACTED]'s phimosis, he would require circumcision. According to his family, he continues to complain of pain, and the circumcision has still not been scheduled.

In addition, Wellpath delayed referral for a cardiac workup in May 2020 because of COVID-19. Mr. [REDACTED] was seen by LSH Cardiology by telemedicine *ten months later* in March 2021. An arrhythmia was detected as well as an artery aneurysm and possible chronic obstructive pulmonary disease (“COPD”). LSH referred Mr. [REDACTED] to BMC’s Arrhythmia/Device clinic for a pacemaker review & BMC Heart Failure clinic for further testing and evaluations. As of April 2021, referrals were all pending for hematology, general surgery, cardiac testing, cardiology, and dermatology. Mr. [REDACTED] required further cardiac testing in order to be cleared for circumcision surgery.

According to DOC, appointments were finally scheduled at LSH general surgery to evaluate the abdominal hematoma, and at the BMC Heart clinics, in mid-June 2021. DLC has not received an updated as to whether Mr. [REDACTED] ultimately had these appointments.

- [REDACTED] is 46 years old and has been an MCI-Norfolk CSU resident since March 2021. Mr. [REDACTED] suffers from a neurodegenerative condition that has led to rapid and progressive deterioration of his physical strength, balance, and overall motor function. He first experienced symptoms in May 2020, including pain in his lower extremities, poor balance, limited motor function in his left arm, very limited dexterity in both of his hands, tremors, muscle spasms, and intense fatigue. These

symptoms worsened over time, and in the fall of 2020 new symptoms emerged, such as core weakness, muscle cramps, irregular gait, and difficulty chewing. By March 2020, Mr. ██████ struggled with basic tasks like walking, writing, typing, buttoning his shirt, tying his shoes, rising out of bed, shaving, and gripping objects. Since May 2021, he has been confined to a wheelchair.

After repeated requests to access care since May 2020, Mr. ██████ had a telemedicine appointment with an LSH neurologist on September 22, 2020 who expressed concern that his progression of weakness indicated motor neuron disease. The neurologist recommended that he come to LSH for in-person neurology evaluation at the next available opportunity. Mr. ██████ was informed that he had an appointment scheduled for early November 2020, but Wellpath canceled it because of the COVID-19 infections at MCI-Norfolk. On January 7, 2021, Mr. ██████'s attorneys at the Criminal Justice Institute (CJI) at Harvard Law School wrote to State-wide Medical Director for Wellpath, Dr. Steven Descoteaux, stating they were in contact with neurologists at LSH who confirmed that an in-person evaluation was essential.<sup>59</sup> Dr. Descoteaux responded that Mr. ██████'s appointment was not a matter of urgency and other cases were to be prioritized. Mr. ██████ did not receive his urgent in-person appointment until February 16, 2021. MRIs of his brain and spine were finally completed in April 2021 and a repeat EMG in June 2021. After well over a year of reporting alarming, progressive deterioration, he was finally scheduled to go to the Massachusetts General Hospital's ALS Clinic, and attended that appointment on October 1, 2021.

- ██████, age 62 (MCI-Norfolk), has a number of chronic care conditions and is immunocompromised due to positive HIV status. He has had numerous hospitalizations for cardiac and seizure activity. He was hospitalized in October 2020 for chest pains and collapse due to a possible seizure, and discharged with recommendations for follow-up with cardiologist and neurologist; these were never scheduled. Following five days of intermittent chest pain, Mr. ██████ was admitted to Good Samaritan Hospital in late January 2021. There, a seizure workup showed electrolyte imbalance. Good Samaritan Hospital discharged Mr. ██████ with the recommendation for Wellpath to follow up with neurology for seizure activity & his Keppra level, and also to follow up with outpatient hematology re: low platelet levels. On May 17, 2021, Wellpath finally submitted a referral to neurology for an EEG, and conducted bloodwork that month, but did not submit referrals for outpatient hematology or further neurologic follow-up as recommended. Mr. ██████ reports that he was hospitalized later in May at Simon Christian Hospital for seizure activity, and hospitalized yet again on September 5, 2021 following chest pains. He remained at Simon Christian for three days for cardiac testing. Mr. ██████ reports that after his discharge to MCI-Norfolk, he met with the Wellpath medical director, who

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<sup>59</sup> The Criminal Justice Institute ("CJI") sent a letter dated January 7, 2021 by e-mail Dr. Descoteaux stating that CJI had been in contact with the neurology specialists at Shattuck. CJI informed Dr. Descoteaux that Dr. Vullaganti, the neurologist who had seen Mr. ██████ by telemedicine in September 2020, expressed that an in-person evaluation as well as an EMG would be essential for diagnosing Mr. ██████'s condition, and that either neurologist could perform the testing and evaluation. CJI offered to coordinate the appointment.

recommended that he see a cardiologist and HIV specialist. Two months later, this follow-up has still not been scheduled.

- [REDACTED] (Age 57, MCI-Norfolk): Mr. [REDACTED] has severe COPD for which specialist care was long delayed. After one of his lungs collapsed in January 2020, he continued to have shortness of breath, at times severe, and required up to daily nebulizer treatments to regulate his breathing. Facility lockdowns prevented his access to nebulizer treatment in the HSU, forcing him to make do with quick inhaler treatments for much of the period from March 2020 through February 2021. Wellpath finally submitted referrals for a pulmonary consult and CT lung scan in May 2021. The CT lung scan was completed in June 2021, and Mr. [REDACTED] saw the pulmonologist in August 2021; Wellpath has not yet submitted paperwork for the follow-up appointment with the pulmonary specialist, which must be take place by February 2022.

On November 27, 2019, Mr. [REDACTED]'s cardiologist recommended a stress test to rule out ischemia and make sure his ventricular functioning is normal; that test was not scheduled until August 4, 2020, which Wellpath reports he refused to attend. Mr. [REDACTED] reports he did not refuse an outside appointment for a stress test but that inmate transport does not consistently have the necessary flexible restraints to transport him. A second referral was not made until March 2021 and Mr. [REDACTED] finally had the stress test during last summer 2021. To date, he has still not seen the cardiologist for the necessary follow-up.

Additionally, since at least January 2020, Mr. [REDACTED] experienced intermittent blurring of vision, headaches, and pain behind and around his left eye. A neurosurgeon at BMC saw Mr. [REDACTED] in February 2020, following a CT scan that revealed an arachnoid cyst pressing on his optic nerve. The surgeon recommended a second CT scan to evaluate enlargement of the cyst, followed by another neurosurgery consultation. Wellpath did not submit referrals to BMC for CT scans of brain and eye orbits until April 2021 and Mr. [REDACTED] had the CT scans completed during the summer of 2021. He hopes to see the ophthalmologist before the end of this year.

- [REDACTED], age 55 (MCI-Norfolk) was hospitalized on May 16, 2021 following an incident where he attempted suicide by climbing to the roof of a building with the intention of jumping and ending his life. He had been experiencing abdominal pain, epigastric burning, and nausea for over two years since a diagnosis of bowel obstruction. Mr. [REDACTED] felt it was worsening, and was deeply frightened and distressed that health providers were ignoring his condition. Mr. [REDACTED] was transferred to Old Colony Correctional Center following his hospitalization to provide a higher level of mental health care. In early 2020, Milford Medical Center recommended a CT scan with a barium swallow test. Wellpath approved the barium swallow test in April 2020 but delayed scheduling the test because of COVID-19.

In the meantime, throughout the year that followed, Mr. ██████ reported to Wellpath nursing staff his worsening pain, poor appetite, difficulty swallowing, nausea, intense abdominal discomfort and constipation, and ultimately black diarrhea. Wellpath staff advised only to drink more fluids, and failed to refer his reports to providers as an urgent matter. Wellpath discontinued a stomach-coating medication in the spring of 2021. Mr. ██████ was taken to the emergency department of Milford Medical Center for severe abdominal pain several days before his suicide attempt, where the emergency department physician determined he should be restarted on stomach coating medication to reduce gastric burning sensation and recommended further GI follow up. Only after his suicide attempt did Wellpath staff plan to order the barium swallow study, refer to GI, and order the recommended endoscopy and colonoscopy. Testing that was carried out after his suicide attempt followed by the barium swallow test in June 2021 and the endoscopy in July 2021, which failed to reveal the source of the gastric distress. Reportedly, another swallow test is being scheduled to review continued acid reflux and difficulties with swallowing.

Wellpath policy and practice delaying and limiting access to vital health care evaluations and services, sanctioned by DOC, resulted in widespread neglect<sup>60</sup> of DOC prisoners with disabilities. DOC and Wellpath must bring access to medical and mental health services during the pandemic into conformity with community and correctional standards. Even when infections rose in Massachusetts last fall and winter 2020/2021, and now again with the introduction of the even more contagious Delta variant, health care providers and hospitals all continue to treat patients in accordance with Massachusetts' reopening plans. DOC cannot permit Wellpath to resume its former level of restrictions. Failure to provide necessary care and treatment for medical conditions and mental illness will violate DOC's clear legal obligations to provide adequate treatment to prisoners in its custody.

### **3. Restatement of Recommended Corrective Actions by DOC**

In keeping with the foregoing, DOC directs DOC to implement the following corrective actions as a matter of urgency to address ongoing risks to the health of prisoners with disabilities:

1. Require Testing of All Staff Consistent with Massachusetts COVID-19 Surveillance Testing Guidance for Congregate Care Settings.<sup>61</sup>
2. Increase Testing and Screening of Unvaccinated Prisoners, Older Prisoners, and Medically Vulnerable Prisoners:
  - a. Target screening and testing measures for all unvaccinated prisoners as well as regular testing of older and/or medically vulnerable prisoners;

<sup>60</sup> See 45 C.F.R. § 1326.19; 42 C.F.R. § 51.2; 29 U.S.C. § 794e(f)(2).

<sup>61</sup> See CDC, *Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes* (updates as of September 10, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>; DPH, *Residential and Congregate Care Programs: 2019 Novel Coronavirus (COVID-19) Surveillance Testing Guidance* (updated August 5, 2021), <https://www.mass.gov/info-details/covid-19-testing-guidance#guidance-for-congregate-care-surveillance-testing>.

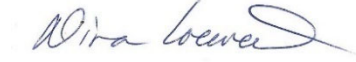
- b. Conduct symptom screening and testing more frequently during periods of rising community transmission;
  - c. Contract for additional infection control nursing staff to ensure that symptom screening and testing is implemented in the CSUs and NCU, and as needed for vulnerable prisoners in the general population; and
  - d. Ensure adequate infection control measures are taken in the CSUs and NCU, including HEPA air filtration.
3. Ensure that DOC's Medical Contractor Provides Continuity of Medical and Mental Health Care During Periods of Restricted Prisoner Movement and Lockdowns:
- a. Reject and mandate modifications to policies and practices of DOC's medical contractor that prevent appropriate access to on-site and off-site medical and mental health care in keeping with CMS and DPH guidance discussed above.<sup>62</sup>
  - b. Ensure that prisoners with chronic medical conditions receive timely access to appropriate medical care, including appropriate monitoring of medications, viral loads, and other outcomes, as well as chronic care appointments on-site, and access to regular off-site specialist consultations;
  - c. Provide regular access to mental health treatment for prisoners who have open mental health cases and timely access to mental health providers for prisoners who are experiencing new or worsening mental health issues, including psychiatric evaluations and the opportunity for confidential communications with their assigned mental health clinicians at least as frequently as pre-pandemic standards required;
  - d. Ensure that there is adequate staff to provide continuity of medical and mental health care, including staff to ensure timely approval and scheduling of off-site specialist consultations;
  - e. Promptly schedule all off-site clinic referrals, evaluations, consultations, and hospitalizations if prisoners are experiencing new symptoms or if not providing the service for a current condition has the potential to increase morbidity or mortality, with telemedicine substituting for off-site evaluations if clinically appropriate; and
  - f. Make telemedicine widely available for both medical and mental health treatment on the units in times of restricted prisoner movement. Mental health clinicians should also consider setting office hours when they will receive phone calls from prisoners during any future lockdown periods.

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<sup>62</sup> See, e.g., CMS, *Non-Emergent, Elective Medical Services, and Treatment Recommendations*, March 18, 2020 (updated April 7, 2020), <https://www.cms.gov/files/document/cms-non-emergent-elective-medical-recommendations.pdf>; Commissioner Monica Bharel, *Order of the Commissioner of Public Health*, March 15, 2020 <https://www.mass.gov/doc/march-15-2020-elective-procedures-order/download>; DPH, *Guidance: Reopen Approach for Health Care Providers*, May 18, 2020 (updated May 25, 2020), <https://www.mass.gov/doc/dph-phase-1-reopening-non-acute-care-hospital-health-care-provider-guidance/download> (noting consistency with CMS recommendations, as well as providers' expansion of telehealth).

DLC appreciates DOC's commitment to addressing the impact of the pandemic on its population and facility operations. DLC has appreciated all of DOC's time and cooperation in this investigation and hopes that DLC and DOC can continue to work together to address these important issues impacting prisoners with disabilities. We ask that you provide any response within thirty days, following which we will publicly release a redacted version of this letter.

Sincerely,



Nina Loewenstein, M.P.H.  
Staff Attorney



Tatum A. Pritchard  
Director of Litigation / Interim Executive Director



## **Attachment B**

Department of Correction's Response to Disability Law Center's MCI-Shirley and MCI-Norfolk  
Investigation Findings and Recommendations for Corrective Action (January 7, 2021)



**CHARLES D. BAKER**  
*Governor*

**KARYN E. POLITO**  
*Lieutenant Governor*

**TERRENCE M. REIDY**  
*Secretary*

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**MICHAEL G. GRANT**  
**ROBERT P. HIGGINS**  
**MITZI S. PETERSON**  
**THOMAS J. PRESTON**  
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January 7, 2022

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Nina Loewenstein, Staff Attorney  
Disability Law Center, Inc.  
11 Beacon Street, Suite 925  
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RE: DLC's Additional Findings Concerning MCI-Shirley and MCI-Norfolk

Dear Attorneys Pritchard and Loewenstein:

The Massachusetts Department of Correction (Department) is in receipt of your November 19, 2021 correspondence to Commissioner Carol Mici, in which the Disability Law Center (DLC) issued additional findings and suggested corrective actions related to DLC's investigations into MCI-Shirley and MCI-Norfolk regarding the care of individuals with disabilities in light of the COVID-19 pandemic. While the Department recognizes the importance of the matters that are the subject of this investigation and appreciates that DLC desired a written response within thirty days of its correspondence, it was not feasible for a comprehensive written response to be completed within such a short time frame.

The Department timely reviewed DLC's November 19, 2021 correspondence and, as detailed herein, did not find substantive evidence to support the findings. Additionally, most of the suggested corrective actions have already been taken by the Department or were similarly not supported by the evidence or recommended by the CDC. For example, the November 2021 letter refers to the "now vacant Ombudsman" with a recommendation by DLC to fill this position. However, not only has an Ombudsman been hired, the Ombudsman's first report was submitted and posted publicly on September 13, 2021, and subsequent reports have been posted biweekly.

The following is the link for the Office of the Ombudsman's website: <https://covidombudsman-madoc.org> , where the reports can be reviewed.

The Office of the Ombudsman was established pursuant to Chapter 227 of the Acts of 2020. The director of the Ombudsman's Office reports directly to the Commonwealth's elected officials seated in both the Joint Committee on the Judiciary and the Joint Committee on Public Health. Although this Office works collaboratively with the DOC, the Office's performance, oversight, and accountability remain independent from the DOC and accountable only to the Massachusetts State Legislature. The mission of the Ombudsman is to protect the health and safety of Department staff, inmates, and their families by working independently of the DOC to assess and monitor the DOC's compliance with Office-established public health standards, using recommended best practices and guidance from public health experts.

As always, the Department is committed to providing appropriate medical and mental health care to all inmates in its custody. Herein, the Department addresses key subjects and/or assertions in DLC's November 19, 2021 correspondence.

DLC's most recent letter continues to imply that the Department is not utilizing applicable guidelines regarding the management of COVID-19 and that the Department's efforts to control the spread of COVID-19 in the prisons remain deficient. Specifically, DLC focuses on MCI-Norfolk and MCI-Shirley, despite the fact that, as of January 7, 2022, there have been no positive cases amongst the inmate population at MCI-Norfolk and 4 positive cases at MCI-Shirley (but not in the Clinical Stabilization or Nursing Care Units) and despite the fact that the Supreme Judicial Court (SJC) has found that the Department's response to COVID-19 throughout the entire prison system has been eminently reasonable.

In June 2020, in Foster v. Mici, 484 Mass. 698, 718-724 (2020), the Supreme Judicial Court (SJC) expressly noted the extensive actions taken by the Commissioner to control the spread of COVID-19 during the pandemic's first wave and held that the plaintiffs in that case were not likely to prevail on a claim that the Commissioner had been deliberately indifferent to the needs of inmates in the wake of the pandemic. At the time of Foster I, these actions included, but were not limited to, designating clinical isolation areas for inmates who might show symptoms of COVID-19, screening of inmates, issuing masks, making alcohol-based hand sanitizer available, providing inmates, patients, and staff with education and other updates in English and Spanish on preventing the spread of COVID-19, temporarily suspending non-attorney visits, closing common areas such as gymnasiums and dining halls to prevent inmates from congregating, and medically evaluating all new admissions to Department facilities and quarantining them for fourteen days before placement in general population.

Since that time, the Department has continued to utilize and expand upon many of the actions which proved to be effective during the beginning of the pandemic. Specifically, the Department continues to minimize the introduction of the virus by requiring visits to be scheduled 24 hours in advance, providing COVID testing of visitors, entrance screening procedures requiring visitors to undergo temperature checks and to fill out a COVID questionnaire prior to any visit. Any visitor with a temperature over 99.0 degrees, or who answers "yes" to one of the questions on the questionnaire, will not be permitted to enter. Visitors must wear masks and are also required to use

hand sanitizer before and after the visit. Social distancing is also enforced during visits. The Department also continues to require mask wearing by staff in all facilities, has increased cleaning and disinfecting, limits group participation in programs to improve social distancing, conducts regular surveillance testing, and medically isolates confirmed COVID-19 patients in accordance with CDC guidelines. In addition, the Department has implemented a comprehensive vaccination program for inmates and staff.

After the decision in Foster I, the plaintiffs again sought a preliminary injunction alleging that their ongoing conditions of confinement and the Department's efforts to decrease the prison population after Foster I constituted a violation of their rights under the Eighth Amendment. (Foster II). On November 18, 2021, the SJC denied the second request for a preliminary injunction filed by Prisoners' Legal Services (PLS), holding that plaintiffs have not demonstrated a likelihood of proving deliberate indifference necessary for a constitutional violation. The SJC specifically credited the Department's extensive "state-of-the-art" vaccination efforts, noting that the scientific community has recognized that vaccination is highly effective in protecting against the risk of COVID-19 infection, and especially against serious outcomes from the virus. Foster II. A copy of the decision is attached.

In Foster II, the SJC emphasized that the Department has continued to implement the measures discussed in Foster I, and utilized additional measures, including offering the vaccine to all medically eligible inmates. Based upon these "nonpharmaceutical interventions" (NPIs), the SJC found that plaintiffs had not demonstrated a likelihood of success on the merits regarding a constitutional violation of deliberate indifference. In addition to the NPIs, the SJC found that the Department took advantage of the availability of COVID-19 vaccines by launching an effort to vaccinate all inmates in its custody. In adopting this "state-of-the-art medical response in combatting COVID-19," the SJC determined that the Department's response was "eminently reasonable." Foster II, p. 20. The SJC found that "[t]he DOC's approach of combining existing NPI measures with a comprehensive vaccination program [was]... a reasonable response resulting in reasonably safe conditions of confinement. Farmer, 511 U.S. at 844." In its findings, the SJC noted that, by February 2, 2021, of the ninety-four percent of inmates deemed medically eligible for vaccination, seventy-one percent had received their first dose of the two-dose Moderna COVID-19 vaccine. The SJC further ruled that the Department was not required to employ or exhaust every measure to reduce the risk of COVID-19 in order for its response to be "reasonable" under Farmer. See Wilson v. Williams, 961 F.3d 829, 844 (6th Cir. 2020) (rejecting contention that prison officials respond unreasonably to risk to inmate health if they do not make "full use of the tools available" or "take every possible step to address a serious risk of harm"). Foster II, p. 23.

The Court specifically stated that the Department's vaccination campaign and modified restrictions -- permitting inmates expanded opportunities for recreation, education and work, as well as renewed contact with loved ones through video conferencing -- significantly altered the risk calculus, rendering plaintiffs' ability to demonstrate substantial harm far more difficult. Accordingly, the Court concluded that plaintiffs did not demonstrate that they are likely to succeed in proving deliberate indifference.

In sum, the SJC concluded that the Department's implementation of a comprehensive vaccination scheme, in addition to its adoption of other non-pharmaceutical measures, reflected a reasonable risk-reduction response without the prison depopulation measures advocated by plaintiffs. See Foster II.

With respect to the suggested corrective actions in DLC's correspondence, many are based upon facts that are inaccurate and do not reflect prior or current practices of the Department. As discussed below, DLC's suggested corrective actions for the Department to, among other things, require staff to wear masks, ensure that housing units are cleaned and sanitized, conduct COVID-19-testing, ensure that inmates in the Nursing Care Unit (NCU) and Clinical Stabilization Unit (CSU) are screened and receive regular care, and that the Department not cancel outside medical appointments and procedures, are completely unnecessary given current practices.

Since March 2020, all staff members working in correctional facilities have been required to wear masks and, depending on circumstances or activities, other personal protective equipment (PPE). If any staff member is found not to be wearing a mask and/or other PPE that is required, the staff member is subject to discipline. Staff are also tested on a regular basis, regardless of vaccine status. Further, regarding DLC's stated concern regarding unvaccinated Department and Wellpath staff, these concerns are also unfounded. Prior to DLC's correspondence of November 19, 2021, Governor Baker had already issued Executive Order 595, which mandated that all Executive Department employees be vaccinated by October 17, 2021 unless the employee has been granted a medical or religious exemption. Although DLC expresses concern that "...it is reasonable to assume that many staff may remain unvaccinated based on approved objections..." there is no evidence to support this theory. In fact, all persons who have direct inmate contact, security or medical, must be vaccinated as there is no reasonable accommodation available.

Similarly, inmates are educated regarding COVID-19, required to wear face masks and are allowed access to alcohol-based hand sanitizer and cleaning products. Inmates have been and continue to be routinely tested for COVID-19, regardless of vaccine status, and every inmate who is symptomatic is medically isolated and tested for COVID-19. When an inmate tests positive for COVID-19, all close collateral contacts of that inmate are also tested. Any asymptomatic collateral contacts are screened twice daily.

DLC incorrectly asserts in its most recent correspondence that the Department was only testing symptomatic individuals and close contacts (see p. 3). As described in previous letters sent to DLC, Commissioner Mici has been and remains proactive in ensuring that testing is taking place in order to identify and quarantine asymptomatic COVID-19 positive cases through surveillance testing; testing and quarantining of asymptomatic cases has regularly occurred throughout the course of this pandemic. On December 3, 2021, the Commissioner signed off on guidelines for quarantining/isolating/testing based upon the Ombudsman's recommendations. These recommendations differentiate between vaccinated and unvaccinated individuals, and symptomatic and close contacts. Testing also continues to be available to all staff, and direct care staff are required to be tested twice per month. Testing is available five days per week on a rotating schedule per institution. The Department also conducts wastewater surveillance and utilizes those lab results to direct additional testing to specific facilities. Therefore, the testing schedule is flexible and may be adjusted due to wastewater surveillance results and known outbreaks.

As DLC was also informed in prior correspondence, inmates in the NCU and CSU continue to be screened every day. Medical staff make rounds daily on each inmate, for each shift in the NCU and CSU, and take every inmate's vital signs at least once a day or more frequently if clinically appropriate. Trained staff always have been, and remain, available to provide assistance with activities of daily living to inmates in the NCU and CSUs. As the Department has explained in previous correspondence, it is important to note that COVID testing involves both Wellpath and contracted ambulance services. The Department occasionally utilizes Wellpath for targeted COVID-19 testing. However, such requests of Wellpath are not often necessary as the Department already utilizes Brewster Ambulance Service (BAS) for surveillance testing and will direct and/or re-direct testing by BAS as deemed appropriate. For example, the Department may direct BAS to conduct testing at a specific facility based on review of wastewater results. Wellpath primarily conducts COVID-19 testing based on individualized scenarios, including but not limited to, when the inmate exhibits COVID-19 symptoms, the inmate is a close contact of someone who tested positive for COVID-19, the inmate is scheduled for a trip outside the facility, the inmate is newly admitted to the Department, or as recommended by the MA Department of Public Health. The Department does not need to make specific requests for Wellpath to conduct such testing as the testing is already conducted by Wellpath in accordance with Wellpath's protocols.

In terms of DLC's suggested corrective actions for the Department to ensure that medical and mental health care in the facilities is not suspended during lockdowns or periods of restrictive movement, the Department notes that, with the exception of certain modifications necessary to minimize the risk of spread of COVID-19, medical or mental health care has never been suspended during periods of lockdown or restricted movement due to COVID-19. As stated in the Department's prior correspondence to DLC, during any periods of lockdown or modified operations in the Department's facilities, rounds are regularly conducted by medical and mental health providers, inmates are brought all required medications, emergent or urgent needs are addressed, necessary bloodwork or other labs are done, and inmates retain the ability to submit sick slips. Additionally, if deemed clinically appropriate, inmates are seen out of cell, with appropriate COVID precautions. Telemedicine was, and is, utilized by the Department. Although Wellpath staffing has sometimes been temporarily affected due to COVID-19 protocols, medical and mental health providers have always been available to provide medical and mental health care to inmates as needed. Although DLC continues to recommend that Wellpath hire additional infection control nurses, the staffing matrix for medical/mental health providers has not changed, and there continues to be sufficient staffing to provide all needed medical and mental health to inmates, even in these extraordinary times.

While backlogs of offsite appointments continue to occur, they have decreased significantly and more outside appointments are able to be scheduled. Capacity limitations at the Lemuel Shattuck Hospital (LSH) impact the number of patients who can be seen per day and are outside the control of the Department and Wellpath. Currently, the maximum capacity limit at LSH is 30 patients per day. Additional factors at all outside hospitals, such as space limitations, hospital staffing issues and cancellations, as well as the Department of Public Health guidance on non-essential, elective services and procedures continue to some extent. The Department continues to work with Wellpath to reduce any existing backlog of appointments.

With respect to your inquiries regarding specific inmates, please see the following, updated as of December 21, 2021:

██████████  
Mr. ██████████ was seen on May 26, 2021 at LSH. At that time, the urologist recommended that he apply Lotrisone twice a day for 2 weeks. If this treatment was not successful, the urologist opined that Mr. ██████████ would require a circumcision. On August 3, 2021, Mr. ██████████ was seen again at LSH for a Urology follow-up. It was determined, at that appointment, that the Lotrisone cream had not been effective. Therefore, circumcision was recommended, provided that it could be done safely. There was also a recommendation that he stop anticoagulation medications. On August 10, 2021, Mr. ██████████ was referred to the Heart Failure Clinic and the Arrhythmia Clinic. He was seen at both clinics on October 28, 2021. Mr. Carriere was also referred, on September 13, 2021, to the Boston Medical Center (BMC) for a Urology pre-op referral. This appointment is currently scheduled for January 4, 2022. If Urology recommends general anesthesia then Cardiology is recommending a nuclear stress test first. He has a cardiac ECHO scheduled for December 30, 2021. Mr. ██████████ was sent to Good Samaritan Hospital on November 6, 2021 due to urine retention due to Phimosis (a condition in which the ridged band of the foreskin of the penis cannot stretch). A urinary tract infection (UTI) was diagnosed and an antibiotic given. An ultrasound and pelvic CT were done without any acute findings and Mr. ██████████ was returned to the institution. He is scheduled to return to Urology on January 4, 2022.

On October 25, 2021, Mr. ██████████ was seen by BMC Cardiology for cardiac clearance for phimosis surgery. It was recommended that he be scheduled with the device clinic. As a further note, it was concluded that if surgery will be completed under general anesthesia, he will require a nuclear stress test and a cardiac echocardiogram. An urgent echocardiogram referral was submitted to LSH on December 6, 2021. On October 26, 2021, Mr. ██████████ was seen by the BMC arrhythmia clinic. His last appointment with an on-site provider occurred on November 3, 2021 after which he was sent to Good Samaritan ER for a urological evaluation due to scrotal edema.

██████████  
On September 28, 2021, Mr. ██████████ was seen at the Massachusetts General Hospital (MGH) ALS clinic. At that time, recommendations were made for an EMG, MRI and a speech evaluation. On November 2, 2021, he was seen by BMC Ear Nose and Throat (ENT) for an evaluation of dysphonia (difficulty speaking). Recommendations were made for a speech pathologist for voice strengthening and supplemental oxygen. On November 5, 2021, Mr. ██████████ was seen by LSH cardiology for an evaluation of chest pain (CP) and shortness of breath (SOB). A cardiology telemedicine appointment follow-up occurred on December 2, 2021. Mr. ██████████ is currently scheduled for an evaluation in the pulmonary clinic at LSH for his dyspnea. He has approved referrals for cardiac electrophysiology, pulmonary function tests, EMG, lumbar MRI, and a follow up with the MGH ALS clinic and a speech pathology treatment clinic. He has been scheduled for an MRI on January 19, 2022 and an EMG on January 25, 2022, both at MGH. Until he returns to the Neurologist (where these studies will be reviewed), the diagnosis remains undetermined.

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Mr. [REDACTED] was seen on October 6, 2021 at Good Samaritan Hospital for cerebral palsy. Mr. [REDACTED] had a telemedicine appointment with neurology for a follow-up on December 2, 2021. Regarding his anemia - he has pancytopenia (slightly low counts on all cell lines). He had a negative esophagogastroduodenoscopy (EGD) and colonoscopy for cancer but varices and hemorrhoids were found. According to Wellpath, the likely etiology of this is related to his HIV disease (it is undetectable by viral load but his CD4 counts are between 300-400) or his HIV medications. Mr. [REDACTED] will be seen by Dr. Stone in January for follow-up on this issue. Regarding his chest pain, which has been investigated by medical professionals extensively, other than an old scar, there appear to be no active cardiac issues causing the symptoms.

[REDACTED]

With respect to Mr. [REDACTED]'s issues regarding chronic obstructive pulmonary disease (COPD), he was seen by a pulmonologist at BMC in August, 2021, with a recommendation to follow-up in 6-12 months. A CT lung scan was completed on June 10, 2021. A referral for a BMC pulmonary follow-up was submitted on November 9, 2021, however, pulmonary function tests, as well as a 6-12 month follow-up with LSH (not BMC), have been approved as Mr. [REDACTED]'s medical needs appear to be within the scope of LSH services. On December 17, 2019, he was referred to Cardiology for a stress echocardiogram. This referral was submitted on December 17, 2019, but cancelled on March 25, 2020 by BMC due to the COVID virus. Mr. [REDACTED] was rescheduled to August 4, 2021 at which time he refused to go to the appointment due to transportation issues regarding restraints. A referral for a nuclear stress test at LSH was submitted on March 22, 2021 and was changed to BMC on May 20, 2021 due to LSH being off-line. The test was completed on June 16, 2021. On May 14, 2021, a referral was made to BMC for a CT scan of the chest. This scan was completed on June 10, 2021.

As for Mr. [REDACTED]'s complaints regarding blurry vision/cyst, he was seen by neurology in February 2020. A CT scan was completed. A second CT scan was recommended as well as a follow-up with neurology. On March 31, 2021, the CT of Mr. [REDACTED]'s brain was requested and the CT was completed on May 28, 2021. On July 2, 2021, Mr. [REDACTED] was referred to BMC for a CT scan of his orbits. This was completed on November 23, 2021. On November 30, 2021, Mr. [REDACTED] was referred to BMC for an MRI of his pituitary gland and his head, which had been recommended by neurosurgery. This MRI is currently scheduled for January 18, 2022. Mr. [REDACTED] has also been by on-site Ophthalmology on December 1, 2021 and BMC Ophthalmology on December 21, 2021.

[REDACTED]

On June 7, 2021, a barium swallow was completed. On July 12, 2021, an EGD and a CLS were completed. On July 22, 2021, Mr. [REDACTED] was referred for an abdominal ultrasound to evaluate him for a hernia. This was completed on September 2, 2021. On September 30, 2021, a CT scan completed. After he was seen by ENT, a barium swallow was recommended. Mr. [REDACTED] was seen by GI via telemedicine for a follow-up appointment regarding his dysphasia. On October 12, 2021, he was referred for a modified barium swallow. This referral was submitted and approved. Mr. [REDACTED] was seen by ENT on November 12, 2021. The modified barium swallow occurred on December 16, 2021. Wellpath is awaiting the results of testing.



As always, the Department continues to be committed to providing appropriate medical and mental health care to all inmates in its custody, and to implementing and enforcing protocols that are necessary to minimize the risk of spread of COVID-19 in Department facilities, while simultaneously allowing inmates as many privileges as may safely be permitted during this pandemic. The Department trusts that this response clearly demonstrates that the concerns noted in DLC's November 19, 2021 correspondence were either unfounded and/or have been adequately addressed by the Department.

Sincerely,

/s/ Mitzi Peterson

Mitzi Peterson  
Deputy Commissioner

Cc: Carol A. Mici, Commissioner  
Nancy White, General Counsel  
Robert Higgins, Deputy Commissioner  
Jeffrey Fisher, Assistant Deputy Commissioner

Enc.