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November 20, 2020

VIA EMAIL

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

Dear Commissioner Mici and Attorney White:

As you know, the Disability Law Center ("DLC") has an open Protection and Advocacy investigation of MCI-Shirley and MCI-Norfolk concerning conditions and treatment available to prisoners with disabilities during the COVID-19 pandemic. The rapid and alarming rise in the rate of COVID-19 infections at both facilities – based on the most recent publicly data, since October 27, 2020 total positive prisoners cases at MCI-Norfolk have gone from 5 to 256 and from 169 to 204 at MCI-Shirley[1] – compels DLC to provide preliminary findings and recommend corrective action to be taken to stem the further spread of infection within Department of Correction ("DOC") facilities, provide adequate quarantine and treatment conditions, and ensure continuity of medical and mental health care. At the same time, we urge DOC to take all possible steps to reduce the populations at MCI-Shirley and MCI-Norfolk as an urgent public health measure both to improve facility conditions and to protect the health of prisoners with disabilities.

[1] ACLU of Massachusetts, Tracking COVID-19 in Massachusetts Prisons & Jails, at https://data.aclum.org/sjc-12926-tracker/ (most recent report: November 18, 2020) ("ACLU Data"). DLC has received multiple reports from prisoners at MCI-Shirley that the current number of infections is far higher than the publicly available reported numbers.

Both MCI-Shirley and MCI-Norfolk house number of prisoners who are particularly susceptible to grave complications from COVID-19 due to age, medical conditions, or both.[2] MCI-Shirley has two specialized units that serve prisoners with serious medical issues and disabilities. As of March 2020, the Nursing Care Unit ("NCU") had 31 total beds – 28 medical and 3 utilized for mental health watch.[3] The NCU is the DOC's only unit that is intended to provide a nursing home level of care to prisoners who are elderly and/or significantly disabled.[4] In addition, MCI-Shirley has a Critical Stabilization Unit ("CSU"), formerly known as the Assisted Daily Living unit, that has approximately 15 dormitory-style beds for prisoners who need help with activities of daily living, but do not need the nursing home level care of the NCU.[5] Both of these specialized units are generally full, creating backlogs. Because MCI-Shirley is the only facility with the capability of providing dialysis, a significant group of prisoners with renal failure are housed there. MCI-Norfolk has the DOC's other CSU, which holds approximately 20 elderly and disabled prisoners in a large dormitory-style room. Moreover, MCI-Norfolk houses the oldest prisoner population in DOC, with over 20% aged 60 and over.[6] More than half of its approximately 1400 prisoners are followed for chronic disease.[7]

Medically vulnerable and older prisoners at MCI-Norfolk and MCI-Shirley, in particular, need enhanced access to screening and testing for COVID-19. All prisoners need improved isolation conditions during facility lockdowns, quarantine, and other periods of restricted privileges, consistent access to treatment for chronic diseases and mental illness during periods of restricted facility movement, and adequate Personal Protective Equipment ("PPE").

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[2] Notable also, percentages of African American/Black and/or Latinx/Hispanic individuals in the populations of MCI-Shirley (32% African American/Black; 33% Latinx/Hispanic) and MCI-Norfolk (33% African American/Black; 24% Latinx) are higher than percentages across all DOC facilities (29% African American/Black; 27% Latinx/Hispanic), which is already grossly disproportionate to the demographic makeup of Massachusetts (9% African American/Black; 12.4% Lantinx/Hispanic). DOC, *Institutional Fact Cards*, July 2020, https://www.mass.gov/doc/institutional-fact-cards-july-2020/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 have persisted through the course of the pandemic, resulting in disproportionately high rates of infection and death among African American and Black as well as Latinx/Hispanic community members. See, e.g., J.A. Gold, L.M. Rossen, F.B. Ahmad, et al., *Race, Ethnicity, and Age Trends in Persons Who Died from COVID-19 — United States, May–August 2020*, MMWR Morb Mortal Wkly Rep 2020; 69:1517–1521. DOI: http://dx.doi.org/10.15585/mmwr.mm6942e1; APM Research Lab, *The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S.*, November 12, 2020, https://www.apmresearchlab.org/covid/deaths-by-race. High infection rates and poor COVID-19 outcomes at MCI-Shirley and MCI-Norfolk will thus have a disparate impact on people of color.

[3] 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").

[4] *Id.*

[5] See *id.*

[6] DOC, *January 1 Snapshot Dashboard*, https://www.mass.gov/info-details/january-1-snapshot-dashboard.

[7] According to an audit conducted in May 2017 by the Department of Mental Health ("DMH"), MCI-Norfolk had 736 inmates followed for chronic disease out of approximately 1400 inmates 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.

DLC reiterates concerns shared in its October 27, 2020 letter (attached) regarding first-hand observations of facility staff mask usage at MCI-Shirley, Souza-Baranowski Correctional Center, and NCCI-Gardner that DOC take immediate steps to ensure that staff consistently wear PPE in accordance with Massachusetts and Centers for Disease Control and Prevention ("CDC") recommendations. MCI-Shirley and MCI-Norfolk prisoners have reported correctional and medical staff members' inconsistent use of masks and PPE, even during meal distribution, medication line, and the provision of insulin shots. DOC should take every step to ensure that all DOC staff wear masks and PPE in full conformity with current public health guidelines.

Based on the above and additional information gathered during our investigation, DLC calls for the corrective actions described below to be implemented as a matter of urgency.

1. DOC Must Implement Regular Screening & Educate Prisoners About COVID-19, Infection Control Practices, Screening, and Testing

DOC must institute regular screening of medically vulnerable prisoners for COVID-19 symptoms, both to prevent the spread of infection and to afford the greatest chance of survival. It is now well understood that individuals infected with COVID-19 who are asymptomatic or pre-symptomatic may nonetheless transmit the virus. While screening staff and prisoners entering a facility should be done consistently, screening alone cannot fully prevent COVID-19 from entering the facility. The risk of introducing the virus is greatest during periods of rising community infections, like the one we are currently experiencing, and is obviously amplified further by poor observance of proper mask and PPE practices by DOC staff. Once the virus is inside, it is sure to spread because only limited social distancing is possible in these congregate environments. Double-celling and dorm environments are still the norm at MCI-Norfolk and MCI-Shirley, including in the NCU and CSUs.

Yet, DOC has not implemented any regular screening of prisoners for symptoms, apart from its intake screening and quarantine process. DLC found in its review of DOC medical records of prisoners who died from COVID-19 at MCI-Shirley, that the prisoners had had symptoms for days before they were tested and isolated. They were hospitalized and died soon after testing positive.[8] Numerous MCI-Shirley prisoners also reported to DLC that, when the infection spread last April, that they and other prisoners showed symptoms for days (and in at least some cases, informed medical staff) before being tested. Prisoners reported that harsh and isolating conditions of quarantine deterred some from reporting symptoms right away, delaying their ultimate positive tests. The quarantine conditions, discussed further below, must be addressed not only to prevent undue isolation and harm, but as part of an effective screening and testing strategy.

The CDC's Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities ("CDC Correctional Interim Guidance") encourages correctional facilities to consider strategies for testing asymptomatic incarcerated persons, even

[8] DLC intends to discuss these findings in greater detail in a final report.

without known COVID-19 exposure, for early identification of COVID-19 in the facility.[9] While not framed as an imperative under the guidelines, the CDC emphasizes that its guidance should be adapted based on a number of factors, including the facilities' population.[10] The populations of older and medically vulnerable prisoners at MCI-Shirley and MCI-Norfolk surely warrant such proactive strategies. DLC urges DOC to screen and test vulnerable prisoners to the same extent as populations in congregate long-term care facilities. According to CDC guidelines, residents of nursing homes, assisted living facilities, psychiatric treatment facilities, and facilities for individuals with intellectual disabilities, are all to be screened for presence of COVID-19 symptoms with temperatures taken daily.[11] At a minimum, this must done for NCU and CSU residents.

Geriatric and correctional health experts have developed recommendations addressing the risk of serious illness or death from COVID-19 for older adults and those with chronic or serious medical conditions.[12] Because correctional facilities are especially susceptible to the rapid spread of COVID-19 and poor outcomes among those infected, testing and contact tracing must be a priority in any plan to limit the spread of infection and reduce the risk of mortality.[13] Accordingly, DLC recommends that, at the least, all adults age 55 or older and/or with chronic medical conditions should receive verbal daily screening for symptoms of fever, cough, and respiratory distress.

An education strategy to reach prisoners and address their concerns must go hand in hand with increased screening and testing. While DOC's posters and videos on preventing infection are helpful, they are not sufficient. The CDC recommends specific and regular in-person education. Corrections and medical staff should provide up-to-date information about COVID-19 to prisoners on a regular basis in accessible formats. As much as possible, this information should be provided in person with opportunities for people to ask questions.[14] The updates should include information about all symptoms of COVID-19, proper infection control practices, and reminders to report COVID-19 symptoms to staff at the first sign of illness. Staff must also be prepared to address concerns prisoners have about reporting symptoms, such as those pertaining to the experience of quarantine and medical isolation, explain the need to report

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[9] CDC, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (updated October 21, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

[10] *Id.*

[11] CDC, *Testing Guidelines for Nursing Homes* (updated October 16, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html; see also Centers for Medicare & Medicaid Services ("CMS"), *Diagnostic Testing of Nursing Home Residents and Patients for Coronavirus Disease 2019 (COVID-19)*, June 19, 2020, https://www.cms.gov/files/document/hpms-memo-diagnostic-testing-nursing-home-residents-and-patients-coronavirus-disease-2019.pdf (stating that residents should be screened daily).

[12] B. Williams, C. Ahalt, D. Cloud, D. Augustine, L. Rorvig, D. Sears, *Correctional Facilities in the Shadow of COVID-19: Unique Challenges and Proposed Solutions*, Health Affairs Blog, March 26, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200324.784502/full/ (hereafter "Health Affairs Blog").

[13] *Id.*

[14] CDC Correctional Interim Guidance.

symptoms immediately to protect everyone, and explain the differences between living condition of quarantine and Restrictive Housing[15] – which must, in fact, be different.

2. Quarantine and Medical Isolation Must Be Completely Distinct from Restrictive Housing, Quarantine and Treatment Conditions Must Be Safe and Sanitary, and Prisoners Should Not Be Subjected to Quarantine as a Rule Following Outside Medical Visits.

Conditions in the units used for quarantine and isolation must be humane and not the equivalent of Restrictive Housing or disciplinary detention, or worse. Prisoners quarantined last spring and early summer in the Restrictive Housing Units ("RHU") at MCI-Shirley and MCI-Norfolk, and now again with the spike in infections, have reported filthy conditions and lack of ventilation; little or no access to exercise or fresh air; poor access to medical care for chronic conditions; no access to personal property; cold food; and concerns about required usage of showers stalls utilized by prisoners who tested positive for COVID-19 and those who have not.

A prisoner with mobility impairments at MCI-Norfolk reported worse conditions in a mental health watch cell, where he was confined for several days without access to showers or to the telephone, because he could not access the quarantine unit on the upper RHU tiers. Moreover, he reported being placed in quarantine despite testing negative multiple times at Lemuel Shattuck Hospital, where he had received treatment unrelated to COVID-19, before transferring back to MCI-Norfolk. Other prisoners also reported a DOC practice of preemptively quarantining all prisoners for two weeks after outside medical trips. According to these reports, prisoners are quarantined without ever actually being tested for COVID-19 infection. DLC received a report of prisoners in COVID-19 high risk groups being subjected to these preemptive quarantines in the RHU adjacent to prisoners who had already tested positive.

DOC must ensure that all cells and units used for quarantine are clean, sanitary, and habitable. Moreover, CDC urges that corrections facilities ensure that medical isolation be fully distinct from punitive solitary confinement, even if both are in the same unit.[16] The mental health risks of solitary confinement are well-established. Prisoners must have regular telephone access to their supports in the community, reading materials, personal property, and commissary.[17] DOC should again provide opportunities for several free calls per week for prisoners quarantined in RHUs or their housing units and all prisoners when facilities are on lockdown. DLC urges that DOC make tablets available to all prisoners quarantined in the RHUs to provide entertainment and facilitate communications. Prisoners must be allowed movement out of their cells to the greatest extent possible consistent with health protections – i.e., socially distant recreation. The RHU recreation cages must be made available for outside recreation for prisoners in quarantine.

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[15] *Id.*; see also Health Affairs Blog; D.H. Cloud, C. Ahalt, D. Augustine, D. Sears, B. Williams, *Medical Isolation and Solitary Confinement: Balancing Health and Humanity in US Jails and Prisons During COVID-19*, Journal of General Internal Medicine 35: 2738-2742 (2020).
[16] *Id.*
[17] *Id.*

DLC has received recent reports that prisoners infected with COVID-19 at MCI-Norfolk are being held in the Probation Units previously condemned due to mold contamination, indicating that the units not a safe environment for any prisoner and pose particular risks for prisoners infected with COVID-19.[18] According to reports, the roof leaks, portions of the floor have fallen in, and only a few sinks and showers are operational for over fifty prisoners. Moreover, the prisoners – who are sick with COVID – have been instructed that they must clean the unit themselves. While DLC has received conflicting reports this week about whether MCI-Norfolk has ceased utilizing the Probation Units and relocated prisoners to the RHU, we hope that DOC has realized that such a placement should have never been considered if the units have not been renovated[19] and any and all mold remediated. DOC must house COVID-infected prisoners in habitable conditions and must provide the necessary services to maintain sanitation and infection control in these environments.

Reports also indicate that, during the wave of infections earlier this year at MCI-Shirley, a number of prisoners infected with COVID-19 were held in the Health Services Unit ("HSU") wards normally dedicated for NCU residents. At the time, prisoner workers normally assigned to clean and aid with activities of daily living were not permitted to enter and, reportedly, HSU staff did not fill in to provide those services. Prisoners housed in the COVID-19 positive NCU wards observed and/or experienced the following: prisoners wearing adult diapers being left in their feces for hours; minimal staff assistance with toileting and bathing for those unable to do so independently; insufficient staff assistance with feeding for incapacitated or immobile prisoners; poor ventilation and filthy conditions within the wards; failures to clean common toileting and shower areas; and failure to change sheets and provide clean towels. As a result, some prisoners with disabilities lay in their own waste, unbathed, and developed bedsores. Prisoners further reported that medical and mental health clinicians were not available to address conditions that were not COVID-19 related. DOC must ensure that such conditions do not recur as infections rise and must establish a contingency plan to meet a possible shortage of medical staff, health aides, and prisoner workers due to COVID-19.

Additionally, DLC recommends that prisoners testing negative at an outside hospital where they have received treatment prior to return to a DOC facility not be automatically quarantined. This has the effect of preventing some prisoners from accessing important medical care, whether due to the prospect of harsh quarantine conditions or the implication that they will certainly get COVID-19 if they seek outside medical care. It likewise has the potential to place prisoners already in high risk groups at an unreasonable risk of contracting COVID-19 during quarantine in close proximity to other prisoners who have tested positive. In reality, the outside hospitals are required to have attested to infection controls as part of Massachusetts' reopening

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[18] Researchers state there has been reported evidence that patients with COVID-19 may be more at risk of lung infections caused by breathing in mold, impeding their recovery from COVID. See Medical Laboratory Observer, *COVID-19 patients could be at greater risk of fungal infections, researchers say* (August 4, 2020), at https://www.mlo-online.com/disease/infectious-disease/article/21148766/covid19-patients-could-be-at-greater-risk-of-fungal-infections-researchers-say.

[19] As of DPH's December 5, 2019 inspection, the Probation Units were "Closed for Renovations" and not inspected as a result. DPH, MCI-Norfolk Inspection Report, December 5, 2019, p. 24, https://www.mass.gov/doc/mci-norfolk-november-14-2019/download.

requirements,[20] and should therefore not be a source of infection. DOC must also, if it has not already, institute transportation protocols that incorporate appropriate infection control measures consistent with CDC guidelines[21]– including requirements that officers and prisoners (medical condition-permitting) wear masks at all times during transport and limitations on the capacity of transport vehicles to facilitate social distancing – to ensure that transportation to and from outside medical appointments is not a foreseeable point of exposure. For those who have not been tested prior to their return to their DOC facility, they should be tested at the facility as soon as possible to avoid unnecessary, lengthy quarantine restrictions.

3. Medical and Mental Health Care Must Not Be Suspended During Periods of Lockdown or Restricted Movement Due to COVID-19 Infections

During this period of rising infections, DLC urges DOC to maintain continuity of medical and mental health treatment. Over twenty 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. Already, DLC is receiving new reports from MCI-Norfolk and MCI-Shirley that access to medical care is now being restricted again. This suspension of operations starkly deviates from community and correctional standards and places prisoners at risk of serious harm.

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.[22] 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.[23] It is not clear from the Wellpath summary if and how telemedicine was utilized, and prisoners at MCI-Shirley and MCI-Norfolk reported that it was not used at all on the units.

Wellpath's cutbacks were in contrast to Centers for Medicaid and Medicare Services ("CMS") and the Department of Public Health ("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

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[20] DPH, *Guidance: Reopen Approach for Acute Care Hospitals*, May 18, 2020; DPH, *Guidance: Reopen Approach for Acute Care Hospitals Phase 2*, June 8, 2020; DPH, *Guidance: Reopen Approach for Acute Care Hospitals Phase 3*, November 3,2020. Links to DPH reopening guidance documents are found at: https://www.mass.gov/lists/reopening-health-and-human-services-in-massachusetts.

[21] CDC, *Cleaning and Disinfection for Non-emergency Transport Vehicles* (Updated April 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/disinfecting-transport-vehicles.html. While these guidelines are specifically directed for transport of individuals with suspected COVID infection, it is prudent that DOC adopt these guidelines for transportation of prisoners who are all at risk for infection.

[22] Wellpath, *MADOC Restart Template*.

[23] *Id*.

concerning patient visits and procedures.[24] Under this framework, evaluations should continue to be conducted for patients exhibiting new symptoms, and for existing medical or behavioral or mental health conditions when not providing the service has the potential for increasing morbidity or mortality. If there are no current symptoms of concern, follow-up can be done via telehealth or by virtual check-ins.[25] On March 15, 2020, the Commissioner of DPH issued an order pursuant to Governor Baker's State of Emergency declaration, consistent with CMS recommendations.[26] Alarmingly, Wellpath defined serious medical conditions that would justify off-site appointments as those "that may cause immediate loss of life or limb needing ongoing evaluation/treatment."[27] Such an extreme definition prevented access to necessary off-site care. Wellpath also failed to substitute telehealth appointments with outside specialists for canceled appointments that could have been conducted remotely.

The National Commission on Correctional Health Care ("NCCHC") recommended in its COVID-19 Guidance to delay chronic care only for a brief periods during restricted operations, and to implement telemedicine as much as possible to provide continuity of care.[28] DOC and Wellpath did not implement telemedicine on the units during this period of restricted care. Moreover, Wellpath did not restrict available care because of limited resources due to COVID-19 care – MCI-Norfolk actually had only three COVID-19 infections among its prisoners from March through July 2020.[29] Even in facilities more burdened with COVID-19 infection, DOC has a constitutional obligation to treat all serious health conditions of prisoners in its custody.

Prisoners interviewed in late June and early July 2020 at MCI-Norfolk consistently reported not seeing their doctors for at least three months, since the lockdown began in late March 2020.[30] A group of MCI-Norfolk prisoners further confirmed suspension of treatment and delays in medication. While Wellpath's operations summary states that patients whose medical conditions were in "fair or poor control" were seen and assessed during this period,[31] prisoners'

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[24] CMS, *Non-Emergent, Elective Medical Services, and Treatment Recommendations*, March 18, 2020 (updated April 7, 2020). Recommendations can be found at: https://www.coms.gov/files/document/31820-cms-adult-elective-surgery-and-procedures-recommendations.pdf

[25] *Id.*

[26] Commissioner Monica Bharel, *Order of the Commissioner of Public Health*, March 15, 2020, available at: 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).

[27] Wellpath, *Off-Site Guidance During COVID-19 Pandemic.*

[28] *Id.*

[29] ACLU Data.

[30] CMS and Massachusetts recognized that health care providers and hospitals were postponing necessary treatment because of limited resources, and by April and May urged "reopening" to resume such care that had been postponed. CMS, *Recommendations: Re-opening Facilities to Provide Non-emergent Non-Covid-19 Healthcare: Phase I*, April 19, 2020, https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-servces.pdf. On May 18, 2020, DPH recommended that health care providers adopt infection control procedures and resume chronic disease management that may have been postponed. DPH, *Guidance: Reopen Approach for Acute Care Hospitals*, May 18, 2020, p. 18, https://www.mass.gov/lists/reopening-health-and-human-services-in-massachusetts. However, according to prisoners interviewed in late June and July, Wellpath maintained its restrictions on services within DOC, as well as referrals for off-site procedures, long after Massachusetts hospitals and health care providers were able to reopen for services pursuant to Massachusetts' reopening guidelines.

[31] Wellpath, *MADOC Restart Template*.

reports indicate that they received no attention for many such conditions. Prisoners reported many chronic and serious conditions for which they were not receiving adequate medical attention, including Parkinson's disease, high blood pressure, cirrhosis, HIV, heart conditions, glaucoma, multiple sclerosis, seizures, asthma, degenerative spinal stenosis, sickle cell anemia, seizure conditions, and neuropathy. In addition to inability to get medical appointments with facility staff and outside specialists, prisoners reported failures to do routine bloodwork necessary to monitor conditions (e.g., viral loads) and effects of medications for HIV, high blood pressure, diabetes, seizure conditions, arthritis, high blood pressure, and psychiatric conditions. Further, prisoners reported detrimental interruptions in their medically ordered therapeutic diets. 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.[32] Wellpath provided only crisis coverage, twice weekly rounds in general population units, and rounds three times per week in RHUs.[33] Wellpath staff purportedly provided alternative means of service for patients whose services were suspended, such as homework and activity packets.[34] If written materials were provided, as Wellpath claims, they made no beneficial impact on the mental health difficulties experienced by these prisoners. Prisoners reported that no telemental health services were provided on the units to help compensate for the lack of in-person sessions.

To be sure, COVID-19 does not excuse a withdrawal of necessary mental health services for DOC prisoners. The U.S. Department of Justice ("DOJ") issued notice this week of its findings that DOC's neglect of the serious mental health needs of prisoners in crisis rises to the level of multiple constitutional violations.[35] DOJ's investigation preceded the COVID-19 pandemic, which has exacerbated existing deficiencies in DOC's provision of mental health treatment. For example, one prisoner returned to MCI-Shirley in mid-October 2020 following two admissions to the Intensive Stabilization & Observation Unit ("ISOU") at Old Colony Correctional Center for suicidality. He reported recently that he has still not yet seen his assigned mental health clinician, nor have mental health staff followed ISOU clinical

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[32] Memorandum from Mitzi Peterson, Director of Behavioral Health, to Superintendents, *Mental Health Staffing During COVID-19*, March 25, 2020.
[33] Wellpath, *MADOC Restart Template.*
[34] *Id.*
[35] United States Department of Justice Civil Rights Division, *Investigation of the Massachusetts Department of Correction*, November 17, 2020, https://www.justice.gov/crt/case-document/file/1337856/download.

recommendations concerning a behavior management plan. One of DOJ's Minimal Remedial Measures include ensuring that "prisoners who engage in repeated self-harm receive individualized crisis treatment plans and, when clinically appropriate, behavioral management plans."[36]

DOC and Wellpath must bring access to medical and mental health services during the pandemic into conformity with community and correctional standards. Now, even with the rise of infections in Massachusetts, 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.

In keeping with the above, DLC calls upon DOC to prioritize the following corrective actions at MCI-Norfolk and MCI-Shirley:

1. Take Immediate Steps to Reduce the Populations of Older and Medically Vulnerable Prisoners:
   - Reconsider all cases for medical parole denied since April 2020 and expedite review of pending petition, giving extra weight to factors rendering the prisoner vulnerable to serious or deadly complications from COVID-19 infection; and
   - Expedite implementation of home confinement for statutorily eligible prisoners.

2. Take Immediate Steps to Reduce the Spread of COVID-19 Infection and Sanitize Environments Where Prisoners are Quarantined or Treated for COVID-19 Infection:
   - Implement daily COVID-19 symptom screening that includes a temperature check of every NCU and CSU resident;
   - Implement daily verbal COVID-19 symptom screening of any prisoners who are over the age of 55 and/or have disabilities or medical conditions that place them at high risk for COVID-19 related complications;
   - Offer regular testing to prisoners who fall within high risk groups for experiencing serious complications if infected with COVID-19;
   - Mandate that all staff wear masks – and other appropriate PPE based on the activities being performed – while on DOC property and while conducting DOC transport services;
   - Provide sufficient supplies of masks, including at least weekly laundering of cloth masks, hand sanitizer, and cleaning products to prisoners housed in all areas of the facility, including quarantine;
   - Ensure that all communal areas and all areas used to quarantine prisoners, including RHUs, HSUs, and all units used for treatment of prisoners who are infected COVID-19 are cleaned and disinfected at least daily by staff or prisoner workers who are

[36] *Id.* at p. 26.

trained in proper infection control practices. Such cleaning and disinfection must be done in accordance with CDC guidelines;[37]

- Provide regular in-person education to prisoners in accessible formats stressing the public health importance of screening and testing for COVID-19; the improved conditions of quarantine and treatment; and the distinction between quarantine, isolation, and solitary confinement;
- Separate prisoners who have been isolated after testing positive from prisoners with suspected COVID-19;[38] and
- Maintain quarantine of COVID-19 positive prisoners (deemed positive by virtue of testing or symptoms) in keeping with CDC's recommendations concerning discontinuation of home isolation for persons with COVID-19,[39] as cited in CDC Correctional Interim Guidance.

3. Improve Conditions for Prisoners in Quarantine Due to Exposure to COVID-19, and in Medical Isolation Because of COVID-19 Infection:
   - Ensure that all units in which prisoners are placed are at all times safe, clean, and appropriate for human habitation;
   - Ensure that units are regularly cleaned and disinfected, on at least a daily basis, by trained individuals, and that surface and objects that are frequently touched in common areas are cleaned and disinfected several times daily, in accordance with CDC Guidelines;
   - Ensure that staff or trained prisoner workers are always available to provide assistance with activities of daily living to prisoners in the NCU and CSUs;
   - Provide at least five hours per week of socially distant exercise periods in outdoor exercise areas, weather permitting;
   - Provide access to daily telephone calls and tablets with recreational content and programming;
   - Provide access to personal property and commissary items;
   - Provide access to regular medical care, including access to clinically appropriate chronic care monitoring;
   - Provide access to regular mental health care, including access to confidential communications with assigned mental health clinicians for prisoners with open mental health cases, at a minimum, in keeping with the frequency in place pre-pandemic; and

[37] CDC Correctional Interim Guidance; CDC, *Cleaning and Disinfection for Community Facilities* (Updated Sept. 10, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html.
[38] CDC Correctional Interim Guidance.
[39] CDC Correctional Interim Guidance; CDC*, Duration and Isolation and Precautions for Adults with COVID-19* (Updated October 19, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html.

- Ensure adequate medical and mental health care, and that prisoners are regularly informed about their treatment, the duration and necessity of quarantine and medical isolation, and that staff are available to address any needs and concerns.

4. Eliminate Blanket 14-day Quarantines Following Trips to Outside Hospitals and Clinics
   - Implement transportation protocols that incorporate appropriate infection control measures, including requiring masks, social distancing, and capacity limitations in accordance with CDC guidelines;[40] and
   - Rather than imposing routine 14-day quarantines, test prisoners following outside hospital stays if they have not been tested at the facility prior to release to minimize unnecessary quarantine.

5. Provide Continuity of Medical and Mental Health Care During Periods of Restricted Inmate Movement and Lockdowns:
   - Ensure that prisoners who require assistance with activities of daily living due to age, disability, or a combination thereof do not experience interruptions in that assistance;
   - Ensure that prisoners with chronic medical conditions receive 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 specialist consultations;
   - Provide regular access to mental health treatment for prisoners who have open mental health cases and 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;
   - Ensure that there are adequate numbers of staff to provide continuity of medical and mental health care;
   - Provide prisoners reasonably prompt access to all off-site clinic referrals and hospitalizations if they 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
   - 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 inmates during lockdown periods.

[40] CDC, *Cleaning and Disinfection for Non-emergency Transport Vehicles* (Updated April 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/disinfecting-transport-vehicles.html.

DLC appreciates your time and continued cooperation in this investigation and hopes that DLC and DOC can work together to address these important issues, as we have in prior matters. Given the urgency, we request a substantive response within fourteen days.

Sincerely,

Nina Loewenstein, M.P.H.
Staff Attorney

Tatum A. Pritchard
Director of Litigation

Marlene Sallo
Executive Director

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October 27, 2020

VIA EMAIL

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Re: Staff Face Mask Usage in Department of Correction Facilities

Dear Commissioner Mici and Attorney White:

The Disability Law Center (DLC) writes as the Commonwealth's Protection and Advocacy Agency[1] (P&A) to report pressing concerns about improper staff face mask usage at MCI-Shirley and Souza-Baranowski Correctional Center (SBCC). With the rate of positive tests in Massachusetts on the rise again, adherence to proper mask practices by staff, who are now able to take advantage of more public activities due to reopening measures, is essential to protecting the health and safety of Department of Correction (DOC) prisoners with disabilities.

As you are aware, DLC has an ongoing investigation of MCI-Shirley initiated on April 27, 2020 based on complaints to the system regarding access of prisoners with disabilities to medical and mental health treatment, their access to assistance with activities of daily living, and general conditions issues in the facility. During the course of that investigation, we have received reports concerning inconsistent use of masks and gloves by MCI-Shirley staff.

[1] Each P&A has a federal mandate to protect and advocate for individuals with disabilities, including those who are criminally and civilly detained in DOC facilities. This mandate was first codified through the passage of the Protection & Advocacy for People with Developmental Disabilities (PADD) Act. 42 U.S.C. § 15043(a). Congress extended the protections of the PADD Act, incorporating them by reference into legislation protecting persons with other forms of disabilities. This includes the: Protection & Advocacy for Mentally Ill Individuals (PAMII), 42 U.S.C. § 10805, Protection & Advocacy for Individual Rights (PAIR) Act, 29 U.S.C. § 794e(f), and the Protection & Advocacy for Individuals with Traumatic Brain Injury (PATBI) Act. 42 U.S.C. § 300d-53(k).

On September 28, 2020, while onsite at MCI-Shirley and SBCC for another matter, DLC had the opportunity to make firsthand observations of how facility staff wear and utilize face masks. Inside both facilities, DLC observed a number of correctional officers and facility administrators wearing masks that covered their mouths, but not their noses. For some staff, such as the MCI-Shirley Deputy Superintendent of Reentry, this was because their masks were ill-fitting and fell off the nose, requiring regular manual adjustments to return the mask to the proper position and resulting in potential contamination of their mask and/or hands. Other staff appeared to place their masks below their nose purposefully while they walked around the facility and interacted with others. In addition, DLC observed several administrators in the administrative offices of SBCC not wearing masks at all while in meetings in enclosed spaces; eating was not a component of these meetings. However, the most disturbing scene by far was the afternoon shift change at SBCC. The SBCC lobby was extremely congested, full of correctional officers who were waiting to get inside, standing very close and speaking with one another, while the majority of them had their masks below their noses and some even below their mouths. Notable also, handshakes still appeared to be a surprisingly common practice by DOC staff and administrators in both facilities.

Staff practices during DLC's visit to NCCI-Gardner on September 29, 2020 appeared better. All staff members who DLC observed were wearing masks over both their mouths and noses in the housing units, health services unit, and administrative offices. In the administrative offices, while staff appeared to often take off their masks when alone, the did appear to put them back on when others entered their work areas.

The CDC guidance concerning effective use of masks make clear that they are intended to serve as a "barrier to help prevent respiratory droplets from traveling in the air and onto other people when the person wearing the mask coughs, sneezes, talks, or raises their voice."[2] This concept of source control is particularly important when people are in close quarters or it is difficult to maintain social distancing – two common circumstances in correctional facilities. Evidence from clinical and laboratory studies shows that wearing a "mask reduces the spray of droplets when worn over the nose *and* mouth."[3] DOC facility staff, who come and go after their shifts and are free to make personal choices regarding masks and social distancing on their own time, are the primary sources of COVID-19 introduction into facilities. Without imposition of adequate controls, such as appropriate mask usage, DOC is placing prisoners whose disabilities and medical conditions place them in high risk groups for suffering serious illness or death if they contract COVID-19 in grave danger. Of course, DOC staff and loved ones of DOC staff in high risk groups are also in danger if infection control measures are not implemented properly. Moreover, the cursory screening and temperature check that each correctional officer completes at the direction of a fellow officer prior to entering facilities dispels few concerns, given the reality of asymptomatic spreaders of COVID-19.

Based on the foregoing, it appears that issuance or re-issuance of consistent directives to all staff across all DOC facilities is necessary. Accordingly, DLC calls upon DOC to issue immediate guidance to its staff, including administrators, correctional officers, and medical and mental health staff employed by DOC's medical contractor, containing the following information:

(1) Clarification that all staff are required to wear masks that fully cover both their nose and mouth while inside of any DOC facility, including the lobby and administrative offices of a DOC facility;

(2) Visual aids exhibiting how masks should fit and be worn;

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[2] Centers for Disease Control and Prevention, *Considerations for Wearing Masks: Help Slow the Spread of COVID-19 - Evidence for Effectiveness of Masks*, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html#recent-studies.

[3] *Id.*

(3) Detailed directions concerning how to safely and effectively put on, wear, and take off masks to try to prevent transmission of COVID-19;

(4) A reminder that failure to comply with the mask requirement is grounds for progressive discipline;[4] and

(5) Instructions about the importance of maintaining social distancing when possible, particularly at shift change when staff assigned to different units and areas of facilities converge in one area.

In addition, DLC asks that DOC inform, or remind, facility administrators as a matter of urgency that they have a responsibility to ensure that all staff within the facility abide by the mask requirement, which must necessarily include proper usage of the mask, rather than merely having a mask somewhere on one's face. Moreover, facility administrators should be urged to lead by example in strictly abiding by the mask requirement and other best practices for infection control.

We request confirmation by November 6, 2020 that DOC has taken the actions requested above. Should you have any questions or concerns regarding our requests or wish to discuss our observations within the facilities further, please let us know. DLC thanks you very much for your time and attention to these important issues.

Sincerely,

Tatum A. Pritchard
Director of Litigation

cc: Sheryl Grant, Esq., Dept. of Correction Legal Division

[4] Per the Justice Robert L. Ullmann's Findings of Fact in *Foster v. Mici*, correctional officers caught without masks are initially given verbal warnings, then written warnings, and may be subject to further punishment. Findings of Fact of the Superior Court, *Foster, et al. v. Mici, et al.,* Superior Court CA No. 20-00855-D, SJ-2020-0212, SJC-12935, p.9 (May 1, 2020).