Suggestions and Comments on the Proposed Amendments to 501 CMR 17.01 et seq.

1. A preamble should be included that informs all parties of a petition for medical parole, pursuant to G.L. c. 127, s 119A (s 119A), in particular the prisoner/petitioner (petitioner) , that the very nature of such a petition invokes the protections of Title II of the Americans with Disabilities Act Amendment Act of 2008 (ADAAA), 42 U.S.C., ss 12131 et seq., the Rehabilitation Act (RA), 29 U.S.C., s 794, and the Massachusetts Equal Rights Act (MERA), G.L. c. 127, s 103, as well all relevant federal regulations, e.g., Department of Justice (DOJ), 28 CFR 35.101 et seq.. This would be in keeping with the directives of the Supreme Judicial Court. See generally, Crowell v. Massachusetts Parole Board, 477 Mass. 106, 111 (2017) (in parole proceedings, parole and correctional authorities should "consider adequately the application of the ADA and our own constitutional and statutory provisions".); See also Buckman v. Commissioner of Correction, 484 Mass. 14, 26 n. 24 (2020) ("ADA requires parole board to make reasonable accommodations for prisoners with disabilities to give them access to benefits of State program.") The application of the ADAAA to s 119A proceedings is particularly appropriate in the area of medical evaluations of a prisoner where most, if not all, evaluations include statements by the "licensed physician" that the medical condition is well controlled by medication or some other mitigating measure. ADAAA statutory and regulatory provisions prohibit the consideration of ameliorative effects of mitigating measurers, such as medication. See 42 U.S.C., s 12102(4)(E), and 28 CFR 35.108(d)(1)((viii). There are numerous court rulings on these provisions. See Yinger v. Postal Presort, Inc., 683 F. Appx. 768, 772-773 (10th Cir. 2017) (district court summary judgment reversed where judge failed to consider plaintiff's heart condition without his pacemaker); Turcotte v. Comcast Cable Comm., LLC, 2019 DNH 024 (DNH 2019) (diabetes will be assessed in terms of its limitations on major life activities when diabetic does not take his insulin injections). The application of the above ADAAA and DOJ regulations to the s 119A medical evaluations is currently the subject of a pending civil action in Suffolk Superior Court; Emmett S. Muldoon v. Department of Correction, et al., No. 2084cv01978H. (Declaratory and injunctive relief). In particular, the issue of whether Title II of the ADAAA preempts the medical evaluation procedure under s 119A is before the court.

2. 501 CMR 17.03. Petitioner's physician of choice: Under s 119A(c)(1) it states that; "(ii) a written diagnosis by a physician licensed to practice medicine under section 2 of chapter 112;". In the original medical parole regulations, at 501 CMR 17.03(3)(b), it explicitly granted the petitioner the right to obtain his/her own physician and diagnosis, i.e., "or a medical provider identified by the petitioner." The Court in Buckman supra, voided section 17.03 in its entirety, including subparagraphs (3)(b), on other grounds. Id., pg. 33. The right of a petitioner to choose his/her own physician to evaluate his/her own medical impairments has been removed from the proposed amended regulations. See e.g., section 17.03. Although the clause, "as determined by a licensed physician", remains unchanged in the definitions for "Permanent incapacitation" and "Terminal illness," at 501 CMR 17.17.02, that phrase will, without doubt, be construed narrowly by the DOC to prohibit petitioners from relying on his/her own physician and independent evaluation. The statutory right to a physician under s 119A(c)(1)(ii) should be made EXPLICIT.

Lastly, I can speak from personal experience that the medical staff, including physicians, of each of the contracting healthcare providers over the years, are beholden to the DOC. Medical decisions are routinely interfered with by DOC administration when a decision may interfere

with their policy. My request to medical staff to evaluate my medical impairments in their unmitigated state, see 42 U.S.C., s 12102(4)(E), was brought to the attention of the physician who eventually evaluated my impairments, but simply ignored that law and medical standard. This was interference that trickled down from the administrative level at MCI Norfolk because of the effect it would have had on the medical parole procedures.

3. 501CMR 17.03(a). Confidentiality of records and information: In the original medical parole regulation, 17.03(3)(c), it stated that a petition shall be accompanied by; "(c) a release form provided by the Department and signed by the prisoner to permit copies of the petition and all supporting documents to be provided . . . to the victim or the victim's family;". That subsection, 17.03, was voided in Buckman, albeit on other grounds. Id. 424 Mass., at 33. In the proposed amended regulations, at 17.03(3)(a), it has eliminated the victim's receipt of "all supporting documents" to the petition, and instead permits a victim or family's family only the receipt of "a copy of the petition and the most recent clinical assessment . . ., upon request;". (making a victim or victim's family's request for a copy of the petition and clinical assessment part of the administrative record). This same language is found at 17.07(3). Significantly, s 119A(c)(2) permits a victim or victim's family only the "opportunity to provide a written statements. In Massachusetts, medical, mental health, and alcohol and drug treatment records or reports are protected by statute and court rule. See, e.g., Massachusetts Rules of Court, Trial Court Rule XIV, (listing authorities designating material as impounded or not available for public inspection). The fact a petitioner is required to sign a waiver, under duress, to release his records cannot be deemed an informed consent where the forms do not identify the individuals the records will be released to.

4. 501 CMR 17.11. Public Safety: In s 119A(e), the plain language provides in relevant part that of the Commissioner's duty is to determine "that the release will not be incompatible with the welfare of society, . . .". Id. In the original version of 17.11, it added to the commissioner's determination, stating, "the release will not be incompatible with public safety or the welfare of society, ...". Id. In Buckman supra, 484 Mass., at 19 n. 9, the Court observed that "[w]here the commissioner determines that the prisoner suffers from 'permanent incapacitation' or a 'terminal illness,' the commissioner has already determined, based on the definition of those statutory terms, that 'the prisoner does not pose a public safety risk." Id. Notwithstanding the Buckman Court's directive, this public safety language has been asserted again in the proposed amended regulations, at 501 CMR 17.11, where it repeats the earlier language that ". . . 'the release will not be incompatible with public safety' . . .'." Accordingly, because the 3rd sentence of the proposed amended 17.11 is framed as the commissioner's determination that the prisoner is terminally ill or permanently incapacitated, which the Buckman Court noted negates the public safety public risk, the inclusion of the term "public safety" in the 3rd sentence of 17.11 is not just superfluous, it is outside the scope of s 119A(e).

5. 501 CMR 17.13. Revocation of parole due to improved impairments: At s119A(f), it provides in relevant part that "upon discovery that the terminal illness or permanent incapacitation has improved to the extent that the prisoner would no longer be eligible for medical parole under this section, the parole officer shall immediately arrest the prisoner and bring the prisoner before the board for a hearing." Both the original and proposed amended versions of 17.13(5) contain identical language that for the most part tracks the statutory language, but adds the command of

obtaining a warrant for custody before pursuing revocation proceedings. See proposed amended 17.13(5). The initial problem under both the statute, and the past and present regulations, is the lack of explanation of how the parole officer discovers or determines the terminal illness or permanent incapacitation has improved. This question leads into the next issue.

Under 42 U.S.C., s 12102(4)(d) of the ADAAA, it provides, "[a]n impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active." See also 28 CFR 35.108(d)(1)(iv) (same). There are many impairments that wax and wane, e.g., Multiple Sclerosis, cancer, ect.. I have numerous impairments currently at issue in my petition for medical parole that would meet the requirements of s 12102(4)(d) and 35.108(d)(1)(iv), e.g., heart, Multiple Sclerosis, diabetes, hypertension, alcoholism, ect.. Under s 119A(f) and the proposed 17.13(5), I would be subjected to constant revocation proceedings and disruptions in the obvious public interest of reacclimation into society

6. 501 CMR 17.14: Subsequent petitions: In s 119A(f) it provides in relevant part that"[r]evocation of a prisoner's medical parole due to a change in the prisoner's medical condition shall not preclude a prisoner's eligibility for medical parole in the future . . . .". However, the language in both the original and proposed amended versions of 17.14 , although identical, is more restrictive, and unlike s 119A(f), conditions a subsequent petition only where a prisoner ". . . experiences a significant and material decline in medical condition.".

In Buckman supra, the Court questioned the more restrictive language of the original version of 17.14, and observed [t]his limitation on a prisoner's ability to submit subsequent petitions, the legality of which we do not address in this opinion, rests on the premise that the commissioner's denial was based on fair and accurate information regarding the physical or mental condition of the prisoner and risk, if any, posed by his or her release." Id., 484 Mass., at 32.

A second clause should be added to address the Buckman Court's concern about the "fair and accurate" and "risk" information provided the petitioner. Additionally, this second clause should be resolved within 30 days instead of the 66 days proposed in the amended 17.14.

In closing, I thank you for the opportunity to make the above suggestions and comments.

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