COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

Suffolk, ss. No. SJ 2020-.

STEPHEN FOSTER, MICHAEL GOMES, **PETER KYRIAKIDES**, **RICHARD O'ROURKE**, **STEVEN PALLADINO, MARK SANTOS**, **DAVID SIBINICH**, **MICHELLE TOURIGNY**, **MICHAEL WHITE**, **FREDERICK YEOMANS**, and **HENDRICK DAVIS**, individually and on behalf of all others similarly situated,

Plaintiffs,

v.

CAROL MICI, Commissioner of the Massachusetts Department of Correction; **GLORIANN MORONEY,** Chair Massachusetts Parole Board; **THOMAS TURCO,** Secretary of the Executive Office of Public Safety and Security; **CHARLES BAKER,** Governor or the Commonwealth of Massachusetts,

Defendants.

PLAINTIFFS' MEMORANDUM IN SUPPORT OF THEIR MOTION FOR PRELIMINARY INJUNCTION

Plaintiffs are persons incarcerated in Massachusetts prisons and jails, all of whom are at immediate and extraordinary risk of infection, serious complications, and death from the novel COVID-19 virus. The named Plaintiffs seek to represent a class of all prisoners who are incarcerated at prisons and jails in Massachusetts, with two subclasses: (1) All prisoners who are

at high risk for serious complication or death from COVID-19 due to underlying medical condition or age, and (2) All prisoners civilly committed to a correctional facility under G.L. c. 123 § 35, for treatment of an alcohol or substance use disorder.[1]

The first reported prisoner case of COVID-19 was on March 21, 2020. As of the date of the current filing, April 17, 2020, 180 Massachusetts prisoners have tested positive for COVID-19[2] and 5 prisoners have died.[3] Prisoners' lives are in immediate danger and efforts made to prevent the spread of COVID-19 are destined to fall short while prisons maintain their current population levels, which do not allow for social distancing. Allowing the spread of COVID-19 inside the prison system will also detrimentally impact the public health at large, as prisoners will become an additional burden on a public health system already being outstripped by community needs.

Emergency relief is necessary to protect Plaintiffs from a substantial risk to their health and safety that violates their rights under the Massachusetts and Federal Constitutions. Specifically, Plaintiffs seek a preliminary injunction ordering Defendants to (1) reduce the incarcerated population as swiftly as possible to ensure that no prisoner is housed in any cell, dormitory, or other living area where the prisoner must sleep, eat, or recreate within six feet of another person; (2) develop a population management plan, prioritizing release of prisoners who are particularly high risk due to age or underlying medical condition, that utilizes all permissible mechanisms to reduce the incarcerated population, including home confinement and furloughs, expanded sentence

[1] Plaintiffs note that the Court may order the requested emergency system-wide relief pending class certification, and may even order system-wide relief in individual cases where such relief is necessary to remedy the constitutional violation and provide the plaintiffs with relief. *See, e.g.*, Newberg on Class Actions § 24:83 (4th ed. 2002) ("The absence of formal certification is no barrier to classwide preliminary injunctive relief."); Moore's Federal Practice § 23.50, at 23-396, 23-397 (2d ed.1990) ("Prior to the Court's determination whether plaintiffs can maintain a class action, the Court should treat the action as a class suit."); *Ashker v. California Dept. of Corrections*, 350 F.3d 917, 924 (9th Cir. 2003) (state-wide injunction issued based on claim by one prisoner).

[2] ACLU of Massachusetts, Tracking COVID-19 in Massachusetts Prison & Jails: Total Positive Tests (prisoners), data.aclum.org/sjc-12926-tracker/ (last visited April 17, 2020).

[3] Deborab Becker, WBUR, "5 Mass. Prisoners Die Due to COVID-19" (April 16, 2020) available at: https://www.wbur.org/news/2020/04/16/coronavirus-deaths-jails-prisons-update (last accessed April 17, 2020).

deductions, medical parole, and modifications to parole criteria and procedures; and (3) release all persons civilly committed to a correctional facility under G.L. c. 123, § 35, for alcohol or substance use treatment.

FACTS

A. Massachusetts Prisons and Jails Are Petri Dishes for Infection That Threaten Public Health and Area Hospital Capacity

The COVID-19 crisis is a global emergency that has hit home in Massachusetts.[4] The Commonwealth's prisons and jails are perfect incubators for the disease,[5] threatening to consume vital healthcare resources and endangering the general public as well as those incarcerated. From April 5 to April 12, 2020, identified COVID-19 cases[6] among prisoners, staff, and vendors across the state shot up from 30 to 243 and the number continues to rise steeply.[7] DOC prisoners now have a rate of infection of 1.06 percent, over 2.7 times higher than the 0.39 percent rate of the general public.[8] Some prisons already show an astonishingly high rate, with 10.1 percent of prisoners at MCI-Framingham testing positive and 7.2 percent of those at the Massachusetts Treatment Center.[9] Others cannot be far behind.

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[4] On March 10, 2020, Governor Charlie Baker declared a state of emergency in the Commonwealth. By April 13, 2020 there were 26,876 confirmed cases in the state, and Gov. Baker had issued emergency orders, including closure of all non-essential businesses, prohibition on gatherings of 10 or more, and a stay at home advisory.

[5] *See* Ex. 1, Declaration of Josiah Rich, MD, MPH, ¶ 6 ("correctional settings are ideal for rapid spread" of viruses such as COVID-19") and *id*. at ¶¶ 6-14 (describing correctional conditions that increase transmission).

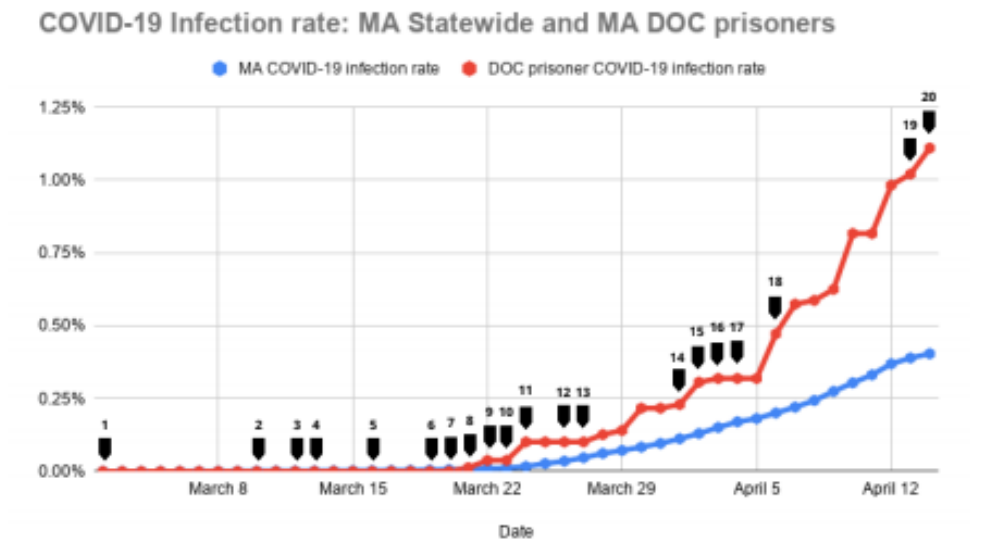
[6] As discussed *infra*, the low rate of testing in prison guarantees that identified cases greatly understate the actual number.

[7] *See* https://data.aclum.org/sjc-12926-tracker/, and Special Master's Weekly Report, *Committee for Public Counsel Services et al. v. Chief Justice of the Trial Court, et al.*, No. SJC-12926 (April 13, 2020) *available at* https://www.mass.gov/doc/sjc-12926-special-masters-weekly-report-4132020.

[8] *See* Special Master's Weekly Report, *supra* (showing 84 out of 7946 DOC prisoners had tested positive); Ex. 2, Declaration of Yoav Golan, M.D. ("Golan Decl.") ¶¶ 8, 11.

[9] *See* https://data.aclum.org/sjc-12926-tracker/. Population numbers for MCI-Framingham and the Massachusetts Treatment Center are based on the most recently available reporting from DOC, *See* https://www.mass.gov/doc/weekly-inmate-count-3302020/download.

The graphic below shows the urgency of this crisis.[10]



1. March 2 - The second case of COVID-19 is reported in Massachusetts.

2. March 10 - MA Governor declares a state of emergency.

3. March 12 - PLS sends letter to the Governor, the DOC Commissioner, the Sheriff's Association, and the Secretary of Public Safety to ask that they immediately develop evidence-based and proactive plans for the prevention and management of COVID-19 in the Massachusetts Department of Correction and in our county jails. The DOC suspends all non-attorney visits.

4. March 13 - DOC issues a memo to prisoners assuring their safety.

5. March 16 - PLS joins the Building Up People Not Prisons coalition calling for an urgent reduction in the prison population.

6. March 19 - PLS joins 763 organizations in a letter to the Acting Director of ICE, calling for detainee releases, a cease to all local enforcement operations, and elimination of ICE check-ins and mandatory court appearances.

7. March 20 - PLS joins over 60 other organizations in sending a letter to New England ICE asking them to protect the health of immigrants in ICE custody in New England by releasing them from custody.

8. March 21 - The first prisoner in Massachusetts tests positive for COVID-19 at Massachusetts Treatment Center.

9. March 22 - PLS in coalition with the Keep Families Together Coalition writes to leadership to urge leaders to ensure maximum free access to telephone and video conferencing for prisoners.

10. March 23 - MA Governor orders non-essential operations to close and limits gatherings to 10 people. DPH issues two-week stay home advisory. CDC issues guidelines for prisons.

11. March 24 - DOC issues memo to staff authorizing using PPE for staff using their own masks until DOC can provide them.

12. March 26 - PLS signs on to a letter in partnership with the Center for Public Representation and others regarding the need for statewide guidelines preventing discriminatory allocation of life-saving medical care. AG Barr recommends Federal Bureau of Prisons develop plan to release at-risk prisoners to home confinement.

13. March 27 - PLS files an amicus curiae letter in support of the ACLU/MACDL lawsuit urging the immediate reduction of prison and jail populations in MA.

14. April 1 - DOC notifies the SJC that MCI-Shirley will be locked down for 14 days in an effort to slow the spread of COVID-19.

15. April 2 - The first prisoner in MA dies as a result of COVID-19.

16. April 3 - Second prisoner death reported. CDC recommends face coverings for all civilians in public settings. AG Barr directs Bureau of Prisons to increase efforts to decarcerate. MA DOC Commissioner Mici issues memo to DOC staff regarding public safety priority testing; the memo limits staff testing to 25 total per day.

17. April 4 - Third prisoner death in MA reported.

18. April 6 - AG Barr directs prosecutors to consider COVID-19 in bail determinations due to crisis in detention centers.

19. April 13 - Fourth prisoner death in MA reported.

20. April 14 - At least 152 state and county prisoners and 129 state and county corrections staff have tested positive for COVID-19. The Department of Correction prisoner infection rate is 1.1%, which is 2.75 times the overall Massachusetts infection rate. There are pockets of the outbreak at several facilities: 22 out of 218, or 10.1%, of people at MCI Framingham have tested positive, making them 25.9x more likely than someone in Massachusetts to have it; 37 out of 566, or 6.5%, of people at the Massachusetts Treatment Center have tested positive, making them 16.8x more likely than someone in Massachusetts to have it.; and 12 out of 229, or 5.2%, of people at Bridgewater State Hospital have tested positive, making them them 13x more likely to have it.

[10] Information tracked by Prisoners' Legal Services at http://plsma.org/covid-19-in-ma-prisons-and-jails/.

COVID-19 cannot be contained in prisons and jails at their current population levels. First, incarcerated people cannot maintain the "social distancing" and hygiene measures urged on the general public, as they live in shared rooms and dormitories, and use common bathrooms, showers, meal spaces, and waiting areas for medication.[11] The public has now been instructed to wear masks when in proximity to people outside the immediate household; this is not possible for most prisoners,[12] and not likely in the near future given the existing shortages, leaving prisoners vulnerable to infection.[13] While most staff in many prisons have access to personal protective equipment (PPE), full compliance with the use of PPE and other rigorous measures necessary to maintain sanitation is "a difficult and likely insurmountable challenge" in a correctional setting, a challenge likely to grow as more staff fall ill and shortages grow.[14]

Second, prisons and jails have extremely limited testing capability, with a testing rate far lower than the general public and no on-site testing, leading to delays.[15] A number of counties have not tested anyone incarcerated.[16] "As a result, COVID infections are far more likely to go unrecognized in prison than in the general population, leading to increased risk of COVID transmission in prisons."[17] Finally, even if positive cases could be rapidly identified, the increase

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[11] *See* Golan Decl.at ¶¶ 5-6; Rich Decl. ¶¶ 11-12.

[12] *See, e.g.,* White Decl. ¶ 8;Ex. 15, Declaration of Plaintiff Hendrick Davis(" Davis Decl.") ¶ 7; Ex. 7, Declaration of Plaintiff Peter Kyriakides (" Kyriakides Decl.") ¶ 7; Ex. 24, Declaration of Ryan Powell ("Powell Decl.") ¶ 8; Ex. 22,Declaration of Tevon Ngomba (""Ngomba Decl.") ¶ 7; Ex. 23, Declaration of Ariel Pena (" Pena Decl.") ¶ 6; Maramaldi Decl. ¶ 10; Duntin Decl. ¶ 6.

[13] *See* Golan Decl. ¶ 7; Rich. Decl. ¶ 13.

[14] *See* Rich Decl. ¶ 13.

[15] *See* Golan Decl. ¶¶ 8-9 Dr. Golan notes that the high rate of positives among prisoners tested, as compared to the general public, indicates that only those with obvious symptoms or exposure are being tested, and those with mild or no symptoms are not being identified.

[16] *See* Special Master's Weekly Report, April 13, 2020, reporting that Barnstable, Bristol, Dukes, and Franklin Counties have not tested any prisoners. Hampshire County did not test anyone until April 10; Norfolk County did not test anyone between April 6 and April 13; and Berkshire County tested one person for the week ending April 12, *available at* https://www.mass.gov/doc/sjc-12926-special-masters-weekly-report-4132020.

[17] Golan Decl. ¶ 9; *see also* Rich Decl. ¶ 13 ("[C]orrectional settings are also unlikely to be able to perform the widespread screening and contact-tracing necessary to prevent further infection.").

in identified cases would rapidly overwhelm limited capacity for isolation and quarantine in prisons and jails, causing further spread.[18] The existing use of dormitory-style (open) housing in medical, nursing, and assisted living units risks COVID-19 transmission to older and infirm prisoners.[19] The fact that some prisons are using solitary confinement ("restrictive housing") cells for suspected and confirmed cases shows that medical units already are unable to hold these patients and raises serious concern over their treatment.[20]

This is not only a prison problem, it is a public health problem. Infected, asymptomatic staff and vendors carry the contagion outside of the prison walls.[21] If the prison surge is allowed to continue, the incarcerated population will make a disproportionate claim on overburdened hospital resources. Prisoners are at much higher risk than the general public of needing hospitalization and intensive care, due to their age and poor health status.[22] Prisons and jails have little or no hospital capacity—the DOC has only 29 hospital beds systemwide[23]—so infected prisoners, at high risk for complications, must be taken to area hospitals and compete for scarce healthcare resources.[24] If current trends are unchecked, "in two to four weeks, which is the time that many of the prison

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[18] *See* Ex.3, Declaration of Victor Lewis, M.D. ("Lewis Decl.") ¶ 13 ("[B]ased on my knowledge from conducting these and other audits over the past 20 years, it is my opinion that DOC's health care system will easily be overwhelmed once the COVID-19 epidemic spreads."); Golan Decl. ¶8 ("As most Massachusetts prisons are close to their design capacity, relying on dormitories and double-celled units, the ability to effectively quarantine all COVID infected prisoners will be limited. Incomplete quarantine will lead to increased COVID transmission within prisons."); *see also* Rich Decl. ¶ 16.

[19] *See* Lewis Decl. ¶ 17.

[20] *See* Lewis Decl. ¶16; Rich Decl. ¶ 17.

[21] *See* Lewis Decl. ¶13; Ex. 4, Declaration of Six Internal Medicine Resident and Attending Physicians at Boston Medical Center ("BMC Decl.")"¶ 9.

[22] *See* Rich Decl. ¶ 14; BMC Decl. ¶¶ 6-9.Golan Decl. ¶¶ 14-17 (citing Maruschak LM, Berzofsky M, Unangst J. Medical problems of state and federal prisoners and jail inmates, 2011-12. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; Feb. 2015) ("Approximately half of state and federal prisoners and jail inmates have had a chronic medical condition (defined as cancer, high blood pressure, stroke-related problems, diabetes, heart-related problems, kidney-related problems, arthritis, asthma, and/or cirrhosis of the liver. Twenty-one percent of state and federal prisoners and 14% of jail inmates have ever had tuberculosis, hepatitis B or C, or sexually transmitted infections (excluding HIV or AIDS)").

[23] The Lemuel Shattuck Hospital has 29 beds. *See* https://www.mass.gov/doc/weekly-inmate-count-3302020/download.

[24] *See* BMC Decl. ¶ 9.

cases among vulnerable prisoners are expected to worsen, prison cases will further tax already overburdened and stressed area hospitals, and adequate supportive care in hospitals for prisoners could not be guaranteed."[25]

Resources in the community are now available to assist even homeless individuals released from prison to access shelter and healthcare in a manner far less likely to increase spread of the disease than in prison. Area shelters have substantially expanded their capacity to house people experiencing homelessness, with precautions to avoid COVID-19 spread such as increased distancing, plastic barriers between beds, meals served in shifts, additional hand washing and sanitizing capacity, and increased cleaning.[26] Healthcare providers and substance use disorder treatment programs are "ready and willing" to meet the needs of those released from prison through expanded capacity and the adoption of telemedicine, and are set up to connect patients to resources such as housing, food, and childcare.[27]

Those released from prison with suspected or confirmed COVID-19—including homeless persons—will be more safely treated and housed in the community, further reducing the spread of the disease. Patients who are unable to isolate at home are being served by programs set up by the Commonwealth, the City of Boston, Boston Medical Center, Boston Health Care for the Homeless, Partners Healthcare, and shelter organizations, and those not eligible for these services are admitted to hospital care.[28] Area hospitals are far better equipped than prisons to treat and contain the disease.[29]

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[25] Golan Decl. ¶ ¶ 13.
[26] *See* BMC Decl. ¶ 21-23.
[27] BMC Decl. ¶ 26; *see also* BMC Decl. ¶¶ 23-25, describing expanded services.
[28] *See* BMC Decl. ¶¶16-20.
[29] *See* BMC Decl. ¶¶ 10-15.

The rising tide of COVID-19 in prison, if not stemmed, will spill into our communities and consume vital healthcare resources. Action now will protect the public as well as those who remain incarcerated.

B. Conditions in Massachusetts Prisons and Jails Expose Prisoners to Serious Risk of Contracting COVID-19

1. Prisoners cannot practice social distancing.

COVID-19 spreads primarily from close in-person contact (within about 6 feet), and through contact with contaminated surfaces or objects.[30] The CDC has found that "[t]he virus that causes COVID-19 is spreading very easily and sustainably between people." People can carry and transmit COVID-19 while asymptomatic, which makes efforts at screening and quarantine on the basis of symptoms ineffective to reduce the invisible spread of the virus.[31] *See Matter of Extradition of Toledo Manrique*, No. 19-mj-71055, 2020 WL 1307109 (N.D. Cal., March 19, 2020) ("Symptoms of COVID-19 can begin to appear 2-14 days after exposure, so screening people based on observable symptoms is just a game of catch up," and therefore requiring detainees to wait for a confirmed outbreak is impractical. "By then it may be too late."). Social distancing is the only effective mechanism to stem the tide of COVID-19, and it is impossible to accomplish under current conditions.

a. Housing

Social distancing is virtually impossible in prison. The DOC admits that approximately 72% of its population cannot maintain the six-foot recommended distancing while sleeping. *See Committee for Public Counsel Services, et al. v. Chief Justice of the Trial Court, et al.,* SJC-12926, DOC letter to SJC dated April 3, 2020, Dkt. 56. Most prisons have dormitory-style housing in

[30] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html.
[31] *See* BMC Decl.¶ 5; Golan Decl. ¶ 9.

which prisoners share space for sleeping, eating, and recreation, and use common toilets, sinks, and showers. Some dormitories hold over 80 or more prisoners, who sleep within 2 to 3 feet of one another.[32] Prisoners who do not live in dormitories mostly live in double- and triple-bunked cells, many of which do not meet the minimum standards for cell and floor space set by the Department of Public Health.[33] Being locked in these small spaces—many of which were often designed for one person—prohibits social distancing.[34]

b. Medication distribution

Despite being locked down, some facilities still require prisoners to stand in line to receive their medications. Prisoners in these "medlines" are often pressed together much less than six feet apart from one another.[35] At MTC, a prisoner with a dry cough and a fever was made to wait in the same tightly packed medline as other prisoners, some of whom were also coughing.[36] A 64-year-old man at Plymouth County with severe chronic respiratory illness went to health services twice recently for ear and throat infections; he waited both times in a small foyer with three or four other people.[37]

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[32] *See, e.g.,* Gomes Decl. Ex. ¶ 3; 21; Declaration of Michael Maramaldi ("Maramaldi Decl.") ¶ 3; Ex. 18, Declaration of Dana Durfee ("Durfee Decl.") ¶¶ 2-3; Ex. 26, Declaration of Noe Zuniga (" Zuniga Decl"). ¶ 4**;** Pena Decl. ¶ 4.

[33] *See,* Declaration of Lucy Eleanor Umphres, Esq. ("Umphres Decl.") ¶ 3 ("Nearly 68% of all facilities across the Commonwealth currently fail to comply with the DPH cell size and floor space regulations, and 99% of the cell size and floor space violations—all but two—are repeat violations."). The Umphres Declaration surveys the most recent Department of Public Health (DPH) inspection reports for each state facility and for each county jail and house of correction, noting the number of total violations and the number of cell size and floor space violations at each institution. *Id.* ¶ 2 & pp 2-14.

[34] *See, e.g.,* Ex. 11, Declaration of Plaintiff David Sibinich (" Sibinich Decl.") ¶ 2 (describing impossibility of keeping six feet apart from cellmate in roughly 8' x 9' cell containing lockers, bunkbed, and desk); Ex. 19, Declaration of Gabriel Guzman (" Guzman Decl.") ¶ 2 ("two men in a very small space, sharing a toilet and sink and sleeping in a bunk bed").

[35] See, e.g., Declaration of Plaintiff Michael Gomes ("Gomes Decl.") ¶ 4 (people less than a foot apart); Ex. 13, Declaration of Plaintiff Michael White (""White Decl.") ¶ 11 ("I can easily touch the person in front of and behind me in line."); Ex. 14, Declaration of Plaintiff Frederick Yeomans (" Yeomans Decl.") ¶ 2 (others are "right next to me"); Sibinich Decl. ¶ 3.

[36] *See* Ex. 17, Declaration of Ryan Duntin ("Duntin Decl.") ¶ 4.

[37] *See* Ex. 8, Declaration of Plaintiff Richard O'Rourke ("O'Rourke Decl.") ¶ 7.

c. Meals

Because of the lockdowns, most prisoners now eat meals in their units instead of a "chow hall." But this does not eliminate risk of contamination or ensure proper social distancing. In dormitory units, prisoners who avoid communal tables and eat at their bunks are still within a few feet of one another.[38]

d. Showers and bathrooms

Prison bathrooms and showers are crowded. Most prisoners share these spaces with many others, making social distancing impossible.[39] This is true even when access is limited to a relatively small number of prisoners at a time, since many of the installations themselves—toilets, urinals, sinks, showers—are less than six feet apart.[40] Compounding the lack of social distancing is the lack of proper sanitation, as discussed below.

2. Prisons and jails are not taking adequate preventive measures.

The lack of social distancing is made worse by prisons' and jails' failure to take adequate or consistent steps or to provide necessary supplies to prevent the spread of disease.

a. Lack of personal protective equipment

Most facilities do not give prisoners masks.[41] Most correctional staff have masks but some officers wear them irregularly, some not at all; officers do not always wear masks or gloves when handing out meals.[42] A prisoner at MTC reports that officers wear gloves, but put bread on

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[38] *See, e.g.,* Durfee Decl. ¶ 5; Maramaldi Decl. ¶ 9.

[39] *See, e.g,* White Decl. ¶ 5 (40 people share bathroom with one urinal, four toilets, and eight sinks one foot apart; all often in use at same time); Ex. 6, Declaration of Plaintiff Michael Gomes ("Gomes Decl.) ¶ 3 (84 people, two bathrooms); Kryiakides Decl. ¶ 3 (large group of people each morning waiting 2-3 feet apart to use toilets and sinks).

[40] *See, e.g.,* Maramaladi Decl. ¶ 5; Declaration of Plaintiff Mark Santos ("Santos Decl.") ¶ 6; Durfee Decl. ¶ 5; White Decl. ¶ 4.

[41] *See, e.g.,* Powell Decl. ¶ 8; Ngomba Decl. ¶ 7; Pena Decl. ¶ 6; Maramaldi Decl. ¶ 10; White Decl. ¶ 8; Duntin Decl. ¶ 6; *see also* Guzman Decl. ¶ 10 (prisoners get one mask every 10 days). A corrections officer at MCI-Concord told a prisoner requesting a mask that prisoners "don't need them." Maramaldi Decl. ¶ 10.

[42] *See, e.g.,* Maramaldi Decl. ¶ 10; Zuniga Decl. ¶ 9, Cummins Decl. ¶ 20.

prisoners' trays using the gloves they've worn while touching cell doors, keys, and other surfaces in the unit.[43] Medical staff do not always wear masks and gloves, or change gloves between patients.[44] Since the lockdown at MCI-Shirley, diabetic prisoners receive insulin injections in their cells from nurses wearing the same gloves used when giving injections to other prisoners.[45]

b. Lack of hygiene, cleaning, and disinfection

Not all prisoners have regular access to hand sanitizer or soap.[46] Prisoners have limited or no ability to clean their cells and common spaces.[47] Phones in many places are less than six feet apart, and they often are not wiped down between uses.[48] Prisoners in one roughly 75-person dorm share hot pots, microwaves, and televisions that are not cleaned between uses.[49]

Since the lockdown, which was supposed to reduce opportunities for infection, cleaning crews work less often,[50] resulting in conditions ranging from unsanitary to squalid: Prison workers used to daily clean the cell of a woman in the health services unit at MCI-Framingham who suffers from morbid obesity and chronic heart, lung, and spinal conditions; no one does this anymore.[51] At Pondville Correctional Center, the floor beneath a urinal shared by 50 prisoners is regularly covered with urine, shared sinks are dirty, and trash receptacles are often overflowing.[52] Toilets in

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[43] *See* Davis Decl. ¶ 6.
[44] *See* Santos Decl. ¶ 7; Pena Decl. ¶ 2; White Decl. ¶ 10.
[45] *See* Pena Decl. ¶ 2.
[46] *See e.g.,* Watkins Decl. ¶ 7 (no hand sanitizer); Guzman Decl. ¶ 9 (same); Ngomba Decl. ¶ 4 (no hand sanitizer, denied soap after running out); Davis Decl. ¶ 7 (hand sanitizer dispenser empty for three weeks); White Decl. ¶ 10 (no hand sanitizer after 3 p.m.); see also Ex. 5, Declaration of Plaintiff Stephen Foster ("Foster Decl.") ¶ 3 (no hand sanitizer since lockdown); Maramaldi Decl. ¶ 7 (hand sanitizer and bathroom soap dispensers often empty); Santos Decl. ¶ 6 (no soap in bathroom).
[47] *See, e.g.,* Guzman Decl. ¶ 8; Pena Decl. ¶ 4.
[48] *See, e.g.,* Powell Decl. ¶ 7; Gomes Decl. ¶ 4; Pena Decl. ¶5; Maramaldi Decl. ¶ 6; Sibinich Decl. ¶ 3.
[49] *See* Zuniga Decl. ¶ 3; Powell Decl. ¶ 4.
[50] *See, e.g.,* Davis Decl. ¶ 10; Ex. 12, Declaration of Plaintiff Michelle Tourigny ("Tourigny Decl.") ¶ 10; Kyriadides Decl. ¶ 3.
[51] *See* Touringny Decl. ¶ 7.
[52] *See* Kyriakides Decl. ¶ 5.

a large dorm unit at MCI-Concord are sometimes clogged with toilet paper and feces.[53] In many places bathrooms and showers are not cleaned daily or with bleach or other appropriate disinfectant.[54] At Souza-Baranowski, healthy prisoners in segregation are forced to share showers and telephones with prisoners who are "quarantined" because of possible COVID-19.[55] Staff at MTC required a prisoner with a fever and dry cough to go back to work serving food and cleaning the dining room.[56]

3. Prisoners do not have access to adequate medical or mental health care.

Prisoners faced obstacles to getting needed medical care even before COVID-19. A state audit report issued on January, 9, 2020, found that DOC sick call request forms were not processed promptly and properly, with prisoners often waiting more than a week to see a medical provider after requesting care.[57] The State Auditor stated, "Without timely treatment for physical and mental health issues, an inmate's condition could worsen." *Id.* A federal court recently found that the DOC was "neither able nor willing to provide" for a prisoner's medical needs, and that as a result of its "woeful disregard" for his well-being, the DOC was "slowly killing him."[58] A recent WBUR investigation—"Dying on the Sheriff's Watch"—documented similar deficiencies in the medical care provided in county facilities.[59]

The strain that COVID-19 has put on prisons' healthcare systems, and prison operations generally, has resulted in dangerous lapses and denials of care. Plaintiff Michael Gomes has a

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[53] *See* Maramaldi Decl. ¶ 5.
[54] *See, e.g.,* Davis Decl. ¶ 10; White Decl. ¶5; Ngomba Decl. ¶ 2; Duntin Decl. ¶ 9.
[55] *See* Ngomba Decl. ¶¶ 2-3.
[56] *See* Duntin Decl. ¶ 3.
[57] Suzanne Bump, Office of the State Auditor, *Massachusetts Department of Correction Official Audit Report* 11-12 (Jan. 9, 2020).
[58] *Reaves v. Mass. Dep't of Correction*, 392 F. Supp. 3d 195, 200, 210 (D. Mass. 2019).
[59] Christine Willmsen & Beth Healy, "Dying on the Sheriff's Watch," WBUR 4-part audio series, available at https://www.wbur.org/investigations/2020/03/26/jail-lawsuits-sheriffs-watch.

transplanted liver but did not receive his anti-rejection medication for three days during the lockdown at MCI Concord.[60] A leukemia survivor at Massachusetts Treatment Center who requires daily blood-thinning medication to prevent life-threatening blood clots did not receive this medication for five days after being put in the COVID quarantine unit.[61] He reports that diabetic prisoners quarantined with him have not been receiving insulin.[62] Another man at MTC, who has a history of chronic bronchitis, went to health services with a fever, dry cough, and headache; medical staff told him he had a "cold" and refused to give him a COVID-19 test.[63] Worcester County House of Correction refuses to provide a nebulizer, which had been prescribed in the community, to a man with severe chronic asthma, chronic obstructive pulmonary disease (COPD), and a history of pneumonias.[64] Lockdown conditions in many facilities, which reduce timely prisoner access to correctional and medical staff, are especially dangerous where COVID-19 is present, since the onset or worsening of symptoms may happen suddenly.[65]

Mental health services have also been inadequate at a time when fear and harsh conditions have increased prisoners' need for them. Many prisoners, particularly those with underlying health conditions, fear they will become severely ill or die if they become infected.[66] At NCCI-Gardner a mental health clinician comes twice a week to a 30-man dorm, but conducts visits in the dorm, where the lack of privacy discourages open communication.[67] Mental health staff came twice in

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[60] Gomes Decl. ¶ 2.
[61] Ex. 25, Declaration of Joseph Watkins ("Watkins Decl.") ¶ 4.
[62] Watkins Decl. ¶ 5.
[63] Duntin Decl. ¶¶ 2-3.
[64] Guzman Decl. ¶ 3.
[65] Rich Decl. ¶ 18.
[66] *See, e.g.,* Gomes Decl. ¶ 7 (prisoner with past suicide attempt: "I try to avoid people, not even talking to them when possible, and I wash my hands constantly. Despite these efforts, I am scared of dying."); Zuniga Decl. ¶ 7 (prisoner with PTSD "going crazy with worry about my family and my own health" has not seen mental health clinician in more than a month); Tourigny Decl. ¶ 9 ("I fear for my life right now. I love my children and family, and want to live."); Foster Decl. ¶¶ 7-8.
[67] Cummins Decl. ¶ 23.

almost three weeks to see the 30 men in the COVID unit at MTC.[68] The lockdown has exacerbated anxiety and tension by forcing people to remain in their cells or dorms 23 or more hours a day without access to therapeutic counseling or programming, or even ordinary stress-relievers like recreation and outdoor time.[69]

C. Patients Committed to DOC Under G.L. c. 123, § 35 for Treatment of Alcohol or Substance Use Disorders Endure Dangerous Conditions and Receive No Treatment

The DOC houses men civilly committed under G.L. c. 123, § 35 for substance use disorder (SUD) treatment at the Massachusetts Alcohol and Substance Abuse Center (MASAC), located at MCI Plymouth, and the DOC has also entered into a Memorandum of Understanding with the Hampden County Sheriff's Department to operate a Section 35 facility in the Hampden County Correctional Center. Conditions for Section 35 patients are at least as dangerous as those for other prisoners and, in a cruel irony, the COVID-19 epidemic has suspended the very treatment that purportedly justifies their imprisonment.

Conditions at MASAC create a great risk of transmission for each man housed there. PLS's extensive investigation of the conditions under which these men are held, undertaken in separate litigation,[70] has produced dozens of consistent accounts of the unit where initial detoxification takes place, describing the unit as filthy and stinking of the vomit, urine, and excrement of patients in the throes of cold-turkey withdrawal. DPH sanitation inspections confirm the "generally dirty conditions," describing plumbing in poor repair, mold on the ceilings, scum on shower walls, and a

[68] Watkins Decl. ¶ 5.

[69] *See, e.g.,* Santos Decl. ¶ 4; Zuniga Decl. ¶ 6; Sibinich Decl. ¶ 5; White Decl. 4; *see also* Duntin Decl. ¶ 8 ("Because there are many sick people coughing on the unit, tension in the unit was high, with people being worried they would be infected.").

[70] *Doe et al. v. Mici et al.*, No. 1984CV00828 (Suffolk Super. filed Mar. 14, 2019).

missing door on bathroom stall.[71] Medical beds in C-Dorm are close together, making social distancing virtually impossible, and do not comply with DPH standards for minimum floor space per occupant.[72] Other MASAC detainees in C-Dorm and the other dormitories live in two-man cells designed for one person. These cells fail to comply with DPH standards that call for each cell or sleeping area to contain at least 60 square feet of floor space for each occupant.[73] Compounding this risk, stays average only 30 to 40 days. This rapid turnover ensures that COVID-19 will continue circulating between Section 35 facilities and the community. SUD patients have particular vulnerabilities to COVID-19, as they have high rates of hepatitis C and other infectious diseases and are generally in poor health.

Since the lockdown began, MASAC patients are confined to their cells all day.[74] They are allowed to leave only to use the bathroom, go to medication line, or use the telephone. Because the cells are so small, social distancing is impossible for patients who have a cellmate. There is only one bathroom for each unit and patients must stand in line close to each other to receive medication. Most take some kind of medication. There is no soap in the bathroom and no hand sanitizer. Like others in DOC custody, MASAC patients have not been given masks.

The risk of COVID transmission would counsel in favor of release even if SUD treatment were occurring; in fact, the U.S. government has recommended that during the COVID-19 pandemic outpatient services be used whenever possible.[75] Here, though, the DOC is holding men

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[71] *See, e.g.,* Department of Public Health, Bureau of Environmental Health, Community Sanitation Program report, February 11, 2020 *available at*: https://www.mass.gov/doc/massachusetts-alcohol-and-substance-abuse-center-masac-in-plymouth-january-30-2020/download.
[72] *See id.*
[73] *See id.*
[74] Santos.
[75] On March 20, 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) - the agency within the U.S. Department of Health and Human Services that leads public health efforts to address mental health and substance use disorders – issued guidance on how to respond to the COVID-19 pandemic. It says: "For those with substance use disorders, inpatient/residential treatment has not been shown to be superior to intensive outpatient treatment. Therefore, in these extraordinary times of risk of viral infection, it is recommended that intensive outpatient

in MASAC in highly dangerous and inhumane conditions *without providing treatment.* Starting in mid-March, MASAC cancelled all classes and reduced treatment to one group per day. In early April, the entire facility was placed in lock-down, and even that group was eliminated. Individuals civilly committed to MASAC for treatment now receive no treatment at all. The use of prison for Section 35 commitments, controversial even in ordinary times,[76] there is now no justification for exposing MASAC patients to an unreasonable and unnecessary risk of COVID-19.

D. The Commonwealth is Failing to Take Minimal and Obvious Steps to Reduce the Prison and Jail Population When Only an Immediate and Substantial Reduction Will Avoid a Public Health Crisis

A reduction in the number of people imprisoned in Massachusetts jails and prisons is the only meaningful way to prevent the spread of the virus. The half measures undertaken by Defendants to date, laid out in an affidavit dated March 27, 2020 by Defendant Carol Mici, have been ineffective.[77] At the time, Defendant Mici wrote that "[a]lthough the Massachusetts Treatment Center is the only Department facility to have confirmed cases of COVID-19 to date, the Department has taken steps to prevent the introduction or transmission of COVID-19 to other facilities."[78] MTC had 10 confirmed cases then.[79] In spite of all the precautions taken, 16 days later on April 12, confirmed cases in DOC increased eight-fold to 84, and they are spread across multiple prisons.[80]

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treatment services be utilized whenever possible." https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf.

[76] In 2017, the Legislature repealed the provisions in Section 35 that allowed women to be committed to a correctional facility. In 2019, the Commission established by Section 104 of the Acts of 2018 to evaluate Section 35 recommended that the "Commonwealth should prohibit civilly committed men from receiving treatment for addictions at any criminal justice facility." Section 35 Commission Report (July 1, 2019) *avaibable at* https://www.mass.gov/doc/section-35-commission-report-7-1-2019/download.

[77] *See* Ex. 27, Affidavit of Carol Mici.

[78] *Id.* ¶ 31.

[79] *Id.* ¶ 58.

[80] *See Comm. for Public Counsel Servs. et al. v. Chief Justice of the Trial Court et al*., SJC-12926, Special Master's Weekly Report, Dkt. 70 at 15 (Mass. decided Apr. 3, 2020).

As medical experts have universally recognized, the only way to slow the spread of the infection within a population is to maintain separation between people; because that is impossible in prisons and jails at the current population levels, those levels must be reduced.[81]

Other states and the federal government have acknowledged this unavoidable fact and have taken swift action to reduce their incarcerated populations. For example, governors have used their executive authority in a number of ways—ranging from commutation of sentences, to early release through good time, to the use of home confinement—to reduce the prison population in their states. *See, e.g.*, Ky. Exec. Order No. 2020-267 (April 2, 2020) (commuting the sentences of "186 inmates identified as at higher risk for severe illness or death" in order to "reduce the inmate population in the overcrowded state prison facilities"); N.J. Exec. Order No. 124 (April 10, 2020)[82] (creating process for expedited consideration of prisoners for temporary home confinement); Ill. Exec. Order No. 9 (March 23, 2020)[83] (relaxing restrictions on early prisoner release for good behavior); Co. Exec. Order No. D-2020-016 (March 25, 2020)[84] (suspending caps on good time and directing the department of correction to cease accepting transfer of prisoners from county jails). Executive branch agencies have done much as well. For example, in Georgia, the Board of Pardons and Paroles has begun considering clemency release for individuals within 180 days of

[81] *See* BMC Decl. ¶ 4 ("[D]econgesting prison and jail facilities and reducing the prison population as soon as possible are the best way to protect the health and safety of the individuals incarcerated and of the public."); Rich Decl. ¶ 19 ("It is imperative to scale up efforts to 'decarcerate,' or release, as many people as possible, including for consideration those sentenced as well as those detained on bail."); Golan Decl. ¶ 20 ("[A] substantial reduction in the prison population is needed in order to help reduce transmission in prison and improve the ability to quarantine, isolate, and treat those infected.").

[82] Available at https://nj.gov/infobank/eo/056murphy/pdf/EO-124.pdf.

[83] Available at https://www2.illinois.gov/sites/coronavirus/Resources/Pages/ExecutiveOrder2020-11.aspx.

[84] Available at https://www.colorado.gov/governor/sites/default/files/inline-files/D%202020%20016%20Suspending%20Certain%20Regulatory%20Statutes%20Concerning%20Criminal%20Justice_0.pdf.

completing their sentences for non-violent offenses.[85] In California, the Department of Corrections and Rehabilitation expedited parole for prisoners with 60 or fewer days left to serve on their sentences.[86] And the Federal Bureau of Prisons, at the direction of the Attorney General, has increased home confinement by over 40 percent by "aggressively screen[ing] all potential inmates" for eligibility.[87]

By contrast, Defendants have taken no meaningful action to reduce the number of prisoners in Massachusetts prisons and jails. Governor Baker has flatly declared that he has no intention of doing so, stating at a press conference, "We believe the correct position is for us to be continue doing the things we're doing to keep the people inside safe, and that's gonna be the way we play this one."[88] Consistent with the Governor's position, on March 31 the Parole Board admitted "it has made no efforts to accelerate the scheduling of parole hearings." *Comm. for Pub. Counsel Servs. v. Chief Justice of the Trial Court*, No. SJC-12926, 2020 WL 1659939, at *14 (Mass. Apr. 3, 2020). Even for prisoners already approved for parole, the Parole Board has made no attempt to speed up issuing the paperwork required for release, *id.*, and has been imposing barriers such as requiring transfers to lower security—which are suspended by the DOC during the pandemic. The Board has thus blocked the release even of people incarcerated for non-criminal, nonviolent parole violations who are medically vulnerable and have homes they could go to.[89] The DOC, through

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[85] *Board Considering Releases to Address COVID-19 in Georgia Prisons,* State Board of Pardons and Parole (March 31, 2020), https://pap.georgia.gov/press-releases/2020-03-31/board-considering-releases-address-covid-19-georgia-prisons.

[86] *CDCR Announces Plan to Further Protect Staff and Inmates from the Spread of COVID-19 in State Prisons*, Cal. Dep't. of Corrections and Rehabilitation (March 31, 2020), https://www.cdcr.ca.gov/news/2020/03/31/cdcr-announces-plan-to-further-protect-staff-and-inmates-from-the-spread-of-covid-19-in-state-prisons/.

[87] *Update on COVID-19 and Home Confinement*, Federal Bureau of Prisons (Apr. 5, 2020, 6:40 PM), https://www.bop.gov/resources/news/20200405_covid19_home_confinement.jsp.

[88] Deborah Becker, *Mass. High Court Considers Releasing Some Prisoners To Prevent COVID-19 Outbreak*, New England Public Radio (Apr. 1, 2020), https://www.nepr.net/post/mass-high-court-considers-releasing-some-prisoners-prevent-covid-19-outbreak#stream/0.

[89] See, e.g., Ex. 28, Affidavit of Catherine J. Hinton, Esq. ¶¶ 5, 8. While DOC and the Special Master indicate that 23 medical parole applications have been approved, they nowhere indicate how many—if any—people have actually been

counsel, likewise admitted that it has made no effort to speed release of prisoners or use alternative methods of detention:

> C.J. Gants: Is DOC or the parole board doing anything different in terms of accelerating the release of prisoners in the wake of the COVID-19 pandemic?
>
> DOC: As far as the Department goes, I mean, our release procedures have remained the same in that they're released on the date that their sentences have expired.
>
> . . .
>
> C.J. Gants: So there's no increase in the rate of furloughs?
>
> DOC: No. There isn't.
>
> C.J. Gants: Is there any effort to examine whether furlough is appropriate for any inmate?
>
> DOC: I don't believe there has been.[90]

Given the inaction and indifference of the Defendants, it is perhaps unsurprising that the number of people in Massachusetts prisons and jails *increased by over 500 last week*—even after entry of the SJC's order in *Comm. Pub. Counsel Servs. et al. v. Chief Justice of the Trial Court et al.*, SJC-12926 (Mass. Apr. 3, 2020). *See id.*, Special Master's Weekly Report, Dkt. 70 at 1, 15.

Defendants' lack of action is not due to a lack of options. They have a wide array of mechanisms to reduce the prison and jail population using their existing authority. First, the Governor has near plenary power to protect the lives of prisoners during an emergency. In response to COVID-19 and "its extreme risk of person-to-person transmission," Governor Baker declared a state of emergency on March 10, 2020, invoking his authority under Chapter 639 of the Acts of 1950. Executive Order No. 591. That authority includes the ability to "employ every agency and all members of every department and division of the government of the commonwealth

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released under the program since the pandemic began. *Comm. for Pub. Counsel Servs. et al. v. Chief Justice of the Trial Court,* SJC-12926 , Special Master's Weekly Report, Dkt. 70 at 15 (Mass. decided Apr. 3, 2020).

[90] *Comm. Public Counsel Services et al. v. Chief Justice of the Trial Court, et al.*, SJC-12926, Oral Argument at 2:45-46 (Mass. decided Apr. 3, 2020), available at https://boston.suffolk.edu/sjc/archive.php.

to protect the lives and property of its citizens[.]" Acts of 1950, Ch. 639, § 5(a). More specifically, the Legislature granted the Governor "any and all authority over persons and property" to the extent permissible under the constitution of Massachusetts to address the emergency, including—explicitly—to protect the "[h]ealth or safety of inmates of all institutions." Id. § 7(a).

Apart from Governor Baker's extraordinary emergency powers, Defendants have myriad constitutional, statutory, and regulatory powers to reduce the number of imprisoned people, including:

- Ordering home confinement and GPS monitoring, *see Com. v. Donohue*, 452 Mass. 256, 265 (2008) (citing G.L. c. 127, §§ 48, 49, 49A);
- Granting temporary furloughs, *see* G.L. c 127, § 90A (allowing prisoners "under prescribed conditions to be away from [their] correctional facility[.]");
- Granting parole, *see* G.L. c. 127, §§ 128, 130, 133; 120 C.M.R. §§ 300 (parole decisions must be based on "welfare of society") and 200.10 (prisoners in houses of correction may be paroled early for "compelling reasons");
- Granting medical parole, *see* G.L c. 127, § 119A (authorizing parole for people terminally ill or permanently incapacitated);
- Releasing prisoners before completion of their sentences for "good conduct" while imprisoned, *see* G.L. ch. 127, § 129D; and
- Commuting sentences, *see* Mass. Const. Pt. 2, C. 2, § 1, art. VIII; *In re Kennedy*, 135 Mass. 48, 51 (1883) ("The power of pardoning offences, as conferred on the executive authority by the Constitution of the Commonwealth, is exceedingly comprehensive.").

ARGUMENT

To issue a preliminary injunction the court must determine (1) that the moving party has demonstrated a likelihood that it would prevail on the merits at trial; (2) that without the relief sought it would suffer irreparable harm not capable of remediation by a final judgment in law or equity; and (3) that the risk of irreparable harm, in light of the chances of success, outweighs the defendants' probable harm and the likelihood of their prevailing at trial. *Commonwealth v.*

Massachusetts CRINC, 392 Mass. 79, 87 88 (1984). Where a public entity is a party, the court may also consider whether granting preliminary relief is in the public interest. *Hull Mun. Lighting Plant*, 399 Mass. 609, 648 (1987).

I. Plaintiffs are likely to succeed on the merits of their claims.

When a person is incarcerated, the state has an affirmative duty to provide humane conditions of confinement—it must ensure that prisoners receive adequate medical care and "must 'take reasonable measures to guarantee the safety of the inmates.'" *Farmer v. Brennan*, 511 U.S. 825, 832 (1994). By their policies, practices, acts, and omissions, the Governor, the Executive Office of Public Safety, the Department of Correction, the Parole Board, and the County Sheriffs are subjecting prisoners, particularly those who are elderly or medically compromised, to an imminent risk of serious illness or death from COVID-19 in violation of Article 26 of the Massachusetts Declaration of Rights and the 8th Amendment to the U.S. Constitution in the case of sentenced prisoners, and in violation of the Articles 1, 10, and 12 of the Massachusetts Declaration of Rights and 14th Amendment of the U.S. Constitution in the case of pretrial and civil detainees.

A. Conditions of confinement are unconstitutional under Arts. 1, 10, 12, and 26 of the Massachusetts Declaration of Rights and under the 14th Amendment of the US Constitution.

1. Arts. 1, 10, 12, and 26 and the 14th Amendment are violated where conditions are objectively cruel or unusual, regardless of Defendants' state of mind.

Article 26 bars "cruel or unusual punishments." Mass. Const. Pt. 1, art. XXVI. Protections under Art. 26 have not been precisely defined but are "at least as broad as the Eighth Amendment to the Federal Constitution." *Good v. Comm'r of Correction,* 417 Mass. 329, 335 (1994). Plaintiffs submit that in interpreting Art. 26, the Court should adopt the "objectively reasonable" standard

established by the Supreme Court for pre-trial detainees in *Kingsley v. Hendrickson,* 576 U.S. 389 (2015). Although *Kingsley* involved a claim of excessive force, numerous courts have held that subjective motive or intent has no role to play in any form of condition-of-confinement case brought by pretrial detainees or those civilly committed to correctional facilities. *See Hardeman v. Curran*, 933 F.3d 816 (7th Cir. 2019); *Colbruno v. Kessler*, 928 F.3d 1155, 1161–63 (10th Cir. 2019); *Darnell v. Pineiro,* 849 F.3d 17, 34–35 (2d Cir. 2017); *Castro v. Cnty. of L.A*., 833 F.3d 1060, 1070–71 (9th Cir. 2016) (en banc).[91] Thus, under 14th Amendment, the due process rights of pre-trial detainees are violated where conditions are objectively unreasonable, or not "rationally related to a legitimate governmental objective" and therefore amount to punishment. *See Kingsley,* 576 U.S. at 389; *Bell v. Wolfish*, 441 U.S. 520 (1974). The motive or subjective intent of the Defendant is irrelevant.

With respect to Art. 26, where conditions of incarceration are so objectively egregious that they rise to the level of cruel or unusual, offending contemporary standards of decency and posing substantial risk of serious harm, then they are also "punishment" as they are no longer "rationally related to a legitimate governmental objective." *Kingsley*, 576 U.S. at 389. Art. 26 demands a remedy for such conditions, regardless of whether correctional officials have the capacity to do anything about them. Indeed, the Supreme Judicial Court has flatly rejected the argument that objectively unconstitutional prison conditions can be tolerated just because prison officials may not have the resources to remedy them. *See Michaud v. Sheriff of Essex Cty*., 390 Mass. 523, 532–

[91] In coming to its holding in Kingsley, the Supreme Court explained that pre-trial detainees may not be subjected to punishment under the 14th amendment, relying on *Bell v. Wolfish*, 441 U.S. 520 (1974), a case about conditions of confinement. *Kingsley,* 576 U.S. at 389. The Court further stated in dicta, "We acknowledge that our view that an objective standard is appropriate in the context of excessive force claims brought by pretrial detainees pursuant to the Fourteenth Amendment may raise questions about the use of a subjective standard in the context of excessive force claims brought by convicted prisoners." *Id*.

33 (1983)("The defendants claim they are 'duty bound' to incarcerate prisoners and have had difficulty raising revenues to install plumbing throughout the jail…this argument has little merit."). *See also In the Matter of McKnight*, 406 Mass. 787, 797 n.9 (1990) ("We have suggested that the unavailability of appropriated funds would not justify the failure of prison officials to stop violating inmates' constitutional rights . . . In such a case, if the authorities lack appropriated funds sufficient to perform all their duties without violating constitutional rights, a cure would be the early release of some inmates.").

Plaintiffs therefore submit that for sentenced prisoners, at least where they seek injunctive relief and not damages, Art. 26 is offended regardless of the subjective state of mind of individual defendant-actors, where conditions they have imposed or permitted are objectively "cruel or unusual in light of contemporary standards of decency which mark the progress of society." *Good*, 417 Mass. at 335. Where Art. 26 is violated, so are Arts. 1, 10, 12, and the 14th Amendment, as pretrial detainees may not be punished at all, let alone cruelly and unusually. *See e.g. Kingsley,* 576 U.S. at 389.

2. Conditions in Massachusetts prisons and jails are objectively cruel and unusual and must be remedied.

Conditions that pose an unreasonable risk of death or serious harm to the health of sentenced prisoners violate constitutional protections. *See Helling v. McKinney*, 509 U.S. 25, 33 (1993) ("It is 'cruel and unusual punishment to hold convicted criminals in unsafe conditions.' It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them.") (citation omitted).[92] Where the population density in a prison system results in the deprivation of basic

[92] *See also Good*, 417 Mass. at 336 ("[A] claim is made out if there is a substantial risk that the inmate will suffer serious harm as a result of the conditions of his confinement."); *Michaud*, 390 Mass. at 532–33 ("An inmate need not wait until actual harm results in order to challenge conditions of confinement as cruel and unusual.").

human needs, the population must be reduced for the prison to comply with constitutional requirements. *See Brown v. Plata*, 563 U.S. 493, 510–11 (2011) ("A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.").

Exposing prisoners to risk of contracting a serious, communicable disease is clearly and objectively a violation of prisoners' rights to reasonable health and safety. *Helling*, 509 U.S. at 33 ("Nor can we hold that prison officials may be deliberately indifferent to the exposure of inmates to a serious, communicable disease on the ground that the complaining inmate shows no serious current symptoms.").[93] Numerous courts have already concluded that COVID-19 poses an unacceptable risk of substantial harm to individuals in detention facilities. *See, e.g., Savino et al. v. Souza,* No. CV 20-10617-WGY, 2020 WL 1703844, at *4 (D. Mass. Apr. 8, 2020) (D. Mass., April 8, 2020) ("In this moment of worldwide peril from a highly contagious pathogen, the government cannot credibly argue that the Detainees face no 'substantial risk' of harm (if not 'certainly impending') from being confined in close quarters in defiance of the sound medical advice that all other segments of society now scrupulously observe."); *Christian A.R. et al. v. Thomas Decker et al.*, 2:20-cv-03600-MCA, Dkt. 26 (D.N.J., April 12, 2020)("Ultimately, '[t]he

[93] *See also Gates v. Collier,* 501 F.2d 1291, 1300 (5th Cir. 1974) (affirming finding of violation where "some inmates with serious contagious diseases are allowed to mingle with the general prison population"); *Randles v. Hester,* 2001 WL 1667821, at *3 (M.D. Fla. June 27, 2001) ("Plaintiff has sufficiently alleged a deprivation of his rights under the Eighth Amendment. He claims he was forcibly exposed by Defendant to a potentially fatal contagion without the benefit of available protective gear. Accordingly, the objective prong is satisfied."); *Joy v. Healthcare C.M.S.*, 534 F. Supp. 2d 482, 485 (D. Del. 2008) ("The Supreme Court has recognized that exposure to contagious diseases may violate the Eighth Amendment if prison officials, acting with deliberate indifference, expose a prisoner to a sufficiently substantial 'risk of serious damage to his future health.' . . . Additionally, inmates may be entitled to relief under the Eighth Amendment where they proved threats to personal safety from the mingling of inmates with serious contagious diseases.") (internal citations omitted).

best way to prevent illness is to avoid being exposed to this virus.' But in truth, avoiding exposure to COVID-19 is impossible for most detainees and inmates.").

As described above, the substantial risk of serious harm presented by COVID-19 in prison and jail environments is clear. The number of infected prisoners and staff increased eightfold between April 5 and April 12, 2020, and continues to grow rapidly. The infection rate inside correctional facilities is outpacing the general population, and in some prisons, such as MCI Framingham, more than 10 percent of women are already infected. Prisoners are unable to socially distance, as nearly all aspects of daily life are conducted in congregate environments, including sleeping, eating, exercise, using the bathroom, taking a shower, and obtaining medical care.

Appropriate preventative measures are impossible to implement to the extent necessary to reduce risk. Few Massachusetts prisoners are provided masks or other PPE, staff are inconsistently using PPE, and prisoners routinely come in contact with shared surfaces and spaces without proper decontamination. Prisoners do not have reliable access to soap, hand sanitizer, and cleaning supplies, and cannot control whether they can maintain a clean cell or common area. Prisons are closed environments where disease can rapidly spread, but they are also open environments because hundreds of correctional and medical staff come and go every day, potentially carrying the disease into and out of the prison, even if they may be asymptomatic.

The threat imposed by the correctional environment is heightened for the many prisoners at high risk for death or serious medical complication from COVID-19 because of age or underlying health conditions. *See Malam v. Adducci,* No. 20-10829, 2020 WL 1809675, at *4 (E.D. Mich. Apr. 9, 2020) ("The Court finds the combination of Toma's age, disability, and continued detention presents a sufficient risk of severe illness or death from COVID-19 such that the analysis in the Court's April 6, 2020 order applies, warranting emergency injunctive relief."). Even young,

healthy prisoners may be at substantial risk of harm. *See Savino,* 2020 WL 1703844, at *7 ("Since COVID-19 is highly contagious and the quarters are close, the Detainees' chances of infection are great. Once infected, taking hospitalization as a marker of 'serious harm,' it is apparent that even the young and otherwise healthy detainees face a 'substantial risk' (between five and ten percent) of such harm.").

As explained above, prison healthcare is notoriously deficient in normal conditions. As COVID-19 spreads through the system, particularly among high-risk populations, the medical system will be stretched beyond its capacity. Shortages of staff, equipment, and available treatment settings will further undermine the ability of prisons to provide humane, minimally adequate care for the sick.

B. Defendants are also in violation of the 8th Amendment to the U.S. Constitution, because they are aware of the risk, and are failing to take reasonable steps to abate it.

The 8th Amendment has a subjective as well as an objective component. State officials are liable for denying humane conditions of confinement only if they know "that inmates face a substantial risk of serious harm and disregard[] that risk by failing to take reasonable measures to abate it." *Farmer,* 511 U.S. at 847. Defendants are deliberately indifferent where they have taken action, but that action is inadequate in light of the risk faced. *See Harris v. Angelina Cty., Tex.*, 1 F.3d 331, 335-36 (5th Cir. 1994) (rejecting the County's argument that it had done everything in its power to relieve overcrowding where there were mechanisms to facilitate releases that it had not sufficiently used.); *see also Savino,* 2020 WL 1703844, at *7 (the question with respect to deliberate indifference is "whether the government is taking reasonable steps to identify those Detainees who may be released in order to protect everyone from the impending threat of mass contagion").

Although Plaintiffs submit that a prison official's subjective intent makes no difference under art. 26, Defendants' failure to adequately address the COVID-19 crisis easily qualifies as "deliberate indifference." In equitable cases, defendants are under ongoing obligation to correct constitutional deficiencies during the pendency of the suit. *See Helling,* 509 U.S. at 36 ("On remand, the subjective factor, deliberate indifference, should be determined in light of the prison authorities' current attitudes and conduct."). Courts have routinely rejected defendants' claims they have responded the best they can in good faith as constrained by their resources, where those good faith efforts have failed to alleviate cruel and unusual conditions. *See, e.g., Michaud,* 390 Mass. at 532–33; *Rozecki v. Gaughan*, 459 F.2d 6, 7–8 (1st Cir. 1972) ("Whether personal good faith of the individual defendants could constitute a defense to monetary damages is not before us. We can only say that it cannot be thought a defense against equitable relief .). Further, the individual Defendants here are sued in their official capacities, and thus their personal intentions are irrelevant. *Surprenant v. Rivas,* 424 F.3d 5, 20 (1st Cir. 2005) (rejecting defendant's claim that he was not personally deliberately indifferent because he was "sued in his official capacity, [] merely a proxy for the county").

1. Defendants' mitigation efforts are woefully insufficient.

Regardless, the mitigation and containment measures Defendants have adopted fall staggeringly short of what is needed to reasonably abate the substantial risk of serious harm from COVID-19. Plaintiffs are routinely exposed to poor hygiene, filthy living conditions, and sanitation practices that compound the inherent risk of COVID-19 in a congregate environment.[94]

[94] In *Christian A.R., et al*., the Court ordered ICE detainees to be released in spite of Defendants efforts' to mitigate risks through measures including indefinite suspension of intakes, social visits and tours, locking prisoners into their cells for all but 30 minutes a day, daily sanitation efforts, and isolation and quarantine protocols. Dkt. 26 at pp. 8-11. The Court found, "Petitioners' underlying medical conditions, their direct accounts of the conditions under which they live, and the undisputed fact that COVID-19 has spread through the Facilities demonstrate that even under the

The Department of Public Health (DPH) inspects all Massachusetts correctional facilities twice per year to assess compliance with the health and sanitation standards set forth in 105 CMR 451. These reports show that nearly every prison and jail in the Commonwealth consistently fail to meet these standards.[95] For example, a recent DPH inspection of the Massachusetts Treatment Center (MTC) found:

> Throughout the facility, bathrooms and shower areas were observed to be poorly maintained resulting in unsanitary conditions. The CSP is concerned with the increased risk of disease transmission with the high number of inmates being exposed to such unsanitary conditions.[96]

Not surprisingly, COVID-19 is rampant at the MTC, with 41 cases and four deaths as of April 13, 2020. Failure to meet the DPH standards shows a disregard for prisoners' health and safety under normal conditions. Now, during the middle of a deadly pandemic, it is unconscionable

On April 3, 2020, the Department of Correction had to resort to a system-wide lockdown, which means that prisoners are confined to their cells or dorms for at least 23 hours daily. This is not a sustainable or effective response to the inevitable spread of COVID-19. Lockdown conditions will take too great a toll on the physical and mental health of vulnerable prisoners since they increase stress and tension, cause psychological harm, and deprive prisoners of the fresh air and exercise that is vital to maintain their health.[97] Indefinite lock-ins will also not be effective at controlling the virus, since they require officers and medical staff to go cell to cell all day long, to

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improved protocols implemented at the Facilities, "there are certain realities that neither [the Facilities] nor ICE can overcome."" *Id.* at p. 15 (citing *Rafael L.O. v. Tsoukaris*, No. 20-3481, 2020 WL 1808843, at *8 (D.N.J. Apr. 9, 2020).

[95] *See Correctional facilities - Community Sanitation*, *Inspection Reports*, Mass.gov, https://www.mass.gov/lists/correctional-facilities-community-sanitation#inspection-reports-.

[96] See Letter from Patrick Wallace, Environmental Health Inspector, DPH, to Lisa Mitchell, Superintendent of MTC (Sept. 26, 2019) DPH September 26, 2019 report at 22, available at https://www.mass.gov/doc/massachusetts-treatment-center-bridgewater-september-17-2019/download.

[97] *See* David H. Cloud, et al., Public Health and Solitary Confinement in the United States, 105 Am. J. Public Health (Jan. 2015)("[n]early every scientific inquiry into the effects of solitary confinement over the past 150 years has concluded that subjecting an individual to more than 10 days of involuntary segregation results in a distinct set of emotional, cognitive, social, and physical pathologies.").

bring food and medicine. Monitoring the health of prisoners in lockdown is also a grave concern since a patient's condition can worsen dramatically in a matter of hours,[98] and the State Auditor found that it often takes DOC over a week to respond to sick-call requests.[99] DOC has no effective plan to address the inherently high risk of COVID-19 transmission once the lock down ends.

2. Defendants have failed to take virtually any reasonable measures to reduce the prison population.

Courts, public health experts, and corrections professionals agree that a significant decrease in the incarcerated populations is essential to combat the spread of COVID-19 among prisoners, staff, and the greater community. Reducing the incarcerated populations serves four critical public health aims: (1) targeting prisoners who are at elevated risk of suffering from severe symptoms of COVID-19; (2) allowing those who remain incarcerated to better maintain social distancing and avoid other risks associated with forced communal living; and (3) helping to "flatten the curve" of COVID-19 cases among incarcerated populations and limit the impact of transmission both inside correctional facilities and in the community; and (4) reducing the burden on the correctional system in terms of treating critically ill patients, as well as the burden on the community healthcare system where they may have to be hospitalized. Defendants must act to reduce the prisoner population sufficiently to ensure social distancing in prisoners' sleeping, eating, and recreation arrangements, as well as to permit personal hygiene in compliance with CDC guidelines.

Other state systems and the federal system have recognized and acted upon the immediate and pressing necessity of reducing prisoner populations. By contrast, Massachusetts officials have

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[98] Rich Decl. ¶ 18.

[99] Suzanne Bump, Office of the State Auditor, *Massachusetts Department of Correction Official Audit Report* 11-12 (Jan. 9, 2020). The Centers for Disease Control (CDC) did not include wide scale lockdowns in its recommendations for correctional facilities. It does recommend that prisons and jails "Implement social distancing strategies to increase the physical space between incarcerated/detained persons (ideally 6 feet between all individuals, regardless of the presence of symptoms)."" available at: https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-correctional-detention.pdf p. 11 (last accessed April 15, 2020).

failed to effectuate the release of prisoners despite their clear authority to do so. The Governor has refused to act on his near plenary emergency powers when it comes to the health and safety of prisoners, publicly confirming his intention to stick with a failing status quo. There have been no commutations, no furloughs, no increase in earned good time deductions, no releases by DOC to home confinement, little if any increase in the use of medical parole, and no effort by the parole board to streamline the parole process, speed up release of people granted parole, or modify eligibility for release in light of COVID-19. The parole board has in fact been so recalcitrant it has refused to release hundreds of prisoners who are already approved for parole. Indeed, even in the face of a Court order which provided presumptive release to some pre-trial detainees and also urged the DOC and the parole board to work together to effectuate releases,[100] the prison population decreased by only 111 between April 5-13, and the jail population actually *increased* by some 600 people.[101]

Defendants' failure to address the unconstitutional conditions in Massachusetts prisons and jails necessitates intervention from the Court. The Court should be guided by the principle that all prisoners must be housed under conditions where they do not have to sleep, eat, recreate, or receive medical care within six feet of another person, and where they can safely obtain necessary medical care. More specifically, Plaintiffs ask the Court to order Defendants to reduce the population to the extent required to ensure that no prisoners be housed in any cell or other space that does not comply with the Massachusetts Department of Public Health Standards governing minimum cell size or floor space. *See* 105 CMR 451.320 ("Each cell or sleeping area in an existing facility should contain at least 60 square feet of floor space for each occupant, calculated on the

[100] *See Comm. for Pub. Counsel Servs. v. Chief Justice of Trial Court*, No. SJC-12926, 2020 WL 1659939, at *2-3 (Mass. Apr. 3, 2020).
[101] https://www.mass.gov/doc/sjc-12926-special-masters-weekly-report-4132020/download.

basis of total habitable room area, which does not include areas where floor-to-ceiling height is less than eight feet."); *see also* 105 CMR 451.321; 105 CMR 451.322. Although these standards are "recommended" rather than required, in a time where close contact with others is perilous, the Court should deem them mandatory.[102]

Plaintiffs also request that the Court order the Defendants to use all mechanisms at their disposal to effectuate immediate releases to reduce the population to a safe level, including but not limited to parole, commutation, clemency, furlough, medical parole, home confinement, good conduct deductions, and the Governor's emergency plenary power. Prisoners in the Medically Vulnerable subclass who are at highest risk of death or serious medical complication from COVID-19 due to age and medical condition should be prioritized for release. This should include prisoners over 50 years of age, which is widely considered to be geriatric for prisoners,[103] those who have any of the medical conditions considered high risk by the CDC: people with chronic lung disease or moderate to severe asthma; people who have serious heart conditions; people who

[102] The DPH standards largely reflect the Design Capacity of each institution. Design capacity is the appropriate yardstick because it refers to the number of prisoners the facility was designed to hold, whereas "operational capacity," merely reflects DOC's judgment about how many prisoners it can manage in the facility. Design Capacity is also what DOC is obligated to compare with the actual population in its statutorily mandated overcrowding reports. G.L. c. 799, § 21. The Supreme Court also relied on design capacity in ordering prisoner releases to address overcrowding in California. *See Brown v. Plata*, 563 U.S. 493, 510–11 (2011). As a practical matter, the main difference is that the Operational Capacity reflects DOC's decision to double- bunk cells that were designed for one person, and house more people in a dorm than it was built to hold.

[103] The prison population is subject to "accelerated aging" and is generally considered old at age 50 because living conditions inside prisons are hard on physical and emotional health. *See* BMC Decl ¶ 8*;* Maurice Chammah, The Marshall Project, "Do You Age Faster in Prison?" (Aug. 24, 2015) available at: https://www.themarshallproject.org/2015/08/24/do-you-age-faster-in-prison; Brie A. Williams, MD, James S. Goodwin, MD, Jacques Baillargeon, PhD, Cyrus Ahalt, MPP, and Louise C. Walter, MD "Addressing the Aging Crisis in U.S. Criminal Justice Healthcare" available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3374923/ (""Accelerated aging" takes into account the high prevalence of risk factors for poor health that are common in incarcerated persons, such as a history of substance abuse, head trauma, poor healthcare, and low educational attainment and socioeconomic status.4,5 While empirical studies of accelerated aging in prisoners are lacking, research shows that incarcerated individuals age 50 or older are significantly more likely to suffer from one or more chronic health conditions or disability than their community-dwelling counterparts.") (last accessed April 15, 2020).

are immunocompromised; people with severe obesity; people with diabetes; people with chronic kidney disease undergoing dialysis; and people with liver disease.[104]

C. Continued incarceration of prisoners civilly committed pursuant to G.L. c. 123, § 35 is unconstitutional under the 14th amendment to the U.S. Constitution and Articles 1, 10, and 12 of the Massachusetts Declaration of Rights.

Prisoners incarcerated pursuant to G.L. c. 123, § 35 ("Section 35"), who are confined pursuant to a civil order and are not serving a sentence for any crime, are entitled to due process protection. *See Zadvydas v. Davis*, 533 U.S. 678, 690 (2001) ("Freedom from imprisonment—from government custody, detention, or other forms of physical restraint—lies at the heart of the liberty that [the Due Process] Clause protects."); *Youngberg v. Romeo*, 457 U.S. 307, 315, 102 S. Ct. 2452, 2458, 73 L. Ed. 2d 28 (1982). Their continued confinement during the COVID-19 crisis violates these Constitutional protections in three ways: (1) it violates their right to be free from unreasonable conditions that place their health and safety at risk; and (2) confinement without treatment bears no relation to the treatment purpose of their commitment. Accordingly, Plaintiffs ask that the Commissioner exercise her authority under Section 35 to release immediately all Section 35 patients at MASAC or Hampden County, and to ensure they receive the DPH case management services, to which they are entitled under Section 35, upon their release. Alternatively, the superintendent could use her authority under Section 35 to transfer patients to a DPH licensed or approved facility where treatment is available.

[104] Centers for Disease Control and Prevention, " People who are at higher risk for severe illness" available at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html (last accessed April 15, 2020).

1. Section 35 detainees face unsafe and inhumane conditions.

Due process requires safe conditions for those held pursuant to a civil order. *Youngberg v. Romeo*, 457 U.S. 307, 315–16 (1982) ("If it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily committed—who may not be punished at all—in unsafe conditions."). The imminent risk of substantial harm to incarcerated Section 35 patients is amply described above: a vulnerable population, subject to Hepatitis C and other diseases, cycles frequently in and out of a crowded, unsanitary facility. Although correctional staff and vendors who come and go daily are screened before entry, they are not tested for COVID-19, and the prevalence of asymptomatic carriers makes transmission of COVID-19 inevitable.

2. The incarceration of Section 35 patients bears no relation to the purpose of confinement.

In addition to requiring safe conditions, "due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." *Jackson v. Indiana,* 406 U.S. 715, 738 (1971). While both DOC policy and DPH regulations[105] mandate that persons committed under Section 35 be offered a minimum of four hours of treatment every day, patients at MASAC are now receiving no treatment at all. Since Section 35 provides that the confinement is "for the purpose of inpatient care for the treatment of an alcohol or substance use disorder," their incarceration does not serve the purpose for which they were committed, and they must be released. *See Thompson v. Com*., 386 Mass. 811, 816, 438 N.E.2d 33, 36 (1982) ("[O]nce the conditions justifying confinement cease to exist, the State's power to confine terminates, and the person is entitled to be released[.]"); *Doe v. Gaughan*, 808

[105] *See* 105 CMR 164.131(D)(2) ("[T]he licensee shall provide the patient with at least four hours of service programming each day.").

F.2d 871, 878–79 (1st Cir. 1986) ("Conceivably, although we do not rule on the question, if Bridgewater were truly indistinguishable from a penitentiary, the mere fact that it prevented patients from doing harm would be insufficient, constitutionally, to justify incarceration there.").

Civil commitment to a correctional facility is also inconsistent with the exercise of professional judgment as required by *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982). No professional would recommend that an SUD patient be subjected to incarceration in an unsafe facility that does not afford treatment.[106] Indeed, even absent COVID-19, the trauma and stigma of incarceration itself are so contrary to SUD treatment principles that imprisoning patients violates *Youngberg*.[107] Furthermore, with COVID-19, federal guidance states with regard to *any* residential SUD treatment, "inpatient/residential treatment has not been shown to be superior to intensive outpatient treatment. Therefore, in these extraordinary times of risk of viral infection, it is recommended that intensive outpatient treatment services be utilized whenever possible."[108] Accordingly, the continued incarceration of men civilly committed under Section 35, instead of quickly discharging them with DPH services, represents a "substantial departure from accepted professional judgment" in violation of Plaintiffs' due process rights. *Youngberg*, 457 U.S. at 314.

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[106] While the Commonwealth has wide discretion to define the precise contours of appropriate treatment in consultation with medical professionals, it does not have the authority to do what it is doing here—imprisoning people and denying them any treatment whatsoever. *Contrast Com. v. Davis*, 407 Mass. 47, 49–50 (1990) (civil detention not unlawful where "clear testimony at the hearing that the treatment center offers professionally supervised programs designed to aid in the rehabilitation of [prisoners]"); *Doe v. Gaughan*, 808 F.2d 871, 885 (1st Cir. 1986) (civil detention not unlawful where staff "provide[d] adequate treatment to Bridgewater patients" including "innovative treatment techniques" and consultations with "nationally known psychiatric experts").

[107] State policymakers have recognized the harm of incarceration. In 2016 the Legislature repealed the provisions in Section 35 that allowed women to be committed to a correctional facility. In 2019, the Commission established by Section 104 of the Acts of 2018 to evaluate Section 35 recommended that the "Commonwealth should prohibit civilly-committed men from receiving treatment for addictions at any criminal justice facility." *Section 35 Commision Report* at 7 (July 1, 2019), available at https://www.mass.gov/doc/section-35-commission-report-7-1-2019/download.

[108] *See Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic*, Substance Abuse and Mental Health Services Administration ("SAMHSA") (March 20, 2020), available at https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf.

II. Without the relief sought, plaintiffs will suffer irreparable harm.

Numerous courts have found that the threat of COVID-19 in carceral settings subjects prisoners to irreparable harm. *See, e.g., Christian A.R. et al.,* Dkt. 26 (collecting cases)("Against this backdrop, Petitioners have demonstrated irreparable harm should they remain in confinement." *Rafael L.O.*, 2020 WL 1808843, at *8; *Thakker*, 2020 WL 1671563 at *7 ("[C]atastrophic results may ensue, both to Petitioners and to the communities surrounding the Facilities."); *see also Hope v. Doll*, No. 20-562 (M.D. Pa. Apr. 7, 2020) ("We cannot allow the Petitioners before us, all at heightened risk for severe complications from COVID-19, to bear the consequences of ICE's inaction."); *Coronel*, 2020 WL 1487274, at *8 (finding that "[d]ue to their serious underlying medical conditions" and their placement in immigration detention, where they are "at significantly higher risk of contracting COVID-19," the petitioners "face a risk of severe, irreparable harm")").

Condemning prisoners to remain incarcerated in veritable Petri dishes of infection is causing ongoing, severe, and irreparable harm. Every day that prisoners remain incarcerated without substantial reduction in the population, including release of highly vulnerable populations, they are at increasing risk of serious illness and death as the result of infection from COVID-19. The highly contagious nature of COVID-19, combined with asymptomatic transmission, virtually guarantees spread throughout the correctional system. Effective screening to prevent introduction into prisons and jails is impossible, and prisoners cannot take effective preventative measures. Medical needs are already beginning to outstrip resources, leading to impossible and inequitable decisions about who will live and who will die during this pandemic. The serious illness and death that will occur if substantial and immediate action is not taken cannot be later repaired.

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III. An injunction will not harm the Defendants, and is in the public interest.

As the SJC has recognized, "an outbreak [of COVID-19] in correctional institutions has broader implications for the Commonwealth's collective efforts to fight the pandemic" because it "will further burden the broader health care system that is already at risk of being overwhelmed." *Committee for Pub. Counsel Servs. v. Chief Justice of the Trial Court,* No. SJC-12926, 2020 WL 1659939, at *4 (Mass. Apr. 3, 2020). The Court also saw the danger that prison contagion will spread through correctional, medical and other staff entering prisons and jails daily and "risk bringing infections home to their families and broader communities." *Id*. That danger is now at our doorstep. During the week that began two days after the Court's Opinion, from April 5 to 12, identified COVID cases grew more than eightfold among prisoners, staff and vendors, from 30 to 243. There can be no doubt that many more unidentified cases are already in the prison population, especially given limited or non-existent testing.[109] Without timely, substantial action, a disaster is in the making. A grant of preliminary relief is mandated by the public interest. *See Hull Mun. Lighting Plant,* 399 Mass. at 648.[110]

In considering preliminary relief, the Court must consider whether harm to the plaintiffs outweighs the defendants' probable harm. *See Mass. CRINC*, 392 Mass. at 87-88. In this case, the Defendants are the guardians of the public interest as well as the custodians of the state's prisoners, and they share an interest in limiting the spread of this deadly disease. Plaintiffs do not seek the

[109] See Special Master's Weekly Report, April 13, 2020; Golan Decl. ¶ 9; Rich Decl. ¶ 13.

[110] Further, there is a "strong public interest in ensuring that the detainees of correctional facilities are treated in a human fashion." Mattsen v. Massimiano, No. 78-cv-2454-F, 1983 U.S. Dist. LEXIS 11891, at *12 (D. Mass. Nov. 8, 1983) (citing Preiser v. Newkirk, 422 U.S. 395, 402 (1974)). And "[i]t is always in the public interest to prevent the violation of a party's constitutional rights." Jackson Women's Health Org. v. Currier, 760 F.3d 448, 458 n.9 (5th Cir. 2014) (quoting Awad v. Ziriax, 670 F.3d 1111, 1132 (10th Cir. 2012)).

release of prisoners likely to cause harm in the community. Rather, they seek population reductions sufficient to allow for reasonably safe conditions in all correctional facilities primarily by releasing elderly and medically vulnerable prisoners whose lives are endangered and who do not pose a substantial threat to public safety. We cannot say with certainty that released prisoners will commit no infractions; however, fears about the risk to public safety may be exaggerated. It is well known that people largely "age out" of crime,[111] meaning prisoners over the age of 50 simultaneously are a low risk to public safety and at high risk of serious harm from COVID-19. This is even true for prisoners convicted of violent crimes. For example, fewer than 1 percent of such prisoners over age 55 —the age group most seriously threatened by COVID-19—are re-incarcerated for any new crime in the three years after release.[112] As a society we have moved toward a more balanced understanding of the harm of over-incarceration and taken steps to reduce reliance on prison, as with the Criminal Justice Reform Act of 2018.[113] COVID-19 requires us to re-examine that calculus once more. No action is without risk, but inaction now carries far more serious risks.

Even prisoners who experience homelessness or have substance use disorder are safer released than incarcerated—and less likely to spread infection. As described *supra*, under current conditions prisons can neither provide adequate preventive measures nor can they adequately identify, isolate and quarantine those suspected or identified as having COVID-19. In contrast,

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[111] *See* Ulmer, Steffensmeier; The Age and Crime Relationship, available at: https://www.sagepub.com/sites/default/files/upm-binaries/60294_Chapter_23.pdf (last accessed April 16, 2020).

[112] *See* Prescott, Pyle, Starr; "It's Time to Start Releasing Some Prisoners with Violent Records" (April 13, 2020) available at: https://slate.com/news-and-politics/2020/04/combat-covid-release-prisoners-violent-cook.html?utm_source=The+Marshall+Project+Newsletter&utm_campaign=8bb8cf76b0-EMAIL_CAMPAIGN_2020_04_15_11_51&utm_medium=email&utm_term=0_5e02cdad9d-8bb8cf76b0-119447241 (last accessed April 16, 2020). In general, people convicted of violent and sexual offenses are among the least likely to be rearrested. *See* Prison Policy Initiative, Mass Incarceration: The Whole Pie 2020, available at: https://www.prisonpolicy.org/reports/pie2020.html (last accessed April 16 2020).

[113] Acts of 2019, Chapter 69.

numerous government and non-governmental agencies have expanded services and established a network of care to safely provide shelter, food, healthcare, and other necessities, as well as substance use disorder treatment, to homeless prisoners—a network that stands ready to receive those released.[114]

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that this Court hold an emergency hearing and allow their Motion for Preliminary Injunctive Relief.

Dated: April 17, 2020

Respectfully Submitted,

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[114] See BMC Decl. ¶¶ 16-23.

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Exhibit 1

Declaration of Dr. Josiah Rich, MD, MPH

1. I am a doctor duly licensed to practice medicine in the state of Rhode Island.

2. I am currently Professor of Medicine and Epidemiology at The Warren Alpert Medical School of Brown University, and the Director and Co-founder of The Center for Prisoner Health and Human Rights at The Miriam Hospital.

3. I have been a practicing Infectious Disease Specialist since 1994. I provide clinical care at The Miriam Hospital Immunology Center, as well as at the Rhode Island Department of Corrections, where I care for prisoners with HIV infection and addiction and also work in the correctional setting doing research.

4. My primary field and area of specialization and expertise is in the overlap between infectious diseases and illicit substance use, the treatment and prevention of HIV infection, and the care and prevention of disease in addicted and incarcerated individuals. I am an elected member of the National Academy of Medicine, and I have served as an expert for the National Academy of Sciences, the Institute of Medicine, and many others. I have also been appointed by Rhode Island Governor Gina Raimondo to the Overdose Prevention and Intervention Task Force Expert Team. I have published over 200 peer-reviewed publications, predominantly in the overlap between infectious diseases, addictions, and incarceration.

5. The matters that I discuss below are proceeding at a rapid pace across the country. I have published about these urgent concerns in the New England Journal of Medicine, the Washington Post, and elsewhere. I attach copies of those articles to this affidavit.

The extreme challenges Covid-19 poses for Massachsetts prison system

6. As we are quickly seeing throughout the United States and the world, highly transmissible novel respiratory pathogens such as SARS-CoV-2 (the virus that causes Covid-19) create a perfect storm for correctional settings.

7. First, correctional settings are ideal for rapid spread of viruses that are transmitted person-to-person, especially those passed by droplets through coughing and sneezing. When

people must share dayrooms, bathrooms, showers, and other common areas, the opportunities for transmission are great. And while there continues to be disagreement about whether SARS-CoV-2 is an airborne virus, in the context of limited information, we must assume that it is. In that case, the poor ventilation systems within correctional facilities will ensure maximal opportunities for transmission.

8. When viruses are transmitted from person to person, the best initial strategy is to practice social distancing. Yet social distancing is extremely challenging in correctional settings. Even when facilities are locked down and use of common space is limited, there is inevitably frequent contact among prisoners, and especially between prisoners and staff. Even a quick cell change or shower involves multiple opportunities for contact with others. Accordingly, no matter what measures we take, correctional facilities are congregate settings that are poorly designed to prevent the inevitable rapid and widespread dissemination of this virus.

9. I understand that Massachusetts, like other systems, has suspended visitation and facility transfers, and has taken certain other measures to try to limit infection. Irrespective of these interventions, however, infected persons -- especially staff members -- will inevitably continue to enter correctional settings. It is essential to understand that, despite being physically secure, jails and prisons are not isolated from the community. Rather, the boundaries between correctional institutions and the communities in which they sit are extremely porous. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, population turnover means that people cycle between facilities and communities. And people often need to be transported to and from facilities, including for disciplinary and/or quarantining purposes. All of this is problematic in the context of this pandemic: While entry temperature checks may be effective screening mechanisms for symptomatic infections, they are ineffective with SARS-CoV-2 due to high rates of asymptomatic or pre-symptomatic infection.

10. Once COVID-19 enters a population, its asymptomatic transmission makes it

extremely difficult to control. Many appear to develop very mild symptoms or none at all, and so spread the disease without knowing. And recent findings indicate that those infected are most contagious shortly before or at the onset of symptoms.

11. As the virus enters a prison setting, where a large group of people live in close proximity and frequently touch the same surfaces, invisible transmission by asymptomatic carriers will grow rapidly, which cannot be prevented by isolation and quarantine of those who are symptomatic.

12. Moreover, there are reduced prevention opportunities in prisons. During an infectious disease outbreak, free people can protect themselves by washing hands. Correctional facilities do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. These facilities are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for both people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but bleach is often unavailable, and cleaning agents used by correctional settings may not have been shown to effectively neutralize this virus, particularly in the diluted form commonly employed. Even where sanitizer, soap, and water are available by policy, as I understand they are in the Massachusetts Department of Correction and in at least some Massachusetts county facilities, full compliance with the rigorous measures necessary to prevent spread of COVID-19 is a difficult and likely insurmountable challenge in a correctional setting, where implementation depends on a large number of correctional and other staff as well as inmate workers. Indeed, there may be a lack of people available to perform necessary cleaning procedures, which will be exacerbated as more staff fall ill and movement is restricted.

13. I am particularly concerned with the continued use of dormitory settings in both the Massachusetts Department of Correction and county jails. Sanitation and the physical distancing necessary to prevent contagion are impossible in a dormitory setting. While lockdown in two-

person cells may limit transmission within the broader population, for those unlucky enough to have an infected cellmate the risk of transmission is extremely high. In a shared cell, avoiding contact through air or shared surfaces is impossible.

14. A containment strategy for this virus requires both widespread screening and that people who are symptomatic be immediately isolated. It also requires that correctional officers and caregivers have access to personal protective equipment, including gloves, masks, gowns, and face shields. The most recent recommendations from the Centers for Disease Control also indicate that any population of potentially infected people (such as any of us going to the grocery store, or prisoners coming into contact with one another) should wear at least a cloth mask. Yet correctional settings are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility where an outbreak is occurring. To my knowledge, while many or most staff in the Department of Correction now have access to masks and gloves, prisoners themselves do not have masks. Even where PPE is available, in a correctional setting it is impossible to ensure full compliance with required usage. Furthermore, correctional settings are also unlikely to be able to perform the widespread screening and contact-tracing necessary to prevent further infection.

15. All of the above is compounded by the fact that half of all incarcerated people in the United States have at least one chronic disease. With limited ability to protect themselves and others by self-isolating, thousands of susceptible people are at heightened risk for severe illness.

Lessening the spread of Covid-19 requires urgent, scaled-up decarceration.

16. The more preemptive measures taken by legal, public health, and correctional health partnerships, the lighter the burden the correctional facilities and their surrounding communities will bear. The global context offers some precedent here. Iran, for example, responded to its escalating pandemic by releasing 70,000 prisoners, something that may have helped "flatten the curve" of that country's epidemic. Conversely, failure to calm incarcerated populations in Italy led to widespread rioting in Italian prisons.

17. At minimum, Massachusetts must be prepared to isolate and separate incarcerated persons who are infected and those who are under investigation for possible infection from the general prison population; to hospitalize those who are seriously ill; and to cope with the high burden of disease and severe staff shortages that are likely to come. Given the limited number of beds appropriate for quarantine and isolation, this is a difficult task which will become only more difficult and likely impossible as the infection spreads. Local hospital capacity will also become overwhelmed.

18. Already, reports indicate that prisoners suspected or identified as positive for the virus are being held in at least three "restrictive housing" or solitary confinement units in the DOC. This is of grave concern, as the design and staffing of such units do not provide for the frequent monitoring that patients with this virus require. A patient's condition can worsen dramatically in a matter of hours. Further, there are reports that some RH units hold both infected and non-infected prisoners, albeit in different sectors or tiers, raising concerns that the infection could spread through correctional officers who re-use handcuffs between prisoners, food carts, telephones that are wheeled from cell to cell, etc.

19. Even where feasible, isolation and quarantine will not be enough. It is imperative to scale up efforts to "decarcerate," or release, as many people as possible, including for consideration those sentenced as well as those detained on bail. Each person needlessly infected in a correctional setting who develops severe illness will be one too many. And public safety will be at even greater peril if we fail to mitigate risks associated with confining too many people in correctional facilities during a pandemic.

20. It is my strong opinion that urgent decarceration is imperative to flatten the curve of Covid-19 cases among incarcerated populations and to limit the impact of transmission both inside correctional facilities and in the community. The abrupt onset of severe Covid-19 infections among incarcerated individuals will require mass transfers to local hospitals for intensive medical and ventilator care -- highly expensive interventions that are already in very short supply. Each

severely ill patient coming from the Department of Correction who occupies an ICU bed may mean others may die for inability to obtain care. These are preventable infections, and we should act to prevent them.

Signed under the pains and penalties of perjury
this 14th day of April, 2020.

/s/ Josiah Rich

_____

Josiah Rich, MD, MPH

Exhibit 2

Declaration of Yoav Golan, M.D.

I, Yoav Golan, hereby declare the following:

1. I am an attending physician and infectious disease specialist with the Division of Geographic Medicine and Infectious Diseases of Tufts Medical Center, and also Associate Professor of Medicine at Tufts University School of Medicine.

2. From June 2001 to December 2014 I provided HIV care at the Suffolk County House of Correction (HOC). In that capacity I became familiar with conditions and practices in the HOC and generally familiar with prevailing correctional practices and procedures. I worked closely with the contracted health care provider at the HOC.

The standard of care for COVID-19 prevention is not possible in prison.

3. As a specialist in infectious disease, I am familiar with the mechanisms through which the SARS-CoV-2 ("COVID") virus is transmitted. Those infected can spread the disease for 1-2 days before developing symptoms, and evidence is emerging that many infected patients never develop symptoms but still transmit the disease to others.

4. A state of emergency has been instituted in all states, and a COVID prevention "standard of care" (SOC) has been established and clearly defined. This SOC is practiced as the current best way to protect society, individuals within society, and particularly vulnerable individuals (those at higher risk of developing severe COVID and dying of it). Prevention is centered around "social distancing," the use of masks and gloves, as well as identification of cases and exposures leading to quarantine.

5. Social distancing or physical distancing is "a set of non-pharmaceutical interventions or measures taken to prevent the spread of a contagious disease, in this case COVID, by maintaining a physical distance between people and reducing the number of times people come into close contact with each other."[1] The two pillars of social distancing are the prevention of gathering and the reduction of persons' interactions. Out of prison, social distancing is kept by requiring that individuals or families stay confined to their residences.

[1] Harris, Margaret; Adhanom Ghebreyesus, Tedros; Liu, Tu; Ryan, Michael "Mike" J.; Vadia; Van Kerkhove, Maria D.; Diego; Foulkes, Imogen; Ondelam, Charles; Gretler, Corinne; Costas (2020-03-20). "COVID-19" (PDF). World Health Organization. Archived (PDF) from the original on 2020-03-25. Retrieved 2020-03-29; Hensley, Laura (2020-03-23); "Social distancing is out, physical distancing is in—here's how to do it". Global News. Corus Entertainment Inc. Archived from the original on 2020-03-27. Retrieved 2020-03-29; Venske, Regula (2020-03-26). Schwyzer, Andrea (ed.). "Die Wirkung von Sprache in Krisenzeiten" [The effect of language in times of crisis] (Interview). NDR Kultur (in German). Norddeutscher Rundfunk. Archived from the original on 2020-03-27. Retrieved 2020-03-27; Johnson, Carolyn Y.; Sun, Lena; Freedman, Andrew (2020-03-10). "Social distancing could buy U.S. valuable time against coronavirus: It's a make-or-break moment with coronavirus to test one of the most basic—but disruptive—public health tools". The Washington Post. Archived from the original on 2020-03-27. Retrieved 2020-03-11.

Gatherings are strongly discouraged. Interactions are minimized by closure of non-essential businesses and public places.

6. These measures are not possible in prison, where multiple prisoners occupy a limited unit space, residing within a short distance from each other, often in multi-person cells. In prison life, there are multiple daily interactions, which include the usage of public showers, collection of medicines, receiving meals, and recreation. Even with the best efforts, the ability to maintain social distancing in a tight-spaced, closed unit is limited.

7. Residents of Massachusetts are guided to use masks in public spaces. In prisons, current use of masks and gloves is partial. While officers and other prison staff have increasingly been using masks, prisoners in most Massachusetts prisons have not been supplied with masks. Given the extreme shortage of masks and the need to replace them when damaged or used for a period (typically- for one day), it is unlikely that prisoners will be supplied with masks soon enough. Given that prisons, and specifically prison units, are public places, lack of masks leaves prisoners vulnerable to infection.

8. Identification of cases is a critical step in preventing transmission and containing an outbreak. It requires enough medical attention to raise the suspicion of a case and the ability to test, to confirm the infection. Adequate testing also requires that test results be provided within hours, rather than days. This is because tested individuals require quarantine until test results become available.

9. Given limited medical resources in Massachusetts prisons, during a COVID prison outbreak there will be insufficient ability to evaluate many prisoners in a short period of time. Tests are not performed in-house, which means that results take days to come back. Data so far indicate that testing in prison has been extremely limited. As of April 12, 2020, the number of COVID tests of all Massachusetts prisoners was 310, and 138 had tested positive,[2] meaning that slightly over half (2.3:1) of those tested were positive. In contrast, in the non-incarcerated community about one-fifth of all tests are positive.[3] The much higher positive rate in prisons and jails is consistent with severely restricted ability to test, with testing limited to those with typical and substantial symptoms, missing many with atypical or less severe symptoms (as many as 50% of COVID-infected may manifest atypical, testing-non-qualifying symptoms). As a result, COVID infections are far more likely to go unrecognized in prison than in the general population, leading to increased risk of COVID transmission in prisons.

10. Even if an immediate change is implemented, making COVID testing unrestricted in Massachusetts prisons and test results available within hours, such a change will lead to increased case recognition and need for quarantine of COVID cases within prisons. Quarantine requires the ability to separate COVID suspected or infected from COVID non-

[2] *See* https://data.aclum.org/sjc-12926-tracker/

[3] In Massachusetts, there have been 24,475 COVID positives out of 116,730 tests; in the entire U.S. there have been 556,044 positives out of 2,805,892 tested. https://coronavirus.jhu.edu/map.html

infected prisoners. When only a small number of COVID patients exists, quarantine in infirmary rooms would solve the problem. However, once the limited beds in each prison are occupied, entire prison units must be dedicated to quarantine. As most Massachusetts prisons are close to their design capacity, relying on dormitories and double-celled units, the ability to effectively quarantine all COVID infected prisoners will be limited. Incomplete quarantine will lead to increased COVID transmission within prisons.

The course of COVID-19 in Massachusetts prisons and jails and its impact on Massachusetts hospitals

11. Since April 5, 2020, the number of recognized COVID cases among prisoners, staff, and vendors in Massachusetts prisons and jails has increased from 30 to 243 and, at the current time, continues to show a sharp increase.[4] While the incidence in the general population of Massachusetts is approximately 0.39%, already, as of April 12, the incidence among prisoners in the Massachusetts Department of Correction was over 2.7 times higher, at 1.06% (84 out of 7946). Different prisons are at different stages of progression. At the DOC's MCI-Framingham, already an alarming 10.1% of prisoners have tested positive, over 26 times higher than the general public. At the Massachusetts Treatment Center, 7.2% have developed COVID, a rate 18.5 times higher than the general public.[5]

12. While studies of COVID transmission trends in prisons are limited, we know a great deal of prison transmission trends of influenza, another respiratory virus, and can use this knowledge to estimate how COVID transmission will progress in prisons. Assuming no change in transmission trends in the next few weeks, the rapid increase in infections will continue.

13. This growth in prison cases would happen at the worst possible time. Massachusetts hospitals are now at the beginning of the surge of severe and critical cases and are expected to gradually lose the ability to manage additional severe COVID cases, particularly those requiring ventilation. This means that in two-to-four weeks, which is the time that many of the prison cases among vulnerable prisoners are expected to worsen, prison cases would further tax already over-burdened and stressed area hospitals, and adequate supportive care in hospitals for prisoners could not be guaranteed.

The challenges presented by the high vulnerability of the prison population

14. The prison population is more vulnerable to COVID than the general population due to age and medical risk factors. This increases the risk to prisoners and the strain that the prison outbreak will place on area hospitals.

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[4] https://data.aclum.org/sjc-12926-tracker/

[5] Population numbers for MCI-Framingham and the Massachusetts Treatment Center are based on the most recently available reporting from DOC. *See* https://www.mass.gov/doc/weekly-inmate-count-3302020/download

15. According to the Massachusetts Department of Correction, eleven percent of those incarcerated in 2019 were aged 60 or older (983 out of 8,784). Older adults are at increased risk for severe COVID-19 complications as well as death. According to the Center for Disease Control, 8 out of 10 deaths from COVID-19 have been persons 65 years old or older, with this age group disproportionately requiring hospitalization and intensive care.[6]

16. The prison population also has a higher rate of underlying medical conditions that increase risk of complications or death from COVID, according to data from the 2011-2012 National Inmate Survey.[7] Approximately half of state and federal prisoners and jail inmates have had a chronic medical condition (defined as cancer, high blood pressure, stroke-related problems, diabetes, heart-related problems, kidney-related problems, arthritis, asthma, and/or cirrhosis of the liver). Twenty-one percent of state and federal prisoners and 14% of jail inmates have ever had tuberculosis, hepatitis B or C, or sexually transmitted infections (excluding HIV or AIDS).

17. This vulnerable demographic is at a much higher risk of infection, hospitalization, and death in prison than elsewhere, due to the lack of ability to prevent transmission in prison and the limited capacity for isolation, quarantine, and treatment, as described above.

Conclusions

18. If strong measures are not taken immediately, COVID will continue to rise sharply in Massachusetts prisons and jails, placing at risk prisoners, staff, and others entering the facilities and burdening area hospitals during the surge in need over the coming weeks.

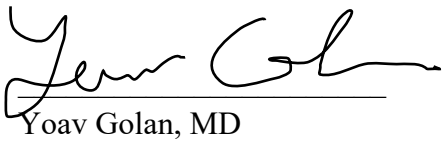
19. While prison efforts at social distancing, sanitation, testing, isolation, and quarantine are important and should be expanded, they cannot be implemented in a correctional setting as they are in the community and so will not be effective tools, on their own, in keeping COVID from overwhelming Massachusetts prisons and jails.

20. Consequently, a substantial reduction in the prison population is needed in order to help reduce transmission in prison and improve the ability to quarantine, isolate, and treat those infected.

21. Those who are vulnerable due to age or medical condition are at highest risk of death from COVID, and all who can safely be released should be released as soon as possible.

[6] https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications/older-adults.html
[7] Maruschak LM, Berzofsky M, Unangst J. Medical problems of state and federal prisoners and jail inmates, 2011-12. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; Feb. 2015.

Signed under the pains and penalties of perjury this 14th day of April, 2020.



Yoav Golan, MD

Exhibit 3

DECLARATION OF VICTOR LEWIS, M.D.

I, Victor Lewis, state the following to be true to the best of my knowledge, information and belief:

1. I received my doctorate in medicine in 1987 and I was practicing physician at Massachusetts General Hospital (MGH) from 1990 through October 2019. During that same time period, I was a member of faculty at Harvard Medical School.

2. During part of that time, 1991-1998, I was a general internist for HIV infected patients at the immunodeficiency clinic at Boston City Hospital/Boston Medical Center. Since 2000, I have also been an independent contractor with the Commonwealth of Massachusetts Department of Mental Health.

3. I retired from my practice at MGH in Chelsea at the end of October 2019. Since the beginning of March of this year I have been working occasional shifts at the MGH Walk-In Clinic which has now become the Acute Respiratory Care Clinic for patients referred for respiratory complaints who need to be evaluated for possible COVID19 but who do not need to be evaluated in an emergency room.

4. In addition to my clinical responsibilities in Chelsea, I had been and still am part of a multidisciplinary team under the Department of Mental Health monitoring the medical and mental health care of inmates who are in segregation in restrictive housing units (RHUs) in both medium and maximum Massachusetts Department of Correction (DOC) facilities. This activity has involved visits to all DOC facilities which have an RHU once or twice a year, meeting with prison officials and interviewing inmates and then subsequently reviewing their medical records. Following these visits, we submit a report with recommendations to the Commissioner of the Department of Correction.

5. The DOC has two infirmaries, one for men at Souza-Baranowski Correctional Center (SBCC) and one for women at MCI-Framingham. It

also operates specialized medical units at MCI-Shirley and MCI-Norfolk, and has a locked hospital unit at Lemuel Shattuck Hospital.

6. On March 6, 2020, I conducted an audit at MCI-Shirley. MCI-Shirley has the DOC's only Skilled Nursing Facility, which provides a nursing home level of care for people who cannot function on their own. The SNF has 31 total beds, 28 of which are medical beds and 3 beds that are reserved for mental-health watch cells. MCI-Shirley is the only facility with capability for dialysis. The SNF is almost always at capacity. As a result there is a backlog to get into the Skilled Nursing Facility (SNF) at MCI-Shirley so patients often have to wait at the infirmary for a bed to become available.

7. There is also an Assisted Daily Living (ADL) unit at MCI-Shirley that has fifteen beds. The ADL is for elderly patients who have trouble getting around. The ADL is also almost always full and there is a wait list to get in.

8. In addition, there is a Critical Stabilization Unit (CSU) at MCI-Norfolk, a dormitory with multiple beds. These patients are largely elderly and have serious medical conditions such as COPD and congestive heart failure. During our March 3, 2019 audit of the RHU at MCI-Norfolk, I was briefed by one of the two medical directors and was told that many of these inmates should have daily medical evaluations by a provider but often times this is not possible due to overall clinical demands on providers. MCI-Norfolk holds an older population serving prolonged sentences who need significant medical care. For example, my May 2017 report states: "The facility had 736 inmates who are followed for chronic diseases."

9. On an audit on June 15, 2018 at SBCC, I was told by the then Medical director that there was a need for probably about 30 additional ADL beds within the DOC system. There were then a number of inmates within the infirmary who did not have acute short-term needs but rather needed an ADL bed or a SNF bed. Some of these inmates had been in the infirmary for many months even though they had no acute medical needs. This situation has remained essentially unchanged as there continues to be inmates who do not have the need of acute infirmary inpatient care and are awaiting transfer to either a SNF, CSU or ADL unit. These inmates must remain in the infirmary until beds in

those units become available. From my report written after our audit at SBCC on June 14, 2019 I wrote, "The HSU infirmary has 18 cells, some of the cells have a capacity for 2 inmates but are generally kept as single inmates cells. In addition to the 18 cells used as infirmary beds there are generally 2 other rooms available for mental-health watches or for occasional other needs. At the time of our June 2019 visit there were 2 inmates in the infirmary who had been waiting for prolonged periods to be transferred. One of these inmates had been in the infirmary waiting for transfer for approximately 4 weeks and the other for approximately 2-3 weeks. Inmates in the infirmary are confined to their cells, they do not have any programming and they did not get any recreation time. Inmates in the infirmary are not necessarily originally from SBCC but can come from anywhere in the DOC system as this is now the only inpatient infirmary within the DOC. The SBCC infirmary cannot provide intensive care unit (ICU) level of care and anyone who needs ICU care would have to be transferred to an outside hospital.

10. On January 3, 2020, I conducted an audit of the RHU at MCI-Framingham. During that audit I was told that the infirmary has 30 beds (this statistic was from June of 2018) and the majority of the patients admitted to the infirmary are for opiate or alcohol detoxification. In the past, the infirmary had ten to fifteen new admissions daily but that is now down to only two to three admissions daily as a result of the reduced population. (MCI Framingham transferred approximately 180 prisoners to county facilities when some county facilities started accepting female inmates who were awaiting trial or had received relatively short sentences).

11. In addition to the above units, each prison has a Health Services Unit (HSU). The HSUs have limited beds and are not set up for very acute care. The HSU is like an urgent care doctor's office, though they do have beds to treat people for a day or two.

12. Patients that cannot be treated within the DOC may be sent to a locked ward at the Shattuck Hospital, which has 29 beds. When these beds are filled, inmates are sent to other hospitals throughout the state.

13. Based on my knowledge from conducting these and other audits over the past 20 years, it is my opinion that DOC's health care system will easily be overwhelmed once the COVID-19 pandemic spreads. The older prisoners are often in poor health and are at high risk of complications and death. As the number of inmates with the infection increases there will be an increase risk to correctional staff, who will then increase the risk to their families and communities.

14. As of March 30, there were 7,841 people in DOC custody, only 276 of those female (at MCI-Framingham and South Middlesex Correctional Center) and the rest male. There are only 18 infirmary beds (unless the SBCC infirmary is shifted from single- to double-celled), 28 skilled nursing beds, and 56 crisis stabilization unit beds to serve the entire male population of over 7,500.[1] As noted in my audits that pre-date the onset of the COVID-19 pandemic, these units are generally full with patients that have non-COVID-19 medical needs. There is virtually no excess capacity for treatment of patients with suspected or diagnosed COVID-19.

15. Furthermore, even where there is bed space, the presence of sick or infirm non-infected patients in each of these medical units will make it difficult or impossible to safely isolate diagnosed cases or quarantine suspected cases in these units.

16. Any plans to isolate inmates in Restrictive Housing Units could be very problematic. Inmates locked alone in RHU cells are generally not visible to medical or correctional staff except when they do rounds of the unit. A prisoner whose condition dramatically worsened in a short period of time might not be noticed, particularly if correctional and nursing staff are strained by absences due to the COVID-19 epidemic. Severe respiratory distress could also make it difficult for an inmate to call for help.

17. The use of dormitory-style housing in the CSU and ADL, and the possible use of shared rooms in the infirmaries, presents further concern. The elderly and infirm patients in these units cannot be isolated from each other. If an asymptomatic carrier introduces COVID-19 into these units it is likely to spread rapidly, with potentially

[1] *See* https://www.mass.gov/doc/weekly-inmate-count-3302020/download

devastating consequences, just as has been seen in nursing homes across the country.

18. Finally, with only 28 beds at the one hospital unit operated by the Department, any surge in need for intensive care will create additional demands on area hospitals that accept patients from the Department.

19. In sum, the Department of Correction, despite its best efforts, does not have the capacity to quarantine, isolate, treat and (when needed) hospitalize a surge in COVID-19 patients. Unless steps are taken to greatly reduce opportunities for infection throughout the system, lack of capacity is likely to thwart efforts to prevent further infection, hinder patient care, and further burden community hospitals receiving inmate patients.

Signer under the pains and penalties of perjury this 13th day of April, 2020.

/s/ Victor Lewis, M.D.

Victor Lewis, MD

Exhibit 4

Declaration of six internal medicine attending and resident physicians at Boston Medical Center (BMC)

1. We are a group of internal medicine attending and resident physicians at Boston Medical Center (BMC), a non-profit academic medical center. BMC is the largest safety-net hospital and the busiest trauma and emergency services center in New England. We are on the front lines caring for patients with suspected or confirmed COVID-19 infection in outpatient, emergency department, inpatient, and critical care settings. In this affidavit, we write as a group of individual physicians and not on behalf of BMC.

2. We care for a socially vulnerable patient population with disproportionately high rates of substance use disorders, histories of homelessness, and histories of incarceration.

3. In this affidavit we describe current clinical practices for prevention and management of COVID-19. We identify inpatient services being provided in response to COVID-19. And we identify some of the many outpatient medical and other community resources that have expanded services to meet and mitigate the risk to our patients and our community's most vulnerable people, including those transitioning out of incarceration.

4. Based on our experience and knowledge, we believe that decongesting prison and jail facilities and reducing the prison population as soon as possible are the best way to protect the health and safety of the individuals incarcerated and of the public. This is true regardless of whether individuals released are homeless and require substance use disorder treatment or other medical care in the community.

Overview of the COVID-19 Pandemic

5. The COVID-19 virus is transmitted through droplets and contact with contaminated surfaces,[1] as well as possible airborne transmission.[2] Both symptomatic and asymptomatic people can carry and transmit COVID-19.[3] The average incubation period (i.e. time between exposure and development of symptoms) for COVID-19 is about five days, and 98% of those who develop symptoms will do so within 12 days.

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[1] 1 Adhikari SP, Meng S, Wu YJ, et al. Epidemiology, causes, clinical manifestation and diagnosis, prevention and control of coronavirus disease (COVID-19) during the early outbreak period: a scoping review. Infect Dis Poverty. 2020;9(1):29. Published 2020 Mar 17. doi:10.1186/s40249-020-00646-x

[2] van Doremalen N, Bushmaker T, Morris DH, et al. Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1 [published online ahead of print, 2020 Mar 17]. N Engl J Med. 2020; 10.1056/NEJMc2004973. doi:10.1056/NEJMc2004973

[3] Tong ZD, Tang A, Li KF, et al. Potential Presymptomatic Transmission of SARS-CoV-2, Zhejiang Province, China, 2020 [published online ahead of print, 2020 May 17]. Emerg Infect Dis. 2020;26(5):10.3201/eid2605.200198. doi:10.3201/eid2605.200198

6. Older adults and people with pre-existing health conditions such as cardiovascular diseases, respiratory diseases, liver disease, and diabetes are at increased risk for severe COVID-19 complications and death. Early data suggest that mortality from COVID-19 increases substantially with age: risk of death starts increasing among people in their sixties and then increases dramatically for each decade of life thereafter.[4] In Massachusetts, 99% of deaths due to COVID-19 have been among residents over age 50.[5]

7. Massachusetts has the highest percentage of elderly prisoners compared to all other states.[6] According to the MA Department of Corrections (DOC), 983 inmates (11%) were over 60 years old and 2,510 (29%) were over 50 years old in 2019.[7] This population bears a significant burden of chronic illness, including respiratory conditions, cardiovascular disease, diabetes, and liver disease.[8]

8. Persons who are incarcerated experience "accelerated aging," meaning they develop chronic conditions and disability about 10-15 years earlier than the general population due to multiple layers of medical vulnerability (e.g. poverty, poor access to health care, substance use). They also experience worsening of chronic health problems due to the resource-constrained, high-stress environments of jails and prisons. Advanced age and chronic health conditions such as these substantially increase risk for severe COVID-19 complications, including death.[9]

9. **The health of those within correctional facilities and that of the general public are intertwined.** The elevated risk of transmission of COVID-19 in correctional facilities threatens to worsen the pandemic not just within the correctional system but also in

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[4] 5 WHO Director-General's opening remarks at the media briefing on COVID-19 - 3 March 2020 - World Health Organization, March 3, 2020.

[5] Andrew Ryan, "Elderly residents continue to bear the brunt of coronavirus infection in Mass., data show, Boston *Globe*, Apr. 9, 2020. Accessed at: https://www.bostonglobe.com/2020/04/09/nation/elderly-residents-continue-bear-brunt-coronavirus-infection-mass-data-show/

[6] ttps://www.pewtrusts.org/en/research-and-analysis/articles/2018/02/20/aging-prison-populations-drive-up-costs

[7] Massachusetts DOC, Inmate and Prison Research Statistics. Accessed at: https://public.tableau.com/profile/madoc#!/vizhome/MADOCJan1Snapshot/Jan1Snapshot

[8] Maruschak LM, Berzofsky M, Unangst J. Medical problems of state and federal prisoners and jail inmates, 2011-12. Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2015 Feb.

[9] World Health Organization (2014). Prisons and Health. Edited by: Stefan Enggist, Lars Møller, Gauden Galea and Caroline Udesen. Accessed at: http://www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf

surrounding communities.[10] Spread of disease amongst inmates and others interacting with the correctional health system has the potential to further overwhelm the already overburdened health care system. Individuals at high risk for severe complications from COVID-19 would likely be transported to community hospitals, using scarce personnel and equipment in the emergency department, general hospital, and intensive care units.

Prevention of COVID-19 Transmission: Current Clinical Practices

10. In the hospital setting, we take multiple measures to reduce the risk of cross-contamination and ongoing spread among patients and staff. Patient waiting rooms, hospital rooms, workspaces, and break areas have been changed to allow for strict physical distancing (i.e. at least six feet apart). Staff only use one workstation and phone during the shift, wiping it with a disinfecting solution at the start and end of each shift. Staff must wash or sanitize their hands with an alcohol-based hand sanitizer before and after every patient encounter. Surfaces are cleaned and disinfected regularly.

11. All clinical and non-clinical staff interacting with patients with <u>suspected or confirmed</u> COVID-19 infection don a gown, two sets of gloves, a mask (surgical mask and/or N95 respirator, depending on clinical task(s) performed), and a face shield. Patients are given a surgical mask to wear at all times. Food service workers and environmental service workers (i.e. cleaning staff) are required to wear PPE when entering rooms of suspected or confirmed COVID-19 patients. After patients with suspected or confirmed COVID-19 are discharged from the hospital, environmental service workers perform "terminal cleaning" of their rooms, an intensive process of disinfection to prevent pathogen spread.[11]

12. Clinical staff wear a clean pair of scrubs every day, and return the scrubs to the hospital at the end of the day to reduce the risk of contaminating their homes and community spaces when they leave the hospital at the end of their shift.

13. When an object leaves a room of a patient with suspected or confirmed COVID-19 infection (e.g. ultrasound or portable x-ray machine), the device is wiped down with a bleach-based sanitizer and must dry before next use.

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[10] Rubin R. The challenge of preventing COVID-19 spread in correctional facilities. JAMA. Published online April 07, 2020. doi:10.1001/jama.2020.5427

[11] CDC FAQ on Infection Control. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Finfection-prevention-control-faq.html

Management of Patients with Suspected or Confirmed COVID-19 Infection

14. Hospitalized patients with suspected COVID-19 infection are placed in single occupancy rooms in wards separate from other patients. Hospitalized patients with confirmed COVID-19 infection may be placed in a room with one other patient with confirmed COVID-19 infection.

15. When caring for patients with suspected or confirmed COVID-19 infection who are stable enough to leave the hospital, we direct patients at discharge to care for themselves in isolation at home. While their COVID-19 test is pending, patients are advised to self-isolate as if they have the infection. We instruct patients to sleep in a separate room from other household members, use a separate bathroom if possible, avoid shared eating spaces and other common spaces, and avoid leaving their home. According to CDC recommendations, patients can discontinue self-isolation after at least three days (72 hours) have passed since resolution of symptoms (as defined by resolution of fever without the use of fever-reducing medications *and* significant improvement in respiratory systems – e.g. cough shortness of breath); and at least 7 days have passed since symptoms first appeared.[12]

16. **Some patients are unable to self-isolate at home.** These include patients who are homeless, patients who live in extremely crowded conditions, and patients who reside in long-term care facilities. **In these cases, our community has found alternative solutions to isolate patients in order to protect the public and meet the evolving standard of care.** The Commonwealth, the City of Boston, health care systems including Boston Health Care for the Homeless (BHCHP), Boston Medical Center, and Partners Healthcare, and shelter organizations have collaborated to orchestrate a rapid response to this problem, creating new spaces to isolate and quarantine our most vulnerable residents.

17. One of the earliest examples was BHCHP's opening of two medical tents to care for patients with suspected or confirmed COVID-19 infection who are experiencing homelessness.[13] One tent is used to isolate confirmed COVID-19 positive patients, and the other houses patients with suspected COVID-19 infection who have pending tests.

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[12] CDC. Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings (Interim Guidance). https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html

[13] Bebinger M. Tent Medicine to Treat Those with the Coronavirus in Boston's Homeless Community. https://www.wbur.org/commonhealth/2020/03/23/tent-medicine-to-treat-those-with-the-coronavirus-in-bostons-homeless-community

Both tents have hand-washing stations, appropriate sanitization supplies, and a negative pressure ventilation system, an isolation technique that allows air to flow inward but not escape from the space. Staff in the tents wear appropriate PPE. Patients continue to receive necessary medications, nutrition, social work services, and mental health and substance use treatment in these settings.

18. Other examples of recent innovations to safely isolate and care for persons who are homeless with suspected or confirmed COVID-19 include the following:
    a. In partnership with BHCHP and Partners HealthCare, the Commonwealth has opened multiple field hospitals to care for hospitalized patients with COVID-19 infection. Among the 1000 beds in Boston Hope, a field hospital opened in the Boston Convention and Exhibition Center, half will be dedicated for COVID-positive patients who are homeless.

    b. Lawrence, MA has established two emergency shelters for people experiencing homeless who need a safe place to self-quarantine or isolate during the COVID-19 pandemic.

19. If patients with suspected or confirmed COVID-19 infection cannot self-isolate due to homelessness or residence in a communal living facility and cannot be admitted to one of the facilities mentioned above due to lack of availability or patient-specific criteria, they are admitted to the hospital. **With this practice, we aim to meet standards for both patient care and public health protection in a pandemic even in the face of barriers like homelessness and other sources of social vulnerability.**

20. While hospitalized, patients with suspected or confirmed COVID-19 continue to receive all necessary services including food service, required personal care (e.g., assistance with changing, bathing, toileting, eating), and medication administration by a variety of clinical and non-clinical staff members wearing appropriate PPE. Patients are evaluated by health care professionals (i.e., physicians or advanced practice providers, nurses, and certified nursing assistants) multiple times a day. At all times, patients are able to obtain attention from staff using a button to activate their room call light.

Housing and Health Care Resources for Persons Transitioning out of Incarceration

21. While acute care hospitals and isolation/quarantine facilities are expanding in this time of increased need, outpatient medical settings, substance use disorder treatment providers, and other community resources are heightening their services as well to mitigate risk of the pandemic and meet the needs of our community's most vulnerable people, including

those transitioning out of incarceration.

22. For those experiencing homelessness who are not COVID-19 positive nor demonstrating symptoms of COVID-19 infection, shelters run by Pine Street Inn and the Boston Public Health Commission remain open and are expanding to include a dormitory at Suffolk University, which will provide 172 additional beds to help reduce congestion and increase social distancing in Boston shelters.

23. Shelters are taking special precautions to protect guests and staff, including: screening guests prior to entry and triaging those with COVID-19 symptoms to either a hospital or a quarantine or isolation site in collaboration with BHCHP; assigning guests the same bed each night as possible; installing plastic barriers between beds; serving meals in shifts to facilitate social distancing; installing additional hand washing and hand sanitizing stations; and heightening the frequency and intensity of their cleaning services to reduce spread of infection among shelter guests and staff.

24. Health care providers across the state, including academic medical centers, community health centers, and Veterans Affairs (VA) facilities, have widely adapted telemedicine to ensure patients get the care they need while continuing to practice social distancing. Patients can be assessed and treated by phone, and an in-person visit can be arranged if medically necessary. Telehealth primary care visits also serve the function of connecting patients to vital resources (e.g., housing, food, childcare, domestic violence support, mental health and substance use disorder services) that are desperately needed during this pandemic.

25. In anticipation of recent policy changes that may facilitate early release of non-violent prisoners and the potential increased need for substance use disorder treatment, our institution has rapidly expanded services in spite of constraints from the pandemic. BMC clinics including OBAT (Office Based Addiction Treatment Program) and clinical programs geared toward reintegration of care for individuals transitioning out of incarceration, such as the PARC clinic (Pre-release Assessment and Reintegration into Care), have increased their capacity by dramatically expanding telehealth resources. Nurses are now conducting intakes for patients telephonically, although in-person visits can be arranged if necessary. Physicians and nurse practitioners are scheduled for on-call shifts to facilitate access to primary care and substance use disorder treatment. Additionally, all patients continue to have access to low-barrier "bridge clinics" such as BMC's Faster Paths clinic, which has also expanded its telehealth capabilities. Faster Paths is an urgent care-style clinic where patients can receive medical treatment and harm reduction counseling for substance use disorders, testing and treatment for injection drug use-associated infections including hepatitis C, and pre-exposure prophylaxis for HIV.

Other programs such as Project ASSERT (Alcohol & Substance abuse Services, Education and Referral to Treatment) continue to engage patients and connect them to intensive residential programs for substance use disorder treatment, including placement in medical detox and crisis stabilization programs.

26. Individuals transitioning out of incarceration often need assistance to secure adequate housing, food, primary and mental health care, and substance use disorder treatment, especially during the current pandemic conditions. **Health care and social service providers are ready and willing to meet those needs through expanded capacity and widespread adoption of telehealth.**

Conclusion

27. As physicians with clinical expertise and strong investment in caring for vulnerable populations, we know that inadequate attention to personal and public health needs in correctional facilities will endanger the general public and the entire health care system.

28. We believe that by far the most effective measure to protect people who are incarcerated, correctional staff, and the public is to expedite the release of detainees and inmates to reduce crowding in correctional facilities and thus mitigate the harm from a COVID-19 outbreak.

Each of us declares under penalty of perjury that the foregoing is true.

/s/Jordana Laks
Jordana Laks, MD, MPH

/s/*Ricardo Cruz*
Ricardo Cruz, MD, MPH

/s/Samantha Siskind
Samantha Siskind, MD

s/Catherine Rich
Catherine Rich, MD

/s/Hannan Braun
Hannan Braun, MD

/s/Jennifer Siegel
Jennifer Siegel, MD

Date: April 15, 2020

Exhibit 5

DECLARATION OF STEPHEN G. FOSTER

1. I am a forty-three-year-old prisoner at Old Colony Correctional Center (OCCC), serving a three-to-five-year sentence for assault and battery and other related convictions. I will be eligible for parole this July -- or sooner if I continue to earn good time credit -- and my wrap date is in 2022.

2. I have serious health issues that place me at high risk of complications or death if I get COVID-19. I have had a long history of serious cardiac and other issues, including: micturition syncope; heart failure with preserved ejection fraction (HFpEF); atrial flutter; stroke; syncope; gastroesophageal reflux disease (GERD); infectious viral hepatitis; infective endocarditis; and more. Additionally, my endocarditis of the tricuspid valve and aortic valve was complicated by septic emboli to the brain, lungs, spine, and joints. I have already undergone cardiac surgery; mitral valve repair; and aortic valve replacement. In October 2019, I fainted and sustained a zygomaticomaxillary complex closed fracture; an orbital floor (blow-out) closed fracture; and epiphora. These injuries required surgery, which took place on November 29, 2019 at Boston Medical Center (BMC). During the surgery doctors inserted a titanium plate and five screws into my face. Unfortunately, after the surgery, I suffered ongoing purulent drainage, indicative of infection, and on December 14, 2019 I had to undergo another surgery at BMC, this time to have the titanium plate and screws removed. Despite multiple courses of antibiotics since then, the sinus infection persists and returns with the conclusion of each course of antibiotics. To this day, some four months since the original surgery, I suffer from chronic sinusitis, a swollen face, and severe and ongoing pain. I am highly susceptible to infection.

3. The conditions at OCCC are not sanitary, and I am afraid that I am sharing the same ventilation system and showers and phones with people who are sick. There are many shared surfaces here, in fact, and we are not able to effectively clean our cells or common areas. There was access to hand sanitizer on the block a few weeks ago, but OCCC has been on lock-down since April 3, 2020. Since then, hand sanitizer has been out of stock and has not refilled.

4. There is no way for me to practice social distancing at OCCC because I am housed in a double-cell. Correctional Officers (COs) bring us our meals.

5. The COs and other staff have been issued masks, but they only wear them when they are around inmates. I have witnessed CO's take the masks off when they're around just each other. I have also witnessed CO's walk across the unit without masks on at all. I have not been given a mask.

6. I only have a few months until I see the Parole Board (fewer, if I continue to earn good time credit), and I have a stable home to go to upon release. My sister is willing to take me in.

7. My biggest fear is catching COVID-19 and dying alone from it, when I am so close to potentially having my freedom back. I am worried, like many other people, about never seeing my family again. I feel like they are rolling dice with my life.

8. The anxiety that the stress of this disease is causing me is not healthy for me in my fragile medical state.

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

Date: April 13, 2020 /s/Stephen G. Foster

Stephen G. Foster

Exhibit 6

DECLARATION OF MICHAEL GOMES

1. I am a 50 year old man in prison because I violated my terms of probation due to missing my required drug tests. In 2019, after my sister, mom and daughter died within 90 days of each other, I attempted suicide and relapsed. As a result, I was sentenced to 24 months in prison. I am parole eligible next month, and I will complete my sentence in July 2021, or in December 2020 with earned good time.

2. I had a liver transplant in 2016, and take an anti-rejection medication daily that keeps me alive by preventing my body from rejecting the transplanted liver. For three days during this lock down, I did not receive my anti-rejection medication, Prograf. This medication also severely compromises my immune system.

3. I am incarcerated in an eighty-four man dorm at MCI-Concord, where social distancing is physically impossible. We live in one big room divided by picnic tables. Our bunk beds are approximately three feet apart. I am less than six feet from the man who sleeps above me. I share two bathrooms with approximately eighty-four people, one has four toilets and one urinal and the other side has four toilets and one urinal. The toilets are divided by only a half wall and there is usually someone in the bathrooms. The antibacterial soap dispenser was empty in both bathrooms for approximately three days until yesterday afternoon, when the CO filled the soap dispensers. Because of my liver transplant, I urinate frequently. This means that even though I remain on my bunk bed for most of each day, I cannot avoid social contact and transmission of germs.

4. Now that we are on lockdown, we never leave the dorm, even to go outside to the yard, so we have even less opportunity to socially distance. Medication is distributed outside in the hallway, and one person goes into the hallway at a time, but we are lined up together at the door, less than a foot apart from each other. When two people are on the phone at the same time we are within two feet of each other. We receive our meals on our bunk beds, but then are allowed to eat them at the tables. I choose to eat on my bed to maximize my social distancing.

5. The correctional officers all have masks, but many don't wear them, or do not wear them to cover their nose and mouth, even some Captains.

6. They put hand sanitizer on the unit, but it is locked in a plexiglass box. The opening on the top of the box is small, so when you press the dispenser, it doesn't go all the way down and dispenses very little hand sanitizer. I use it anyway, in addition to washing my hands multiple times per day. At night, the hand sanitizer is completely locked up.

7. My biggest fear is that I will contract COVID-19 and my body won't be able to fight it off. I try to avoid people, not even talking to them when possible, and I wash my hands constantly. Despite these efforts, I am scared of dying.

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

Date: April 14, 2020 *<u>/s/Michael Gomes</u>*
MICHAEL GOMES

Exhibit 7

DECLARATION OF PETER KYRIAKIDES

1. I am a fifty-two-year-old Caucasian prisoner at Pondville Correctional Center (PCC) serving a one year sentence for a probation violation. My sentence will be completed on June 11, 2020.

2. I suffer from severe asthma and have been prescribed two separate inhalers. I am afraid that I will get seriously ill or die if I get COVID-19 because of my asthma.

3. PCC currently holds approximately one hundred and fifty inmates, most of whom are living in two-man cells. There are ten cells and with a total of 19 prisoners all packed within my 25 feet long tier. We share communal sinks, showers, toilets, phones, and laundry facilities. Access to the toilets and sinks is minimal so there is usually a large group of people waiting every morning to use the limited number of toilets and sinks. Prisoners are no more than two to three feet apart when waiting in line to access these necessities. The six phones are also about one to two feet apart and are shared among 80 people. The frequency of phone cleanings has also decreased drastically since the lockdown. From what I understand, they are only being cleaned once every other day.

4. PCC is now on lock-down, forcing inmates to stay in their cells with their cell mates for almost twenty four hours per day. There is no way to keep at least six feet away from my cellmate in our cell with only about five feet by four feet standing room.

5. Before PCC was on lockdown, I was assigned to a cleaning crew that disinfected doorknobs and door handles with a yellow colored disinfectant. Most of the cleaning and disinfecting procedures have drastically declined since the lockdown began last week. Specifically, the floor beneath the urinal that is shared between 50 prisoners consistently has urine on it. The shared sinks are visibly dirty and the trash receptacles are often overflowing.

6. Staff is cooking and delivering food in styrofoam trays to our cells. I have witnessed a few occasions where staff have not been wearing masks.

7. Prisoners have not been given masks or gloves. We have access to hand sanitizer but two out of the three containers are currently empty. I was told that the facility is awaiting a new shipment of hand sanitizer. As of the morning of April 15, we only have about a quarter gallon of hand sanitizer to share between 80 prisoners.

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

Date: April 15, 2020 *_/s/ Peter Kyriakides*

Peter Kyriakides

Exhibit 8

DECLARATION OF RICHARD O'ROURKE

1. I am a 64-year-old man imprisoned at Plymouth County Correctional Facility. I am serving a 3 year mandatory minimum sentence for Operating Under the Influence. I have served more than 14 months of my sentence and am eligible for parole in around 7 months.

2. I have a long history of respiratory illnesses. I have been hospitalized multiple times for bronchitis and severe pneumonia. Chronic recurring pneumonia has especially taken a toll on my lungs' ability to withstand any form of infection.

3. I have also been diagnosed with Lyme disease, hypertension, hyperlipidemia, and gastroesophageal reflux disease. I also have a long history of substance use disorder and alcohol abuse. I am terrified about what COVID-19 would mean for me because of these medical conditions.

4. I am trying to do everything I can to be careful about social distancing and avoiding potentially contaminated surfaces, but it is impossible given the conditions in my unit, FS1. There are approximately 25 men in the unit. We share a single 20 feet by 100 feet common room for meals, medications, and all out of cell time.

5. Although I am in a single cell, the rest of the facility is mostly composed of cells with five prisoners. The five man cells are about 12 feet by 15 feet.

6. Before April 15, we had no access to hand sanitizer. Now there is a single hand sanitizer dispenser for the entire unit. We are issued a single bar of antibacterial soap once a week.

7. I have been struggling with a chronic ear and throat infection and have had to visit medical twice in the last two weeks. When I visited medical, there were three to four people also waiting in the foyer, which is roughly 6 feet by 8 feet. This makes it impossible to stay 6 feet away from others.

8. Many of the staff and nurses have recently started wearing masks but it is not consistent. Most correctional officers are not wearing masks. About two weeks ago, three maintenance workers came in to change light bulbs in several cells and none of them had masks on. We still have not received any masks.

9. The shared items and facilities are only cleaned once a day. There is no way for me to avoid using the same six showers and nine phones as the other 25 individuals on my unit. I am sharing these same facilities with half the unit at a time.

10. I am faced with the impossible choice of maintaining social distance or seeing medical for potentially serious health concerns and showering. I feel as though I am gambling with my life every time I step out of my cell.

11. My biggest fear is that I will contract COVID-19 and not be able to be there for my son. My 14 year old son, John, has autism and seizure disorder, requiring constant care. At present, my wife is the only primary provider for our son. My wife is a first responder and is still mandated to go to work.

12. I have established an extensive support network, ranging from substance use disorder programs to a loving family waiting for me to come home, in anticipation of my upcoming parole eligibility.

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

Date: April 13, 2020 /s/Richard O'Rourke

Richard O'Rourke

Exhibit 9

DECLARATION OF STEVEN PALLADINO

1. I am a 62-year-old prisoner at MCI Norfolk. I am serving a sentence of 10 to 12 years for non-violent larceny and related convictions, with a 24-month consecutive sentence for contempt. With good time, I will be eligible for parole in May 2021. My wife and children normally visit me weekly, but they have been unable to come since March when visits were suspended due to COVID-19. I still speak with my wife and daughter every night, and I keep in touch with other family members through email and periodic phone calls. I have a stable, safe, family home to go to upon release.

2. I have diabetes and need insulin twice per day. I also have kidney disease, caused by diabetes. My medical condition makes me very worried about COVID-19.

3. MCI Norfolk is a medium security prison, with housing units that are set up like dorms on college campuses. Even though the prison has been locked down since April 4, 2020 due to the virus, it is not possible to isolate people in their rooms because there are open sections within the prison. For example, I am located in the 3-1 housing unit, which has 68 men living in three tiers. My tier has 12 people living in 10 cells, and people within the tier are able to mingle freely despite the lock down.

4. I would like to have a mask, but masks are only available to staff, not prisoners. While there is hand sanitizer in the common area, prisoners do not have access to it unless we go downstairs, which I am not able to do all the time due to the lockdown. Currently, we are only allowed downstairs to get food or to use the phone if we have signed up for a time slot.

5. I am very worried that I cannot protect myself from COVID-19. The people that seem to be most affected by the virus are those that are housed in large groups like nursing homes, and I am afraid the virus will be similarly bad if it spreads in MCI Norfolk where the majority of the population is older and people live close together.

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

Date: April 13, 2020 *_/s/ Steven Palladino_*

STEVEN PALLADINO

Exhibit 10

DECLARATION OF MARK SANTOS

1. On March 4, 2020, I was committed under Section 35 to the Massachusetts Alcohol and Substance Abuse Center in Plymouth, MA (MASAC). My mom petitioned the court for my commitment to an addiction treatment center because she was concerned about my substance use disorder. I agreed to be civilly committed because I wanted help for my addiction. Instead, I ended up in prison.

2. Beginning in mid-March, when COVID-19 began to be recognized as a public health crisis, requiring social distancing on a societal level, I got scared, and repeatedly asked to be released. Social distancing is not possible at MASAC.

3. I did not receive one-on-one addiction treatment counseling while at MASAC, but with the help of a counselor, I had a supportive release plan in place. I live with my mom, where I can socially isolate. I was started on Medication Assisted Treatment, specifically Subutex, and had an appointment set up in the community for both MAT maintenance and counseling. My mom was ready and available to pick me up. I was anxious to go home. Instead, I was told that the Superintendent would not release me from my civil commitment, and I remained at MASAC, even after all treatment was cancelled. I was not told why I could not go home.

4. Treatment classes were cancelled in mid-March, and we began attending only one group per day. Then, on approximately April 3, even that group was cancelled, and we went on lockdown, sitting in our cells all day, with no activity or recovery support

5. Once MASAC was on lockdown, our cell doors remained unlocked, but we were only allowed to leave our room to go to the bathroom, use the phone, or receive medication. . I was on A unit. Correctional officers started going from cell to cell to pass out meal trays. We were not allowed to go outside at all. The lockdown was still in place when I was discharged on April 9th.

6. Staying in my cell all day did not make me feel safe and protected from COVID-19. There is only one bathroom in my unit that everyone shared. By the time I was discharged, there were approximately 25 patients in A unit sharing the bathroom. The bathroom was not big enough for us all to stay six feet apart, and the toilet and shower stalls and sinks were not six feet apart. There was no hand soap in the bathroom, I had to carry my bar soap from my cell to the toilet, and then use it to wash my hands.

7. By the time I was released, the correctional and medical staff were finally wearing masks and gloves most of the time, but not all of the correctional staff always wore their masks and gloves. Also, correctional and medical staff did not change their gloves between interacting with different patients. So, I didn't feel safe receiving meal trays from correctional officers, or medication from nurses.

8. Beginning in late March, the National Guard had a tent outside of the barbed wire fence at MASAC, but they were not testing people for COVID-19. Rather, they were taking temperatures and asking staff questions before they entered MASAC to begin their shifts. I know it is common for someone to be an asymptomatic carrier of COVID-19, so taking the temperature of those entering MASAC didn't make me feel protected or safe.

9. For at least the last week I was at MASAC, I did not receive any substance use disorder treatment. I simply sat in a prison cell, in close contact with over two dozen other men, waiting to go to my mom's safe, clean, isolated home. I don't understand why I was forced to remain at MASAC for so long.

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

Date: April 14, 2020 /*s/Mark Santos*
MARK SANTOS

Exhibit 11

DECLARATION OF DAVID SIBINICH

1. I am a resident of Pondville Correctional Center, which is a minimum security/work-release prison. I am 61 years old and I have high blood pressure and a highly probable diagnosis of prostate cancer.

2. I am very concerned about contracting the coronavirus. Social distancing is not possible in my unit, which is Unit 2-1. There are 20 people on my tier. The cells in my tier are double cells, so I have a cellmate. My cell is about 8'x9', most of which is taken up by the bed, lockers, and desk. It is not possible to maintain a 6' distance from my cell mate.

3. I am frequently 2-3 feet away from the other people on my tier. For example, when I'm speaking on the phone there are men on either side of me doing the same. The phones are about 18 inches to 2 feet apart. Another example is when I am waiting in medication lines during the second shift, people are lined up about three feet apart while we're waiting.

4. Hygiene supplies on my tier are limited. There is now hand sanitizer available at each end of the tier, though it is not always filled. We are given a small bar of soap weekly that doesn't last more than one shower. It's the size of a small hotel soap. If we need more, we have to purchase it. DOC is not giving prisoners here face masks. While the correctional officers do have face masks, they don't always wear them. Sometimes the officers will wear the masks down around their necks. Most of them don't wear gloves. We all touch the same doorknobs, which are never cleaned except for the ones going into the officer's offices. We all touch the same phones and I can't even remember the last time those were cleaned.

5. We aren't getting any ventilation or fresh air because they stopped us from going outside.

6. Our food is being delivered to our cells now, but the inmates that live down by the kitchen have told me that they can see that when making the food, some of the correctional officers are not always wearing masks.

7. From the second floor landing, I can see the officers enter the facility. A few weeks ago, they were all having their temperatures taken on the way in, but they are no longer doing this. I'm up pretty early in the morning and I can see them come in at 5 and 6am. There was supposed to be a

superintendent or a deputy superintendent who were going to be taking the temperatures on their way in, and they did for a little while, but now the superintendent doesn't come in until 8am, so the officers who are arriving earlier aren't having their temperatures taken.

8. I was convicted of Armed Robbery and given a life sentence in 1982. I was given a positive parole vote in March of 2019, after which point I was to serve six months in minimum security and then go to a long-term residential program via interstate compact to New York, my home state. My attorney and I had located and confirmed a bed in a program in New York that I was going to transfer to on March 23rd, 2020, but the spread of COVID-19 made that impossible. My attorney tells me that interstate compacts are now open for emergency transfers again.

9. I'm very concerned about catching COVID 19- I don't want to get sick and have the possibility of dying like this, especially when I should have been released already.

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

Date: April 16, 2020 *<u>/s/ David Sibinich</u>*

David Sibinish

Exhibit 12

DECLARATION OF MICHELLE TOURIGNY

1. I am a prisoner at MCI Framingham serving a second degree life sentence. I have been incarcerated there for over 20 years, and am parole eligible. I am 53 years old.

2. I live in the Health Services Unit at MCI Framingham because I suffer from debilitating spinal stenosis. I also suffer from morbid obesity. I also have a heart condition that requires a pacemaker. I take coumadin for blood clotting. I had a piece of my right lung removed due to an infection. Because of that, I now use a spirometer to help me breathe. I believe these medical conditions increase my risk of serious complications and death from COVID-19.

3. I wish I could socially distance, but am completely dependent on medical and correctional staff to meet my daily needs. I feel vulnerable and afraid.

4. Because I live in the HSU, it is impossible to remain six feet away from nurses and medical providers. I come into contact with medical staff frequently, and they are in my cell throughout the day to take my vitals and change my bedding. Medical staff usually wear masks and gloves but not always. I am especially worried that they also care for prisoners with COVID-19.

5. I also interact with correctional officers on a daily basis, and worry I may contract the disease from correctional staff. There are three officers on the first shift and three different officers on the second shift. They bring me my meals and the phone.

6. The officers have masks but do not always put them over their mouth and nose. They have gloves but do not always wear them. We prisoners have no access to either.

7. A prisoner worker used to come every day to my cell and clean and wipe down surfaces. But since we have been on lockdown, no one does this anymore.

8. I understand that there are already women incarcerated here, and staff working here, who have tested positive for COVID-19. .

9. I fear for my life right now. I love my children and family, and want to live.

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

Date: April 13, 2020 /s/Michelle Tourigny
MICHELLE TOURIGNY

Exhibit 13

DECLARATION OF MICHAEL WHITE

1. I am a 35-year-old prisoner at MCI-Concord serving a sentence of one and a half years for unarmed robbery. My sentence is scheduled to end in July.
2. I have Chronic Obstructive Pulmonary Disease (COPD), and asthma caused by my COPD, for which I have 2 inhalers. Sometimes I need a nebulizer treatment to clear up my breathing, which is administered by nurses in the Health Services Unit. I am afraid that my health condition makes me extremely vulnerable to severe complications if I get COVID-19. I am afraid that I might die if I contract the virus.
3. I am concerned about the spread of COVID-19 in MCI-Concord because of the lack of preventive measures taken to protect us from contracting coronavirus. I am currently housed in the L2 dorm with over 80 other prisoners, and there are always people within arms length of me, even when I am sleeping.
4. The L2 dorm is one room, divided down the middle by five big picnic tables. It houses 84 people, with 21 double bunks each side of the room. The tables have benches that are meant to seat approximately 16 people per table. In the dorm there are only six windows that each open approximately seven inches. Due to COVID-19, we are currently on lockdown; we never leave the room in which we are incarcerated. We no longer go to the gym, programs, classes, or even outside to the yard. This means that all 84 prisoners who live here are forced to remain in the dorm at all times, making it even harder now to keep six feet away from others.
5. There are two bathrooms in the dorm, one located on each side of the room. On my side, I share the bathroom with over 40 people, and there are multiple people in the bathroom at all times, except during the night when we are sleeping. The bathrooms each have one

urinal, four toilets, and 8 sinks, and often they are in use at the same time. The sinks are about a foot away from each other. Showers are in a separate area, in the middle of the unit, and are not cleaned between each use, or even daily. Even on a good day, you don't want to accidentally touch those walls.

6. The double bunk beds we sleep on are approximately three feet apart from each other. When I am sleeping on my top bunk, I am able to touch the person in the top bunk next to me.
7. We are given our meal trays on our beds. Some correctional officers wear gloves to pass out the meals, but sometimes they do not. Likewise, some officers passing out meal trays wear masks, but some do not. Since the COVID-19 crisis began, I now sit on my locker (like a storage box) in front of my bunk bed to eat. I used to eat at the tables, but I no longer feel comfortable sitting so close to other people. Even when I eat on my locker, I am not six feet apart from the next guy when he sits on his locker to eat, but it is less crowded than the tables. Many people still sit at the tables throughout the day.
8. Some correctional officers wear masks in the dorm, but not all of them are wearing masks. Even some Sergeants do not wear masks. It is common to see officers wearing their masks on the tops of their heads. Prisoners were not issued masks so I don't have one, but wish I did.
9. When I make calls to my friends and family, there are other men using the phones next to me, and each phone is approximately two feet apart. There are four phones in the row, and multiple phones are often being used simultaneously during the day.

10. There is hand sanitizer mounted on the wall but it is locked up after 3pm, so the dispenser won't push down enough for the sanitizer gel to come out. We have not been told why the hand sanitizer is locked up after 3pm.
11. I typically go to the medline to receive medication once a day. When it is time to distribute medication, we all stand in a single line together to wait for our turn to receive our medication. Sometimes the med cart is in the dorm, and sometimes it's in the hallway. Either way, we wait in a line of about 15 people. I can easily touch the person in front of and behind me in line. The nurse is wearing gloves while passing out the medication, but she doesn't change her gloves between patients. Some nurses consistently wear masks, but not all of the nurses always wear their masks while passing out medication.

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

Date: April 13, 2020 /s/Michael White

MICHAEL WHITE

Exhibit 14

DECLARATION OF FREDERICK YEOMANS

1. I am a prisoner in the Barnstable County Correctional Facility. I am serving a two-year sentence for operating a motor vehicle under the influence with a suspended license. My sentence will be completed on October 26, 2021, and I will be eligible for parole this year.

2. I am 72 years old. I have been diagnosed with heart disease and high blood pressure, for which I take daily medication. A nurse does a medication call in the morning and I take one medication for my heart, one for my blood pressure and aspirin. The nurse has a cart with medications in it and they pop each cell door and I come out and stand in line with 6 or 7 prisoners. The other prisoners in line are right next to me.

3. I work in the kitchen and every morning about ten prisoners are in a sallyport and we wait to go to work in the kitchen, the sallyport is 10' by 6' and sometimes we stay in this area for up to ten minutes. This happens on the way to work and coming back from work.

4. I sleep in a single cell in J pod in cell 18. There are 35 other cells in the unit. When prisoners have free time, they can congregate in the unit's common area, where they are often very close to one another. This area is cleaned daily and the prisoners try to keep the area clean but I am still worried about catching the COVID virus. There is no hand sanitizer available in the unit. I do have my own soap for washing my hands. The common area has a sink with a soap dispenser but not everyone uses it.

5. For meals they come in with a cart and you come out of your cell and get the plastic tray and go back to your cell. Then you are called back down to give back your plastic tray. I think the tray could pass the virus along just like anything solid.

6. The seven phones are about 2 feet from each other in the unit, chairs in front of the TVs are right next to each other and people touch the chairs all day long. The chairs are not cleaned everyday, maybe they are cleaned once a week, and then they are sprayed with cleaner and wiped down.

7. All thirty four people in the unit come out for recreation at once. Sometimes a group of ten prisoners go to the kitchen to work but there are still twenty four prisoners sharing the common area, which is pie shaped and about the size of a half court basketball court.

8. I would like to have a mask but I have not been given one. No prisoners have been given masks but some of the higher ranked staff are wearing masks. The COs on my unit do not wear masks.

9. I'm worried when I hear about the struggles people are having to breathe that have COVID-19, also prisoners don't always report when they are sick. It is so hard to get results from medical staff that many prisoners don't bother seeking medical care unless they have a really serious condition.

10. The COs switch all the time in this unit on the second shift, we see four to six different COs in a week. When COs take a break, another CO takes his or her place in our unit. To me, that means there is more of a chance of contracting the virus.

11. I feel this situation cannot be contained, even though they stopped the programs last week. It is hard to know what is safe and what is not safe and this makes me worried.

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

Date: April 15, 2020 *__/s/Frederick Yeomans__*

Frederick Yeomans

Exhibit 15

DECLARATION OF HENDRICK DAVIS

1. I am 37 years old, and I am currently imprisoned in the Massachusetts Treatment Center ("MTC").

2. I suffer from stage-four kidney disease. The disease has required multiple surgeries to remove kidney stones, including three last year with the most recent in September 2019.

3. There have been at least three dozen diagnosed cases of COVID-19 in prisoners and staff at MTC. I understand that three prisoners from MTC have died.

4. There are 48 prisoners in unit D-1, which is where I am housed. I have seen six people taken out of the unit in the last few weeks because they were sick, I believe with COVID-19.

5. I share a cell with a cellmate. The cell is only approximately 6 by 10 feet, so it is impossible to maintain six feet of separation from my cellmate.

6. The corrections officers (COs) wear masks and gloves. But I've seen them touch numerous surfaces--gates, keys, cell doors, our food trays, etc.--without changing their gloves in between. After touching other surfaces I have then seen them reach into the bags that the bread comes in, take out pieces and put them on prisoners' trays without ever changing gloves.

7. Prisoners are not given masks or gloves. There is a hand sanitizer dispenser in the unit but it has been empty for three weeks.

8. We have been locked in our cells for approximately 23 ½ hours a day for almost 30 days. We are allowed out of our cells only to make a phone call. Some days we are not allowed to make a phone call.

9. There are four phones in the unit but only two are working. The two phones that work are close enough so that I can touch one of the phones when I'm talking on the other.

There is some kind of spray for the phones but all 48 people in the unit touch the spray bottle.

10. We are only allowed to take showers every three or four days. During that time we are also given spray to clean and wipe down our cells. A cleaning crew used to clean the unit every day. Now it is about one time a week. I want to maintain good hygiene, but I cannot because I am imprisoned here.

11. I am afraid that I will catch the virus due to its rapid spread within the facility, and that I am at heightened risk of death or complications due to my kidney disease.

12. I was sentenced to be imprisoned for five years to five years and a day for masked armed robbery and armed assault. I have been imprisoned since January 2016 and am scheduled to complete my sentence in less than a year. With good time, I might complete my sentence in October or November of 2020.

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

Date: April 13, 2020 /s/Hendrick Davis

Hendrick Davis

Exhibit 16

DECLARATION OF TODD CUMMINS

1. I am a 56 year old African American man serving a life sentence for first degree murder.
2. I am currently housed at North Central Correctional Institution in Gardner, Massachusetts.
3. I live in A2, North, bunk 16. That is the second floor of A Building, in the North wing.
4. All of the housing in A building is dorm style housing.
5. The bottom floor, A1, has two dorms: A1 South and A1 North. Both have 30 beds in them. A1 South is a recycle unit and the population changes. A2 North is a permanent housing unit and is generally full.
6. The second floor has three dorms: A2 South, A2 West (sometimes called middle) and A2 North. A2 South and A2 North have 30 beds each and A2 West has 16 beds, all in bunk beds.
7. The West dorm is right in the day room, but sectioned off with a wall. The CO's desk is also in the day room.
8. B building has the same set-up as A building, except the first floor has an RHU instead of a second housing unit..
9. The bunk beds in my dorm are approximately three feet apart from each other and are fixed in place. I can reach out and touch the people on the beds on both sides of me when lying down.
10. DOC sent a memo out to prisoners recently suggesting that we try to sleep in the opposite direction from the other person in our bunk, so that our heads are at opposite ends of the bed.
11. It isn't really possible to do this because of the built in shelf on one end of the beds. You couldn't sleep with your head at that end because the shelf is in the way.
12. We are currently locked down due to the coronavirus.

13. We are allowed out of our dorms two times a day since the lockdown for about an hour and a half at a time. During that time we can go to the day room. We are not allowed to go outside.
14. A2 South and West are let out together, a total of 46 people at a time. A2 North is let out at opposite times from them, 30 people at a time.
15. There are 9 telephones, a microwave and 2 tables in the day room that are shared by all the men out at any one time. The phones are 18 inches apart, but in 3 groups, with a kiosk and a doorway in between the groups. The bathroom is also shared. It has 4 shower heads in a gang shower, 3 toilets and 2 urinals.
16. The officers in this unit have been good about giving the runners cleaning supplies to clean the phones and other surfaces between different units being out, but there is nothing done between different people using items during one recreation period.
17. Since the lockdown started a week and a half ago, we get our food brought to the day room where we go to pick it up and bring it back to our beds to eat and are locked back in the dorm. There really isn't any other option for where to eat because there are no chairs in the dorms.
18. We are getting only cold meals since the lockdown, no hot meals. Additionally, I was not provided my religious meals for Passover or Seder.
19. The COs wore masks and gloves the first day of the lockdown, but since then they only wear masks when they are within 6 feet of prisoners or in the dorm.
20. When staff are putting out our food on the day room tables to prepare it to get picked up, they don't wear masks. You can see them talking while they're doing it. They also don't wear masks at the CO's desk when we go to the counter.
21. We now have hand sanitizer available to us but it is only in the day room. It seems more oily than it did in the beginning and you can't smell the alcohol anymore.

22. DOC has given 2 free calls within this country a week since the lockdown. Those who have family outside of the country are not provided any relief for calling internationally. There are men in the South dorm who need to call family in Brazil, for example, who are unable to check on the health of their families.
23. During this lockdown, a mental health clinician comes twice a week to the dorm and will speak with anyone who chooses to speak with them about coping with the circumstances. These talks happen in the open dorm with no privacy, which discourages people from talking openly. If you don't choose to speak to them, they do not check in on you.

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

Date: 4/14/20 *_/s/ Todd Cummins_*

Todd Cummins

Exhibit 17

DECLARATION OF RYAN DUNTIN

1. I am a thirty-eight-year-old African American man at the Massachusetts Treatment Center serving a 7-10 year sentence for sex trafficking. I have been incarcerated for seven years and I have a little over two years remaining on my sentence.

2. I am in unit South 1 and I believe I have been infected with COVID-19, but medical providers here will not test me for it. Many other men in my unit are coughing and have fevers but no testing is being done. I have a history of chronic bronchitis and this made it difficult to breathe when I was sick. Still, in the middle of the night, I have a dry cough and a sharp headache. I can hear myself wheezing when I try to speak.

3. I work in the kitchen as a food server and I clean the dining room at MTC and while at work on a Sunday, March 8 I began to feel very sick at work and I went to work again on Monday. Tuesday I was off and slept most of the day. On Wednesday, I was taken to the Health Services Unit by Lt. Palmer and my temperature was taken. My temperature was above normal but I was told I had a "cold" and was given a cold pack of tylenol, mucinex and a little yellow pill. I told medical staff that I had a dry cough and a headache and that I might have the COVID-19 virus. I was told I could take the rest of that day off work and then I must return to work on Thursday. When I asked for the COVID-19 test, I was told my temperature was not high enough.

4. During the time I was told that I was suffering from a "cold", I stood in the medication line with ten or fifteen prisoners, some coughing within feet of me. I worked in the kitchen within feet of prisoners and staff. At the time, I was coughing and had a fever, but no one would take it seriously, and I was forced to go about my daily activities as if I were a healthy person. If I stayed in my cell, I would have not been able to eat, get another cold pack or shower.

5. I believe many if not all of the prisoners in South 1 were exposed to COVID-19 and many prisoners are still coughing and probably running fevers, but no testing is being done so these cases are being hidden from the public. We have no masks. Everyone wants to get tested because people were sick in this unit before they were moved out, they had hacking coughs and fevers.

6. I have requested a mask and a test for COVID-19 and these have been denied. All the prisoners here are asking to be tested for COVID-19 and for masks. I have been told by COs and medical staff that since there is a shortage of masks and tests and that prisoners won't get these.

7. I lived across the hall from two prisoners that died of COVID-19. I live in cell 111 and the men that died were in cell 112. Cells 111 and 112 have six men each and are about 30' long by 12' wide. I knew both men that died and interacted with them while they were sick, as they were allowed to stay on the unit while they were sick. Anthony

McCaffery died and I knew him, in fact I pushed his wheelchair to help him on occasion. Many prisoners asked the CO on the unit for him to be taken to the hospital but he was on the unit for about four to five days before he was taken out. Mr. McCaffery used a breathing machine at the dayroom table with other prisoners within three to four steps of him. Larry Reopel was taken out of the block first and he was on the unit for about a week showing symptoms. I heard both men in the cell died and after they died the cell wasn't even quarantined. There are five prisoners living in that cell now.

8. Because there are many sick people coughing on the unit, tension in the unit was high, with people being worried they would be infected. We had to deescalate the situation amongst ourselves as correctional staff didn't notice or didn't care that tensions were running so high.

9. We are trying to wipe everything down with a cleaning solution that has no bleach, it is just a yellow cleaning fluid or a purple cleaning fluid they have been using for years. Both fluids are clearly watered down, although the purple cleaner is "heavy duty." We fend for ourselves, without masks or testing, and we do the best we can to stay alive. The COs are allowing us to disinfect phones, but we had to struggle to do that..

10. South 1 has seventy other prisoners in it and we are housed in six-man cells. There is not social distancing taking place as we are too close to each other all day. I am two to three feet from other prisoners in my six-man room and some of them are currently coughing. All the bunk beds are against one wall.

11. I share six toilets and five urinals with seventy other men.. There are six or seven sinks on each side. The sinks have hot water.

12. No staff has cleaned the unit. The prisoners must take it upon themselves to clean the unit. All the prisoners in this unit must share the bathrooms and sinks. The toilet handles and sink handles are not wiped down between uses unless a prisoner takes it upon himself to do it. The prisoners who clean the bathroom get one bottle of Ajax for two bathrooms and ten showers, five showers on each side. There is one bathroom scrub brush. We clean the bathrooms early in the morning when we wake up and at night. We do get gloves to clean.

13. Food is being brought to the unit, the COs bring a food cart. Our food portions are smaller than if we were going to the chow hall. We had no phone calls for five days while locked down. We advocated for calls because we needed to get in touch with our families. We knew they were worried and we were finally allowed two free twenty minute calls on weekends and one free email per day. Prisoners have to have money already in account to use the email.

14. Medical staff come around for medication time only. Once in morning, afternoon and at night. Two nurses come around and they have masks on and gloves. We have been locked in for about twenty six days now.

15. COs are going to Morton hospital everyday and they don't have N95 masks and they are coming right back and serving us food. Some COs have home made masks. COs are wearing gloves when they serve food.

16. I am worried that I am at great risk of death from COVID-19 because of my history of chronic bronchitis and respiratory issues.

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

Date: April 14, 2020 /s/Ryan Duntin

RYAN DUNTIN

Exhibit 18

DECLARATION OF DANA DURFEE

1. I am a forty-five-year-old prisoner at NCCI-Gardner serving a 2-year sentence for receiving stolen property. I finish my sentence in October 2020, with earned good time.

2. The conditions at NCCI -Gardner are not sanitary and I am constantly exposed to other people while in my dorm-style housing unit. The G unit holds 71 other men and is approximately 24 feet by 40 feet, about the same footprint as a single-family house. We share communal sinks, showers, and toilets. There is a line of people every morning to use the limited number of toilets and sinks. It is hard in the best circumstance to stay away from germs inside prison, but with everyone locked in a small space all day long for weeks, it is impossible.

3. There is no way to social distance as I am a little over 2 feet away from my bunkmate and the bunks on either side of me are within 4 feet of my bunk and each hold 2 men. We are in the unit all day. People in the unit cough, sneeze and snore all the time and none of the prisoners have been given masks.

4. There is access to hand sanitizer on the unit and I have my own soap.

5. Our meals are now served on the unit, but I am still within a few feet of many other prisoners during all time in my unit including meals times where I eat in my bunk bed, some prisoners sit on their foot locker near the bottom bunk to eat so people are 2-3 feet from each other during meals. We have been getting only 1 hot meal a day during the lockdown with the other meals being cereal for breakfast and cold cuts for lunch. The dayroom is open and prisoners are playing cards and they are within feet of each other and all touching the same cards. Often there is a line to use the bathroom in the morning. It seems like there are always two or three people in the bathroom. The sinks are about 14 inches apart at most, the stalls are right next to each other.

6. The Correctional Officers (COs) and other staff have been issued masks but many COs wear the masks around their necks or on their heads instead of over their mouths. No prisoners have been given masks but some prisoners have made their own.

7. I only have seven months left on my sentence and I have a stable home to go to.

8. My biggest fear is catching COVID-19 and dying from it, when I am so close to having my freedom back.I am worried about never seeing my family again.

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

Date: 4/14/20 /s/Dana Durfee

DANA DURFEE

Exhibit 19

DECLARATION OF GABRIEL GUZMAN

1. I am a resident of the Worcester County House of Corrections. I am 35 years old. I have a long history of severe lung problems. I am afraid that I could die if I contract coronavirus while I am incarcerated.

2. I live in I Building, which is a general population unit in "the mods." The cells are all double celled, with two men in a very small space, sharing a toilet and sink and sleeping in a bunk bed.

3. I have severe chronic asthma and chronic obstructive pulmonary disease (COPD). I have been hospitalized for my asthma many times, including earlier this year. I was intubated for lung problems 4 years ago. I am very prone to getting pneumonia and have had it many times, and I have scarring on my left lung. I am prescribed two inhalers, a regular one and a steroid one. I also have a nebulizer on the street but they don't give it to me here. My peak flow measurement yesterday was 300; 500 is when I'm doing well. They wouldn't give me a nebulizer treatment even with that low measurement.

4. I also take high blood pressure medication that I get at my cell door during the lockdown instead of a medline. A nurse brings an envelope with my medication to the cell, wearing a mask, but no gloves.

5. Some officers are wearing masks, more so in the last few days, but few are wearing gloves.

6. During lockdown, which started about two weeks ago, we are let out of our cells only once a day for 50 minutes. We get let out at 7 am one day, then 3 pm the next, alternating between those times. This means that we are locked inside our cells with another person for about 31 hours at a time every other day. Ten men are allowed out at one time. During that time we can make calls, shower, and order canteen. We can only go into the common area of the unit; we can't go outside at all.

7. There are 4 working phones in the unit, about 17 inches apart. There are also 9 tables. We are not allowed to use the tables now, but they are sanitized between each rotation of 10 men out. Phones are also sanitized between each rotation. We can use the two microwaves in the unit, but I haven't seen them cleaned. The tables and phones are cleaned between rotations with some

kind of sprayer that they put a powder into. Sometimes it is the COs that clean, sometimes it's the runners.

8. We have been given nothing to clean our cells at all. No sanitizer or cleaner, no gloves.

9. I have no way to access any hand sanitizer. There is none available to prisoners in this unit. The jail gives out hand soap to everyone once a week. This is not new. I am able to buy myself antibacterial soap in the canteen because I have money in my account. My cellmate and I wash our hands as often as possible.

10. The jail gives prisoners one mask about every 10 days.

11. We are getting food by COs bringing our trays to our cells. They usually wear gloves and masks when they do this. We eat in the cells with our cellmates.

12. I was convicted of conspiracy to distribute and probation violations. On March 5th, 2020, I was sentenced to 18 months with 5 months served and there are now about 13 months remaining. I think I am eligible for parole in August of 2020.

13. If I am released I will go home to my mother's house and will have the full support of my family, including my uncle who I am very close to.

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

Date: April 13, 2020 *_/s/ Gabriel Guzman*

Gabriel Guzman

Exhibit 21

DECLARATION OF MICHAEL MARAMALDI

1. I am a thirty-five-year-old, white man serving a 1.5 to 2.5 year sentence for a probation violation for failing a drug test, with an underlying charge of receiving stolen property (motor vehicle). I am at MCI-Concord.

2. I have been diagnosed with Hepatitis C and severe anxiety. I am not taking medication for either diagnosis. I believe that my Hepatitis C diagnosis puts me at higher risk for death or severe illness if I contract COVID-19. I have one year and five months left of my sentence. I am eligible for parole in either August or September of 2020, or earlier if I can earn additional good time. Upon my release, I will go to live at my mother's house in Salem, MA.

3. The conditions at MCI-Concord are not sanitary and I am constantly exposed to other people while in my dorm-style housing unit. I live in unit L2, which has about 80 men living in it. I would estimate that it is about the size of a basketball court. MCI Concord has been on 24-hour lockdown since Friday, April 3, 2020. That means that we are locked in the unit 24 hours per day. We do not leave.

4. We sleep on bunk beds. When I am sitting on my bed, I estimate that I am three feet away from the person sleeping above me, three feet away from the person on the bunk to my right, and three feet away from the person on the bunk to my left.

5. There are two communal bathrooms in my unit that each have 3 toilets, 1 urinal, and 5 or 6 sinks. The bathrooms are cleaned once a day, in the morning. By noon they are filthy. The toilets and sinks are sometimes clogged with fecal matter and toilet paper and there is a rush of people every morning to use the limited number of toilets and sinks. When I am at the sink brushing my teeth, I am close enough to the person next to me to touch them with my elbow.

6. We also share phones that are located in the unit. I believe that the phones are sprayed with disinfectant once per day, in the morning. They are not cleaned between uses.

7. One bar of soap is handed out to everyone once a week. The soap is smaller than a bar of hotel soap. It only lasts for one use. When I asked for another bar of soap after less than a week, I was told there is none. There is hand sanitizer in the unit, as of last week, but it runs out at least every other day. The soap dispensers in the bathrooms have been filled for the first since I got to this prison. They are only filled once a week, and they run out every week. I would estimate that they are empty at least three days a week.

8. Medical staff come to the unit to hand out medications three times every day. The staff who hand out medications wear masks. Everyone in the unit who needs medication has to line up to get them. There is not space where we line up to have six feet of space from each other. We line up with the same amount of space between us as we did before COVID-19.

9. Our meals are now served in the unit, but I am still within a few feet of many other prisoners while eating. I eat sitting on my bed, where I am within about three feet of the bunks next to me and above me. If I were to eat at one of the tables, I would be about 3 to 4 feet from the person sitting next to me.

10. The Correction Officers (COs) and other staff that I have seen have masks, but many COs wear the masks only some of the time, or they wear them around their necks, not over their mouths. I have witnessed multiple COs come in and out of my unit over the past several weeks without masks. I have not seen any of the COs are wearing gloves, even when they are handing out meals. I have not been given a mask or gloves and no other prisoners in my unit have masks or gloves. When I asked for a mask, a CO told me that prisoners "don't need them."

11. Since we are locked in the unit 24 hours per day, we cannot go to the yard or gym. There is no space to have any kind of recreation except playing cards or watching television. Both of those activities would put me in close contact with other people.

12. There are two fans blowing in the unit all the time. There are air vents in the ceiling, but when I stand underneath them, I cannot feel any air coming out of them. There are five windows in the unit, but they only open about a foot each. It is very stuffy and there is very little fresh air.

13. I am frightened that with the conditions in this unit, I could catch coronavirus, and I feel like I am at high risk.

14. I complete my sentence in September of 2021, possibly sooner if I earn good time, and I am eligible for parole in less than six months.

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

Date: April 13, 2020 /s/Michael Maramaldi

MICHAEL MARAMALDI

Exhibit 22

DECLARATION OF TEVON NGOMBA

1. I currently reside in the Restricted Housing Unit (RHU) at Souza-Baranowski Correctional Center. I am 27 years old and I suffer from asthma, hypertension, and high blood pressure.

2. I currently reside in J3, low side. There are individuals who are quarantined with possible cases of COVID-19 on J3, high side. There are 4 individual showers cells that are shared between J3 low side and J3 high side. A total of 30 prisoners maximum use these 4 showers. One of my biggest concerns is that the people here are sharing showers and phones with the people who are quarantined with possible cases in the unit next to mine. Myself and other prisoners will refuse to shower when we observe that a shower has not been cleaned after a prisoner under quarantine has showered in that shower. I will just use my sink inside my cell to wash myself. Many other prisoners are not even using the showers at all because of the fear of being infected by people who have the virus. Myself and many other prisoners have a clear view of the shower cells from our cells. Therefore, we know that the showers are not cleaned every day and are usually cleaned once per week.

3. The phone is wheeled down the unit between J3 low side and J3 high side. Prisoners under quarantine are using the same phone as those in J3 that are not under quarantine nor showing symptoms of COVID-19. The phone is not cleaned between uses. I use soap or shampoo that I have inside my cell to clean the phone to the best of my ability before I make a call. I have filed an informal grievance on this matter after I discovered the phone was used by a man under quarantine and then shared with those on my unit who are not under quarantine on April 4, 2020.

4. We are not given any hand sanitizer here. Soap is distributed once per week. The soap that is distributed often does not last a week. I have been denied when I ask officers on my unit for an additional bar of soap.

5. Prisoners in the quarantine unit have told me that individuals in that unit are not being tested, just that they are being kept there for 14 days. I have communicated with

individuals on the quarantine side and I have been told that some of them have left the unit after only 4 days or so.

6. The officers have masks, although they don't always wear them. I put in a formal complaint about this and have not yet received a response. I put in the complaint on April 7, 2020 after I saw an emergency team of officers respond to a prisoner in quarantine who was complaining of shortness of breath and chest pain. The officers were not wearing masks. This incident occurred within close proximity of my cell.

7. The prisoners do not have masks.

8. I am serving 5-6 years for a probation violation from March 2016. My original charges were armed robbery, kidnapping, and carjacking from February 2012.

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

Date: April 14, 2020 /s/Tevon Ngomba

Tevon Ngomba

Exhibit 23

DECLARATION OF ARIEL PENA

1. I am a prisoner at MCI Shirley serving a 6 to 8 year sentence for drug possession with the intent to distribute. I will be eligible for parole in November 2020, or sooner if I can earn good time between now and then. I have four kids with whom I am close. I am currently a student at Boston College.

2. I have diabetes and am dependent on insulin. I also have high blood pressure and high cholesterol for which I take medicine daily. I check my sugar three times and a day and usually take insulin three times a day. We're in isolation right now, so nurses draw the insulin and inject it into me themselves. They don't always change their gloves between patients.

3. It is impossible to maintain distance from other people here, even in segregation. We are in lockdown right now, meaning we are in our cells all day and night except for approximately 40 minutes daily to use the shower and phones. I have a cellmate and depend on nurses and correctional officers to meet my needs so I am still not able to socially distance.

4. I live in a double cell in unit F-1. On my unit there are about 36 double cells, and 24 single cells. My cellmate and I sleep on a bunk bed. We're not given cleaning supplies daily, or even every few days to clean our cells. For example, we haven't been able to clean them since we've been locked down for over one week now. We use shampoo, bar soap or whatever we have. It is not possible to stay more than 6 feet from him at any time when we are in the cell.

5. For the past week, we have been locked in our cells except for 40 minutes per day. About 8 people are allowed out at a time to use the phone or take a shower. The phones are less than 2 feet from each other, so when more than one person is on the phone at a time, we are right next to each other. The phones are not always sanitized between use, and showers are not cleaned between use.

6. Since we are locked in, staff deliver food and medication directly to our cells. Some staff members wear masks, but many do not. I do not have a mask, and no prisoners that I know of have masks. Usually after I eat I walk around outside in the yard, in the gym or even in the unit and that helps keep my sugar low. Because we are now locked in and I can't walk around after meals, my sugar has consistently been in the 200s or 300s after eating, which is not safe. This is causing my feet to go numb and I am worried that I am developing neuropathy.

7. My mental health is deteriorating and I recently asked to speak to mental health. The lockdown and the news cause me a lot of stress. My biggest fear right now is dying in prison, alone.

8. I have heard about at least one positive case in another unit, and I know from the news that there are already confirmed cases at MCI Shirley.

9. From what I've learned about COVID-19 I am at high risk for serious illness or death if I get COVID-19. I feel I am in danger. I will be eligible for parole in less than 6 months if I can earn good time between now and then.

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

Date: April 13, 2020 /s/Ariel Pena

Ariel Pena

Exhibit 24

Declaration of Ryan Powell

1. I am a 28 year old prisoner held at MCI-Concord. In 2016 I was sentenced to 3-5 years for armed robbery.

2. I am very worried about being infected with covid-19. I have chronic obstructive pulmonary disease (COPD) which puts me at a higher risk of serious complications from COVID-19.

3. I am in Unit J6. While we have access to soap and hand sanitizers, I am held in a double cell, and it is impossible to maintain distance from my cellmate. There are about 90 people on the unit now housed similarly. All cells are double celled and all are full.

4. We are let out of our cells 6 men at a time, into a 30 by 40 foot common area, which also has two COs at a desk, five tables, a tv, 2 microwaves, and a commercial hot pot. We have 30 minutes to use the phone, shower or talk to people in the common area. The runners clean this stuff at night, but don't clean between groups of people using them. We are not allowed to go outside. We are let out like this once per day.

5. COs in this unit occasionally wear masks and never wear gloves. We were never told to keep a 6 foot distance from one another.

6. Medical staff come into the unit 3-5 times a day. Some of them wear masks or gloves.

7. There are 8 phones for the 90 man unit and they are about 2 feet apart from each other.

8. No prisoners were given masks or gloves. I asked both COs and medical staff for a mask and was told they didn't have any.

9. There are 8 showers shared on the unit. They are cleaned every other day.

10. My sentence ends in November 2020, and I will be released in August or September due to earned good time.

11. If I am released I will go to live either in sober housing or with my mother who I keep in regular contact with.

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

Date: April 14, 2020 /s/Ryan Powell

Ryan Powell

Exhibit 25

DECLARATION OF JOSEPH WATKINS

1. I am a thirty-one-year-old African American prisoner at the Massachusetts Treatment Center serving a ten to twelve-year sentence for manslaughter. I have a very old indecent assault and battery on my record. I am hoping to be released May 29, 2022, depending on how much good time I can earn. I am unable to read or write and this affidavit was read to me over the phone.

2. I have COVID-19. For the first two weeks of the illness, I had a high fever and a dry cough. I had trouble breathing and no sense of taste when I was sickest.

3. I was moved to C-1, the COVID quarantine unit, around March 25, 2020. I was in South 1 feeling sick for a week before I was moved. Since I have been in this unit the conditions are bad. I was only allowed to shower twice the first week I was in the unit. The nurses only come around to pass out Tylenol, a small cup of ice and to take my temperature, the providers come to my cell and pass the medication through the food slot. The nurses use the same gloves to pass the medication to each cell, they do use a cleaning solution on the gloves in between each cell. I also had a swab done for COVID-19 on April 1st, 2020. One of the medical providers came and told me he was "sorry" that I "tested positive for the coronavirus." Other than that no one talks to me at all about my condition or how long I might be housed on this unit. I still feel weak from having COVID-19 but I am no longer coughing and I don't have a temperature that I know about.

4. I am a leukemia survivor, in remission, but my immune system is still weak and I have a history of dangerous blood clots in my jugular vein. I received cancer treatment through a port in my neck and then developed complications at the treatment site. I am on the medication coumadin, which is a blood thinner and helps to prevent the blood clots. I need to take this medication everyday or I could die. DOC did not provide this medication for the first five days I was on the COVID unit.

5. I can hear many other prisoners coughing. There are at least twenty nine other sick men in C-1, all tested positive for COVID-19. The people in this unit appear to be very sick and in need of help from the outside world. Everyone is in a single cell. The unit holds sixty prisoners when full. Some diabetic prisoners are not receiving insulin. Some of the people are too sick to talk to the medical staff, take showers, or talk on the phone and many prisoners are losing weight. Mental health staff have come to this unit twice since I have been here. There are three Salvadorian people here who don't speak English and no one translates anything for them or even talks to them. I think that because many people here are convicted of sex offenses, people don't care at all.

6. I heard that more than four people from MTC went to the hospital and some have died. All the prisoners who were taken to the hospital are African American and this makes me very afraid. The first person to die was an older gentleman and he was taken out on a stretcher.

7. We have to ask for soap and toilet paper and they don't have hand sanitizer or proper cleaning solution. We are just here locked in our cells. The Deputy Superintendent comes in the unit and just moves through the unit as fast as she can. The COs will give you a solution to clean the phone before use, but only on the second shift.

8. Food and medication are being brought to my cell but there is no time to ask questions or express concerns as the food is left and the staff hurries down the tier. The food we are receiving is cold, when it should be hot.

9. I am terrified of staying in prison as I have a compromised immune system and I take coumadin and this dangerous medication must be monitored closely so I do not get another blood clot.

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

Date: April 14, 2020 /*s/Joseph Watkins*
JOSEPH WATKINS

Exhibit 26

DECLARATION OF NOE ZUNIGA

1. I am a twenty-four-year-old Hispanic prisoner at MCI-Concord serving a sentence of two and a half years with three years probation for armed robbery. I have one month left on my sentence.

2. I am scared of catching COVID-19 because I have high cholesterol and am pre-diabetic. Additionally, I have heard on the news that COVID-19 is hitting people of color and Hispanic people harder than others.

3. The conditions at MCI-Concord are disgusting because the facility is not following the proper precautions to prevent the spread of COVID-19. I am constantly exposed to a large amount of people while in my dorm-style housing unit. I live in unit L2 that houses 75-80 other inmates. We all share communal sinks, showers, and toilets. Our bunk beds are right next to each other and are less than an arms length away from each other. We also share the TV, hot pots, and the one microwave on the unit. Many prisoners touch these items throughout the day and they are not cleaned between uses or after meal periods.

4. There is no way to practice social distancing. The bunk beds holding other men are less than three feet away from mine. We are in the unit for most of the day. We spend our time watching tv and working out and we are well within six feet of one another while doing so.

5. I have access to hand sanitizer on the unit but I am indigent and the DOC only gives me a small hotel size bar of soap. I get one of these small bars a week and it is not enough to keep clean under the best circumstances. The small bar is usually done after one shower.

6. I am locked into a unit with at least seventy-five other men and we are unable to use the yard or law library so we are stuck in the unit all day with nowhere to go.

7. I usually see my mental health clinician once a month but have not seen anyone from mental health since early March. I have been diagnosed with PTSD and prescribed medication for it. I have also been prescribed medications for high cholesterol and prediabetes. I take these medications once a day through medline. When I'm in medline I am always less than 6 feet away from the other inmates who are also in medline.

8. I am going crazy with worry about my family and my own health. I call my family often and I am so stressed out. I think the worry of contracting COVID-19 is driving me insane.

9. Food is served on our unit but I am afraid to eat it because I don't know if the kitchen workers preparing the meal have been wearing protective gloves. The prisoners who deliver the food to our unit do wear gloves but I am still concerned I could catch COVID-19 from a food tray or from contaminated food. The inmates do not wear masks when delivering food.

10. The Correctional Officers (COs) and other staff have masks but many COs don't wear the masks. I have not been given a mask and I have not seen any other prisoners get masks.

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

Date: April 13, 2020 /s/Noe Zuniga

NOE ZUNIGA

Exhibit 27

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

SUFFOLK, ss. No. SJC-12926

COMMITTEE FOR PUBLIC COUNSEL SERVICES, et al., Petitioners,	)
v.	)
CHIEF JUSTICE OF THE TRIAL COURT, et al. Respondents.	)

AFFIDAVIT OF CAROL MICI

I, Carol Mici, hereby depose and state as follows:

1. I am the Massachusetts Commissioner of Correction. I was appointed Acting Commissioner of Correction on December 6, 2018, and then appointed Commissioner of Correction on January 22, 2019. I have worked for the Massachusetts Department of Correction (Department) since 1987. The statements in this affidavit are based upon my own personal knowledge, my discussions conducted in the course of my professional duties, and my review of records maintained in the usual course of the Department.
2. The COVID-19 virus pandemic is affecting all levels of government. Here at the Department, our primary focus during this pandemic has been on the health and safety of inmates and staff.
3. The Department, utilizing external and internal regulation and policy enforcement bodies, and provides a safe and hygienic environment for both staff and incarcerated offenders.
4. As detailed more fully below, by utilizing the following agencies, units and staff members, the Department ensures that its diverse infrastructure and facilities are maintained in such a manner as to provide a high standard of quality of life for incarcerated offenders and working conditions for its staff members.

5. The Department's COVID-19 plans and procedures are frequently reviewed and updated to reflect the continual changes in this public health emergency situation.

Periodic Sanitation and Public Health Audits of Correctional Facilities

6. The correctional institutions in the Commonwealth of Massachusetts are subject to external and internal regulations that govern sanitation and hygiene.
7. Externally, the Department of Public Health (DPH) inspects Department of Correction facilities twice per year.
8. These comprehensive DPH inspections are conducted by sanitation code compliance experts utilizing 105 CMR 451.
9. The 105 CMR 451 contains standards for diverse operations such as food services, housekeeping, living area requirements, washroom minimum requirements, etc.
10. At the conclusion of these inspections, each institution must submit a plan of corrective action addressing each deficiency cited in the inspection report.
11. These plans of action are submitted to DPH for review and acceptance.
12. In addition to the external inspections, each institution is required to have a trained environmental health and safety officer (EHSO).
13. Department policy requires that these officers conduct a comprehensive monthly inspection of the entire institution to identify and address sanitation and hygiene concerns.
14. These officers are also tasked with training other institution staff members to conduct required weekly sanitation and hygiene inspections throughout the entire institution.
15. The Department conducts a comprehensive training course for all new EHSOs.

16. As part of this training, Department instructors as well as external stakeholders (to include staff from DPH) train these individuals in the nuances of sanitation and hygiene inspections.
17. Annually, each institution is audited by the Department's Policy Development and Compliance Unit (PDCU).
18. As part of these PDCU audits, a complete physical plant tour is conducted where the most recent DPH report is utilized to determine if corrective action has been taken to address cited issues.
19. Lastly, the Department has achieved Eagle status with the American Correctional Association (ACA).
20. This ACA status is bestowed upon correctional departments that have achieved 100% institution and central office accreditation.
21. ACA standards include requirements for sanitation and hygiene, and in order to prove compliance, the Department must maintain accreditation folders that contain samples of required documentation.
22. Once every three years, auditors from ACA will audit each institution to determine compliance with these standards.

Responses to COVID-19 for Inmates and Staff

23. Upon the declaration of a State of Emergency by Governor Baker on March 10, 2020, the Department began implementing its epidemic control plans.
24. Since March 12, 2020, inmates and staff have received several directives regarding COVID-19 and efforts to prevent its spread.

25. On March 12, 2020, I issued an employee advisory listing the coronavirus's symptoms, and who was at most risk of exposure (those who travelled internationally within the past 14 days to countries with sustained transmission; residence in a community where the virus is spreading). Employees also were instructed not to return to work until cleared by DPH, and given procedures for handling visitors with possible symptoms of COVID-19. The advisory also provided the necessary steps to be taken to prevent infection by the virus, as detailed by the CDC and DPH. Exhibit 1.

26. On March 13, 2020, I issued a COVID-19 preparedness advisory (in English and Spanish) to all inmates. The advisory assured inmates that all necessary steps were being taken to provide them with a safe, secure environment. Among the information given to inmates: the importance of frequent hand washing, social distancing, use of soaps and cleaning supplies, availability of additional information about the virus, additional cleaning plans, access to medical providers, and new precautions for visitors who might be at risk for transmitting the disease. Exhibit 2.

27. On March 20, 2020, I issued a COVID-19 update (in English and Spanish) to all inmates. This update informed inmates that they would be provided two free 30-minute phone calls a week, that phone privileges for inmates serving a loss-of-phone sanction would be restored, that all medical co-pays were waived, the importance of social distancing, and letting them know that mental health services, as always, were available to them. I issued a similar update (in English and Spanish) the same day to all inmates being treated by the Department's medical provider, Wellpath, within correctional facilities. Exhibit 3.

28. Also on March 20, 2020, I issued an update to all staff. Among the steps taken by the Department to assist staff: relaxing restrictions on bottled water; screening of all staff

prior to entry in accordance with CDC/DPH guidelines; limiting of inmate transports and transports between facilities; authorizing staff in areas with high risk of infection to wear personal protective equipment (PPE), based on specific evaluations based on need; working with individual facilities to ensure sufficient infectious disease plans are in place; upgraded cleaning/disinfection protocols; determining what staff might telecommute; and allowing staff to bring in their own disinfecting wipes. Exhibit 4.

29. The March 20, 2020 update also included flyers illustrating the CDC's recommended infection control procedures and the proper use of PPE. Exhibit5.. On March 23, 2020, the CDC issued Interim Guidance on the Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities, which the Department has received and has followed. Exhibit 6.. Among other items, the CDC recommends restricting transfers between correctional facilities, which the Department has done. This Interim Guidance is being sent to superintendents today along with a summary sheet, directing superintendents to review and review their plans for any necessary adjustments. The Department had already implemented most of the recommendations contained in the Interim Guidance. The Department will continue to adjust its operations during the pandemic as CDC guidelines evolve. 87.

30. On March 24, 2020, I issued a memo to all employees regarding the issuance of PPE in certain circumstances, and authorized staff members to use their own masks until being issued PPE by DOC. Exhibit 7. The Department has sufficient PPE inventory for its needs: as of March 27, 2020, the Department had 4,338 protective face masks, 467,600 Nitrile examination gloves, 268,000 vinyl examination gloves, 252,000 vinyl non-medical gloves, 100 disposable protection gowns, 60 disposable lab coats, and 5,000

polyproplene coveralls. The Department's Industries Division has produced 300 PPE gowns, 100 face masks, and bottled 2,500 four-ounce individual hand sanitizers. All Department employees who have direct contact have already received masks and gloves, which are being worn.

31. Although the Massachusetts Treatment Center is the only Department facility to have confirmed cases of COVID-19 to date, the Department has taken steps to prevent the introduction or transmission of COVID-19 to other facilities. Superintendents have been instructed to slow down meal times to reduce chow hall numbers, reduce gym activities to limit numbers and prevent contact sports, implementing social distancing in programs, libraries, and classrooms, and encouraged facilities to extend outdoor exercise periods. The Department has limited the number of inmates able to be out of cell and on tiers. In addition, all inmates will be offered seven free emails per week, and we have increased quarterly care packages from Keefe, the Department's canteen vendor, from $75 to $90 per quarter. All of the Department's preventative measures are drawn from national and state public health and inmate advocacy organizations.

32. Medical providers at Department facilities meet with inmates who present with symptoms consistent with a viral illness. As with any patient, if an inmate has symptoms and meets the criteria for testing, DPH determines whether to have the inmate/patient tested. Inmates who are symptomatic undergo a quarantine protocol, receiving meals and full medical care within their rooms. The Department's contract medical provider has implemented multiple COVID-19 procedures and protocols within Department facilities, including but not limited to: COVID Screening and Triage Process, including screening questions and temperature checks; collection of Diagnostic Respiratory Specimens from

patients; identification and monitoring of patients both confirmed and unconfirmed for COVID; ongoing monitoring for the cohort of patients that are COVID-positive; COVID tracking of all patients tested for COVID; N95 mask fit testing and distribution to staff; education for patients and staff regarding COVID mode of transmission, standard precautions, hand washing, social distancing, and housekeeping/cleaning; identification of patients who are at high risk; proper use of PPE; protocol for clearing patients post-COVID diagnosis; notification to DPH for all COVID-related reporting; and cancellation of non-essential and elective procedures for off site appointments.

Entrance and Screening Procedures

33. The most effective deterrents against the spread of COVID-19 in the correctional setting are (1) limiting the number of people coming into the prison; and (2) screening the people who must enter the facility.
34. To that end, on March 12, 2020, the Department suspended all general visits at all correctional facilities. While the Department remains committed to ensuring that family and friends may visit loved ones who are incarcerated, the public health emergency and the need to prevent the virus's spread require this temporary suspension.
35. This temporary suspension of general visits does not apply to attorney visits.
36. Attorneys are still permitted to visit inmates, albeit with enhanced screening procedures, except, as noted below, with respect to the Massachusetts Treatment Center (MTC).
37. As an additional precaution, hand sanitizer is made available in each facility's lobby.
38. Following the suspension of general visits, the Department issued additional restrictions on <u>all</u> persons who enter the facilities.

39. Under these procedures, all persons entering a correctional facility—whether employee, vendor, contractor, or attorney—must successfully pass an enhanced entrance screening prior to access being granted.
40. Each facility has reduced access points to one Single Point of Entry (SPE). The National Guard has assisted the Department at the SPE's by setting up tents, generators, lighting, and heaters to run the SPE.
41. At the SPE, a staff member and a manger are assigned to supervise an entrance screening of every individual seeking entrance into the facility.
42. The staff members assigned to the SPE are clothed in PPE consisting of gloves and a mask.
43. Screening is based on CDC/DPH recommendations, and consists of a series of health-related questions and a self-administered non-intrusive health check for fever conducted by the employee.
44. Each person entering is required to fill out the questionnaire and a thermometer is available for each employee to take their own temperature. The thermometer is disinfected between each use.
45. Completed questionnaires are handed to the on-site manager and upon review, the manager makes the final determination to approve/deny the person entrance.
46. No person with a temperature reading above 99.9 degrees Fahrenheit is permitted to enter the facility. Any person denied entrance is advised to consult with a medical professional.
47. A copy of the new entrance procedures and a blank questionnaire are attached hereto as Exhibit 8.

48. Tables and items at each SPE are cleaned and disinfected after each shift change is completed.

49. In addition to the enhanced screening procedures stated above, Department correction officers are considered first responders and may be tested for COVID-19, by appointment, in a drive-up testing site at the CVS in Shrewsbury.

Cleaning and Disinfecting Procedures for Correctional Facilities

50. Frequent cleaning of areas accessible to inmates and staff is among the most important defenses against COVID-19.

51. As a primary mechanism to ensure sanitation, each correctional facility is required by Department policy to create a housekeeping schedule.

52. These housekeeping plans outline cleaning schedules for all areas, instructions on proper cleaning, and specific assignments and duties.

53. Ongoing cleaning is happening at all facilities, concentrating on high touch areas, with inmates and staff ensuring, as much as practicable, that sufficient amounts of bleach and other cleaners are used to kill the virus and prevent its spread.

Hand Washing Opportunities Within Correctional Facilities

54. Soap and hot water are readily available in all inmate living areas.

55. The Department distributed pump containers of isopropanol-based hand sanitizers to all housing units as a secondary means of hand cleaning for inmates. Before the COVID-19 pandemic, Department dispensers contained alcohol-free sanitizer. On March 26, 2020, 328 half gallon containers of hand sanitizer were delivered to facilities, as well as hand pumps for the bottles. The Department has additional sanitizer in stock and it is being delivered to facilities the same day it is requested.

56. Inmates are also being provided with bar soap, and are being told that they may request additional soap, at no charge, as needed.

57. As of March 25, 2020, the Department had acquired almost 158,000 bars of soap to provide to inmates, distributed as follows: NCCI-Gardner, 31,500; Souza-Baranowski Correctional Center, 34,992; MCI-Shirley (Medium/Minimum), 24,500; MCI-Concord, 2,750; NECC, 877; MCI-Framingham, 20,000; South Middlesex Correctional Center, 75 bars; Pondville Correctional Center, 6,000; MCI-Cedar Junction, 12,960; MCI-Norfolk, 15,264; Boston Pre-Release Center, 1,450; MASAC, 1,440; MTC, 3,500; and Old Colony Correctional Center (Medium/Minimum) 2,444.

Specific Precautions at the Massachusetts Treatment Center

58. As of March 27, 2020, the MTC has ten confirmed cases of COVID-19 in its population (for purposes of this affidavit, the civilly committed individuals and state prisoners are collectively referred to as "inmates"). These ten inmates represent less than 2% of the 568 inmates and committed residents at the MTC, and about one-tenth of 1% of the Department's custody population, which reflects the Department's ongoing enhanced efforts to prevent introduction or transmission of COVID-19 within its facilities. Of these ten inmates, eight are currently housed on the C-1 unit. The two other inmates are being treated at outside hospitals. The most recent confirmed diagnosis was received on March 27, 2020. There are four confirmed staff cases of COVID-19, three are security staff members and one is a medical staff member. Currently, there are thirteen other inmates who have been quarantined due to the presence of symptoms of possible COVID-19 virus; test results are pending on these inmates. Of these thirteen inmates,

eleven are housed in the C-1 unit, one is housed in the MTC's health services unit, and one is at an outside hospital. No other inmates are being housed on the C-1 unit.

59. All staff (correctional and vendor medical/mental health) entering the MTC are being screened according to DPH protocols. All staff members who are cleared upon screening to enter the MTC have been directed to wear personal protective equipment (PPE), including masks and gloves.

60. The MTC correctional staff members are feeding all inmates in their cells on disposable paper products. The MTC medical staff members are providing medication to all inmates in their cells. Enhanced facility cleaning has been implemented. All inmates are offered cleaning supplies during the 3x11 shift daily. Correctional staff members working inside the MTC are provided with chemicals to clean their areas, handrails, and staff bathrooms. Unit runners (inmates) clean the bathrooms and showers on the modular housing units. The cells in the main facility have their own toilets and sinks which the inmates living in the cell clean. Access to showers is provided for based on the physical plant of the housing unit. For those inmates housed in the modular units, the inmates may shower daily. For those inmates housed in the units in the main facility, showers are scheduled on a rotating basis by unit, with inmates being offered a shower every third day. The showers are being sprayed with cleaner between uses. After the last shower of the day, the assigned unit runner cleans the shower. The MTC's environmental health and safety officer (or back up) then sprays the showers with chemical cleaner.

61. As of March 25, 2020, the MTC had 3,500 bars of soap available for inmate use. Bars of soap are being issued upon request to inmates. Hand sanitizer is available for use by staff and inmates (when they are out of their cells) on each housing unit. The MTC continues

to receive deliveries of hygiene and sanitation supplies on a daily basis. Inmates have access to showers.

62. Inmate laundry is being done on the same institution schedule that was in place before the lock-in. During the lock-in, the unit correction officer picks up the inmates' laundry bags; Department maintenance workers launder the items; the unit correction officer returns the laundry bags to the inmates.

63. A member of the MTC senior administration makes a daily round through all housing units. Correctional program officers (akin to case managers) make rounds in housing units three times a week. Correctional officers are assigned to each housing unit. To provide inmates with general reading materials, Recreation staff members will conduct weekly rounds with a book cart beginning on Saturday, March 28, 2020.

64. In-person attorney visits have been temporarily suspended since March 21, 2020 as part of enhanced health and safety precautions at that facility. Inmates and civil commitments are afforded the opportunity to make attorney telephone calls. Inmates continue to have access to send and receive mail and to send e-mails on personal tablets. Inmate access to telephones was temporarily suspended while medical staff screened the population for COVID-19. Telephone access was reinstated on March 24, 2020. Telephone access is provided on a staggered basis to limit the number of inmates near the telephones and to permit cleaning of the telephones between users.

65. To ensure access to courts, a protocol for legal photocopying during the lock-in was put in place on March 25, 2020. Inmates continue to have the ability to order personal items through the canteen.

Release of Appropriate Prisoners on Medical Parole

66. G.L. c. 127, § 119A permits prisoners who are "terminally ill or permanently incapacitated" to petition for release from custody on medical parole. Per the statute, "[i]f the commissioner determines that a prisoner is terminally ill or permanently incapacitated such that if the prisoner is released the prisoner will live and remain at liberty without violating the law and that the release will not be incompatible with the welfare of society, the prisoner shall be released on medical parole." G.L. c. 127, § 119A(e).

67. Upon receipt of a medical parole petition, the superintendent completes a public safety risk assessment by reviewing the inmate's file for criminal and institutional history, including circumstances of the crime, disciplinary and classification reports, and inmate's participation in education, work and recommended programming. At the same time, the Department's contracted medical provider, Wellpath, is asked to provide an updated clinical review as to the inmate's medical condition.

68. The medical parole statute contains definite timelines: the superintendent must issue a recommendation to the Commissioner "***not more than*** 21 days after receipt of the petition" and "[t]he commissioner shall issue a written decision ***not later than*** 45 days after receipt of a petition" (italics and bold added).

69. But these timelines represent the outer limit of what is permitted; there is nothing preventing superintendents from exercising their discretion and making recommendations in less than 21 days; nor is the Commissioner prohibited from rendering her decision in less than 45 days. Department staff typically expedite decisions on medical parole petitions if the inmate's condition is significantly dire.

70. The medical parole statute requires that, upon receipt of a petition, the Commissioner must "notify, in writing, the district attorney for the jurisdiction where the offense resulting in the prisoner being committed to the correctional facility occurred, the prisoner, the person who petitioned for medical parole, if not the prisoner and, if applicable under chapter 258B, the victim or the victim's family that the prisoner is being considered for medical parole." G.L. c. 127, § 119A(c)(2).

71. The persons who receive the notice have a statutory right to submit written statements to the Commissioner. Id. In the case of an inmate serving a sentence for murder, the district attorney and victim's family have the right to request a hearing. Id. The Commissioner is also required to notify the district attorney, department of state police, local authorities, and SORB at least 24 hours prior to any prisoner's release on medical parole. G.L. c. 127, § 119A(e).

72. Superintendents work closely with interested stakeholders in developing medical parole plans and identifying potential placements for inmates who are medically paroled.

73. The Department initially required a petitioner to submit a medical parole plan in order for the petition to be considered. However, following Buckman v. Comm'r of Correction, 484 Mass. 14 (2020), the Supreme Judicial Court ruled that this practice was contrary to the statutory language.

74. Accordingly, while a medical parole petition may be accompanied by a medical parole plan developed by the petitioner, in the event that the petition is not accompanied by a medical parole plan developed by the petitioner, the superintendent develops a medical parole plan for the inmate. And, where the superintendent takes the lead in developing a

medical parole plan, input from the petitioner and outside stakeholders (CPCS, PLS, etc.) is always welcome.

75. The Department's reentry staff coordinate between Wellpath and MassHealth to increase the chance of placement in a viable Long-Term Care Facility (LTCF) and to ensure that MassHealth has the documents needed so that the LTCF can bill MassHealth upon the inmate's release from custody on medical parole.

76. The Departmet's reentry staff also work directly with MassHealth to have MassHealth applications expedited as much as possible, and to provide MassHealth with any additional documentation (which is often needed) as well as explain documents that the Department cannot provide. (While an SC-1 form is required before the person can obtain MassHealth, the document can only be submitted from the LTCF, or a MassHealth request for DOC to prove that the inmate has filed for Social Security. -An inmate can only file for Social Security in person at an SSA office, after their release).

77. Parole takes the approval from Department reentry staff and submits it to the field Parole Officer, who is responsible for conducting a visit to the proposed housing placement. If Parole approves the proposed placement and MassHealth is in place, the inmate can be released from custody.

78. The Department's reentry staff also work with inmate advocacy organizations such as Prisoners' Legal Services (PLS), where PLS has informed the Department that they had submitted applications on an inmate's behalf (e.g., to Tewksbury State Hospital, or Farren Health Center).

79. In these cases, the Department works to ensure the LTCF has all the information they needed from PLS and provides additional information as needed. PLS has also assisted in

coordinating access to an inmate's guardian (a court-appointed guardian is needed where an inmate is incompetent to make his own decisions due to dementia, e.g.) to obtain the guardian's signatures where required for the MassHealth paperwork. A medical parole release to a residential home placement is easier to expedite, as the MassHealth application is simpler, with fewer requirements, than the MassHealth application for a LTCF.

80. Generally there are difficulties in finding places that will accept medically compromised inmates. Nursing homes are consistently denying the inmate population placements with stated reasons such as the nature of the crime, will not accept murderers or sex offenders, will not accept any individuals on parole, etc. (so-called sober homes are totally unacceptable for an individual released on medical parole needing even in-home nursing assistance; you need to pay rent, and have a documented Substance Use Disorder). It is difficult for a member of the public to achieve placement in a nursing homes; it is even more difficult for a releasing offender to obtain placement in a nursing home.

81. At the start of the COVID-19 crisis there were four inmates approved for medical parole for whom appropriate outside housing could not be found. As of March 23, 2020 two of those four inmates have been accepted at a nursing facility pending the results of their COVID-19 tests. As of March 26, 2020 all twelve medical parole petitioners have had their cases reviewed. Four of those cases are awaiting comment from District Attorney offices; the Parole Board is reviewing the home plans of the remaining eight. As of March 26, 2020, 18 medical parole petitions have been allowed, 10 are being reviewed at the Commissioner level, and eight are pending with superintendents.

Inmate Reentry

81A. One year prior to an inmate's expected release date, a Reentry Specialist (RS) at theinstitution will meet with the inmate to discuss the level of assistance they will need for their release plan. During this interaction, the RS will ask if there is a need for housing, identity documents, health care, employment plans, need for wrap-around resources in the community, etc., and will schedule additional meetings with the inmate based on their responses using motivational interviewing techniques. As indicated by policy, if intensive reentry planning is not required, the RS will encourage the inmate to contact them if anything changes and then interview the inmate again six months prior to release to ensure nothing with the original plan has changed and to discuss their reentry plan. If the inmate indicates they do not need further assistance in the areas mentioned above, the RS will meet with them, at a minimum, three months, two months and 30 days prior to release to complete the MassHealth application (an average of 92 percent are approved at release, based on information received from MassHealth).

82. If the inmate requires additional services, the RS will meet with the inmates as many times as required to assist the releasing inmate. This could be multiple times a month in order to complete applications, phone interviews, and follow-up calls with residential recovery homes, sober homes, and single room occupancy (SRO) options. Additionally, the RS will reach out to community-based wrap-around services (such as BHJI, Roca, and Utec), complete forms required to obtain identity documents (SSA cards, birth certificates, state IDs, DD-214), and review for any benefits (VA compensation and benefit evaluations in the institution and SSI/SSDI). The Reentry Specialist also schedules in-person meetings with

external stakeholders to inform RRH, sober homes and other housing options of soon-to-be-released state inmates.

83. Presently, all medication-assisted treatment (MAT) is handled through DOC Health Services and then Wellpath's medical discharge planners. Re-entry staff are informed of who is approved for MAT for the purposes of making referrals to appropriate community wrap-around services and ensuring that any residential sober living facilities are aware of medical information for the inmate's MAT care. The RS will ensure that the medical discharge planners have the release address for MassHealth and will coordinate the Managed Care Organization (ACO and/or PPC) for the medical discharge planners to make those appointments within the community.

84. There are limits on options for released prisoners. For example, sober houses may close, shelters might be full or house families, or have at-risk residents. Prior to COVID-19, the Department had been releasing on average 22 percent of inmates to sober or residential recovery homes with no systemic issues.

85. However, some of the sober homes have recently suggested that if an ex-inmate cannot find work, they will not be accepted to the sober home; or, if the ex-inmate is already there, they would be removed from the sober home. Conversely, some sober homes have stated they will work with current tenants to find employment or prioritize SSI/SSDI clients to ensure they can collect rent. In the past, when an inmate was adamant that he wanted to be released to a shelter -- and all effort was made to discourage that choice -- the RS would talk to the shelter director and exchange information to help with the transition, sharing any attempts at securing a safe residential address (average around five percent of our releases).

Intake/Department Capacity

86. As of March 23, 2020, the Department houses 7,916 inmates in its facilities. See Weekly Count Sheet Dated March 23, 2020, attached as Exhibit 9. Of this amount, 7,364 inmates are housed in general population beds in Department facilities. Exhibit 9. The operational capacity, which is the number of beds authorized for safe and efficient operation of the facility (and not including beds used for discipline, investigations, infirmary or other temporary holds), of Department facilities is 10,157 inmates. As of March 23, 2020, the Department is running at 73% of its operational occupancy, so Department facilities are not "overcrowded." As is shown in the March 23, 2020 Count Sheet, no individual correctional facility is "overcrowded"—facilities are at a operational capacity range between 31% (at South Middlesex Correctional Center, a minimum/prerelease security facility for women), to 95% (at North Central Correctional Institution, a medium security facility for men).

87. These numbers are a slight decline from the March 16, 2020 Count Sheet. As of that date, 7,405 inmates were housed in general population beds in Department facilities, resulting in the same occupancy rate of 73 percent. See Weekly Count Sheet Dated March 16, 2020, attached as Exhibit 10. The Weekly Count Sheet before this shows that, as of March 9, 2020, there were 7,406 inmates housed in general population beds in Department facilities. See Weekly Count Sheet Dated March 9, 2020, attached as Exhibit 11. The daily population fluctuates, dependent on whether there are more admissions than releases. Since March 10, 2020, when the State of Emergency was declared, newly sentenced admissions to the Department have slowed to a trickle: since that date, there have been three sentenced females received at MCI-Framingham, and seventeen at MCI-

Cedar Junction. Daily admissions to MCI-Cedar Junction were at a pre-March 13th rate of three to four inmates, and, since March 13th, there have been only two days where one inmate has been received; the rest of the days have had zero admissions. In contrast to the twenty new inmates received, the Department has released thirty-eight inmates from March 10, 2020 through March 26, 2020. As recent count sheets and daily admissions/releases show, the Department's population has had a slight decline during the month of March, 2020—Department facilities are not becoming more crowded. It is fair to say that there are no Department facilities that are overcrowded; all facilities are operating with vacancies.

88. It is expected that Department population will decline in the short-term. There are currently 250 criminally-sentenced inmates who are within ninety days of the maximum date of their governing offense, 228 males and 22 females. The maximum date is the current and adjusted release date, including sentence deductions such as Earned Good Time, which is associated with an inmate's governing offense (the offense whose sentence results in the latest release date). Based on their governing offense, this cohort includes 136 violent offenders (107 with Person offenses and 29 with Sex offense); and 114 non-violent offenders (47 with Drug offenses, 38 with other crimes, and 29 with Property offenses).

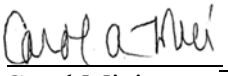
89. Male inmates sentenced to Department custody are processed through the Department's reception center, MCI-Cedar Junction. Female inmates sentenced to Department custody are processed at MCI-Framingham, and, for the most part, remain housed at MCI-Framingham. Inmates are processed in accordance with the Department's Booking and Admissions policy, 103 DOC 401, a copy of which is attached as Exhibit 12.

90. The Booking and Admissions policy requires that incoming inmates receive a medical, dental and psychological screening. Exhibit 12 at 103 DOC 401.01 (1)(L). This screening is done in accordance with the Department's Medical Services policy, which requires thorough medical screening and physical examination. See Medical Services, 103 DOC 630, attached as Exhibit 13, at 103 DOC 630.06 (describing medical entrance screen for all new arrivals to a facility). This screening includes the questions asked of anybody entering the facility, and should determine whether any new admissions are at risk of COVID-19. All new commitments to the Department receive a complete physical examination within seven days of admission; the contents of this examination are in compliance with American Correctional Association and N.C.C.H.C. standards, as well as the contract between the Department and its medical vendor. Exhibit 13 at 630.09 (describing intake physical examination of inmates). Finally, both the Booking and Admissions and Medical Services policy provide for the quarantining of incoming inmates with proper medical authorization. Exhibit 12 , at 103 DOC 401.01 (1)(L); Exhibit 13, at 103 DOC 630..

91. The Booking and Admissions policy also requires that inmates be provided with soap, toilet paper, a toothbrush and toothpaste. Exhibit 12 at 103 DOC 401.01 (1)(J).

92. When male inmates complete their intake, orientation, and initial classification at MCI-Cedar Junction, they are transferred to housing facilities. These housing facilities are required to do the medial screenings as required by the Medical Services policy, referenced above, for each inmate transferred to that facility.

Subscribed under the pains and penalties of perjury on this the 27th day of March, 2020.



Carol Mici
Commissioner of Correction

Exhibit 28

AFFIDAVIT OF CATHERINE J. HINTON, ESQ., RESPECTING PAROLE BOARD PREREQUISITES BLOCKING ACTUAL PAROLE RELEASE OF PREVIOUSLY-APPROVED INDIVIDUALS DURING COVID-19 PANDEMIC

I, Catherine J. Hinton, hereby depose and state under the pains and penalties of perjury as follows:

1. I am an attorney licensed to practice law in the Commonwealth of Massachusetts, and other jurisdictions. I hold Massachusetts BBO license number 630179, and am a member of the bar in good standing. I am a partner in the firm of Rankin & Sultan, and my work address is 151 Merrimac Street, Boston, MA 02114.

2. In the course of my professional work, I have represented several juvenile homicide offenders who are eligible for parole pursuant to *Diatchenko v. District Attorney for Suffolk County*, 466 Mass. 655, 675 (2013).

3. Two of my parole clients have received recent positive parole decisions (dated February 19, 2020 and March 26, 2020) declaring them to be rehabilitated and suitable parole candidates, and each of them has a private home to go to in the community, **but they have not yet been released from incarceration**. Instead, the Parole Board has required them to serve additional time in lower security and to complete a Long Term Residential Program before they can actually be released to their home plan.

4. These requirements are expected in ordinary times, but in the unusual context of the COVID-19 pandemic, these requirements ensure that the parole petitioner cannot actually be released, for the reasons explained below.

5. The requirement to serve additional time in lower security means that a parole petitioner, despite being deemed a suitable candidate for parole, cannot be released because the DOC has halted all transfers between institutions, so that no one can actually be transferred to lower security at

this juncture (see *CPCS et al v. Chief Justice of the Trial Court et al*, SJC-2020-12926, p. 5: "...the CDC recommends restricting transfers between correctional facilities, which the Department has done...").

6. The requirement to complete a Long Term Residential Program means that a parole petitioner, despite being deemed "a suitable candidate for parole," cannot be released in a timely manner because there are currently no Long Term Residential Programs that will admit parolees without waiting on a waiting list.

7. In *CPCS et al v. Chief Justice of the Trial Court et al*, SJC-2020-12926 (April 3, 2020), the SJC stated (p. 39): "We urge the board to expedite release of these previously-approved individuals...." The SJC further stated (p. 39, fn 24): "The parole board should use every effort to expedite the several stages of [the release] process as far as reasonably possible so as to reduce the over-all number of incarcerated inmates as quickly as possible."

8. One of my parole clients (#W36275) is over age 60, has pre-existing medical conditions making him particularly vulnerable to COVID-19, was previously released on parole and is currently re-incarcerated solely due to non-criminal, nonviolent parole violations. He was issued a positive parole decision, declared to be "rehabilitated," and deemed a "suitable candidate for parole" on February 19, but he was required to serve 12 months of additional time in lower security and complete a Long Term Residential Program before actual release. He cannot be transferred to lower security because transfers are currently restricted. Nearly two months have gone by since his positive parole vote was issued. On March 18, 2020, I filed an appeal of the Parole Board's decision under 120 CMR 304.02(3)(e); 304.03(a); and 304.03(d), seeking relief from the prerequisites of time in lower security and a long term residential program, and seeking release to his previously-approved home plan. Instead, the Parole Board issued a change

of vote decision dated March 27, 2020 merely reducing his requirement of additional time in lower security from 12 month to 6 months. On April 3, 2020, I filed a request for further change of vote/reconsideration. His previously-approved home plan has not been investigated by parole staff, and his request for further change of vote/reconsideration has not been responded to in any way as of the date of this affidavit.

9. Another of my parole clients (#W82532) was issued a positive parole decision on March 26, 2020, declaring him to be "rehabilitated" and a "suitable candidate for parole," but requiring him to serve 12 months of additional time in lower security and complete a Long Term Residential Program before release. He cannot be transferred to lower security because transfers are currently restricted. On March 30, 2020, I filed an appeal of the Parole Board's decision under 120 CMR 304.02(3)(e); 304.03(a); and 304.03(d), seeking relief from the prerequisites of time in lower security and a long term residential program, and seeking release to a single family home owned by his mother. A further submission in support of his appeal was filed on April 3, 2020. His proposed home plan has not been investigated by parole staff, and his appeal has not been responded to in any way as of the date of this affidavit.

10. In my experience, the Parole Board has not "expedite[d] release" of these "previously-approved individuals...." since the Court's decision in *CPCS et al v. Chief Justice of the Trial Court et al*, SJC-2020-12926 was issued on April 3.

Signed this 15th day of April, 2020.

Catherine J. Hinton, BBO # 630179
Rankin & Sultan
151 Merrimac Street, Second Floor
Boston, MA 02114
617-720-0011
chinton@rankin-sultan.com

Exhibit 29

Declaration of Lucy Eleanor Umphres, Esq.

1. I am an attorney licensed to practice in Massachusetts since November 2018. I am working as an independent contractor for Prisoners' Legal Services of Massachusetts.

2. I reviewed the most recent Department of Public Health (DPH) reports for each state facility and for each county jail and house of correction, noting the number of total violations and the number of cell size and floor space violations at each institution.

3. I also made note of repeat violations, i.e., of conditions that had been cited on previous inspection reports but not resolved. Nearly 68% of all facilities across the Commonwealth currently fail to comply with the DPH cell size and floor space regulations, and 99% of the cell size and floor space violations—all but two—are repeat violations.

4. Massachusetts General Law requires the DPH to make rules for correctional facilities and detention centers for the general health and safety of the detainees, and to inspect each correctional facility and report on its findings. The DPH promulgated 105 CMR 451.000 to govern the minimum health and sanitation standards and inspection procedures for correctional facilities.

5. Twice-yearly, the Community Sanitation Program (CSP)—a subdivision of the DPH charged with preventing avoidable death and morbidity through enforcement of the State Sanitary Code—inspects Department of Correction facilities and county jails and houses of correction within the Commonwealth and produces a report. These reports are available on the Mass.gov website at: https://www.mass.gov/lists/correctional-facilities-community-sanitation#inspection-reports-.

6. A portion of 105 CMR 451's regulations pertain to cell size and floor space, including:

   - 105 CMR 451.320 – Cell Size in Existing Facilities: "Each cell or sleeping area in an existing facility should contain at least 60 square feet of floor space for each occupant, calculated on the basis of total habitable room area, which does not include areas where floor-to-ceiling height is less than eight feet."
   - 105 CMR 451.321 – Cell Size in New or Renovated Facilities: "Each cell in a new facility or a part of a facility constructed after the effective date of 105 CMR 451.000 should contain: (A) For segregation and special management areas where inmates are usually locked in for greater than ten hours per day, at least 80 square feet of floor space for a single inmate. (B) For inmates usually locked in for less than ten hours per day, contain at least 70 square feet of floor space for a single inmate. Provided, however, two inmates may occupy a room or cell designed for double occupancy which has a floor space of 120 square feet. Floor space shall be calculated on the basis of total habitable room area which does not include areas where floor-to-ceiling height is less than eight feet."

- 105 CMR 451.322 – Dormitories in New or Renovated Facilities: "Each dormitory in a new facility or a part of a facility constructed after the effective date of 105 CMR 451.000 should contain a minimum of 60 square feet for each occupant. Floor space shall be calculated on the basis of total habitable room area which does not include areas where the floor-to-ceiling height is less than eight feet."

7. The .100 and .200 Series of 105 CMR 451 are required standards, and the .300 Series, pertaining to cell size and floor space, are recommended standards. What follow are my institution-specific findings.

State Facilities

- **Boston Pre-Release Center**
    - 52 total violations
        - 33 repeat violations
    - 2 cell size / floor space violations
        - all 2 = repeat violations
        - **Note:** There are four living spaces in this institution. Therefore, half of the living spaces fail to comply with the standards. In the two living areas with inadequate floor space, the cells are triple bunked.
    - February 5, 2020 report: https://www.mass.gov/doc/boston-pre-release-center-january-29-2020/download

- **Bridgewater State Hospital**
    - 606 total violations
        - 362 repeat violations
    - 0 cell size / floor space violations
        - **Note:** Despite no space-related violations, the inspector wrote: "Throughout the facility, bathrooms and shower areas were observed to be poorly maintained resulting in unsanitary conditions. Specifically, the shower area in building # 8 which had recently been renovated. CSP is concerned with the high number of inmates being exposed to such unsanitary conditions."
    - January 3, 2020 report: https://www.mass.gov/doc/bridgewater-state-hospital-december-16-2019/download

- **Lemuel Shattuck Hospital Correctional Unit**
    - No DPH report exists.

- **MASAC at Plymouth**
    - 118 total violations
        - 45 repeat violations
    - 5 cell size / floor space violations
        - all 5 = repeat violations
        - **Note:** There are five living spaces at this institution. In other words, every living space at MASAC fails to comply with the standards. Three dorms have inadequate floor space with all cells double bunked. The remaining two bunk houses have inadequate floor space.
    - February 11, 2020 report: https://www.mass.gov/doc/massachusetts-alcohol-and-substance-abuse-center-masac-in-plymouth-january-30-2020/download

- **MCI-Cedar Junction**
    - 365 total violations
        - 172 repeat violations
    - 2 cell size / floor space violations
        - all 2 = repeat violations
        - **Note:** Inspectors looked at fifty-seven separate living spaces at this institution. Cells on the first floor of 2 Block and the first floor of 3 Block have inadequate space with cells double bunked.
            - Additionally, all of the cells on the second floor of 10 block have dusty wall vents; all of the cells on the left side of the first floor of 10 block have dusty wall vents; all of the cells on the right side of the first floor of 10 block have clogged wall vents; there is mold on the wall of cell #32 on the second floor of A1 Block; a wall vent is blocked in cell #61 on the third floor of A3 Block; and there is mold on the ceiling of cell #43 on the second floor of A3 Block.
    - December 20, 2019 report: https://www.mass.gov/doc/mci-cedar-junction-december-11-2019/download

- **MCI-Concord**
    - 223 total violations
        - 90 repeat violations
    - 6 cell size / floor space violations
        - all 6 = repeat violations
        - **Note:** There appear to be ten possible living spaces at this institution – one RHU with cells, one medical unit with cells, six J Housing Units, and possibly two dorms. All six of the J Housing Units fail to comply with the standards, with inadequate floor space in the cells.
    - December 19, 2019 report: https://www.mass.gov/doc/mci-concord-december-11-2019/download

- **MCI-Framingham**
    - 196 total violations
        - 95 repeat violations
    - 1 cell size / floor space violation
        - 1 = repeat violation
        - **Note:** Out of eight living spaces at this institution, the floor space violation occurs in the Infirmary's Medical Cells, with inadequate floor space.
            - Additionally, the inspector wrote: "The CSP is concerned with the chronic rodent and insect issue in the food service areas," and: "At the time of inspection, the warewash machine did not reach the appropriate temperature to properly sanitize dishes."
    - February 14, 2020 report: https://www.mass.gov/doc/mci-framingham-january-30-2020/download

- **MCI-Norfolk**
    - 738 total violations
        - 405 repeat violations
    - 22 cell size / floor space violations
        - all 22 = repeat violations
        - **Note:** Of twenty-three living spaces, including the RHU, the HSU, twenty regular units, and one South Yard Housing Unit, only the South Yard Housing Unit had no space-related violations. In other words, every living space at MCI-Norfolk, except one, fails to comply with the standards.
    - December 5, 2019 report: https://www.mass.gov/doc/mci-norfolk-november-14-2019/download

- **MCI-Shirley**
    - 746 total violations
        - 365 repeat violations
    - 17 cell size / floor space violations
        - all 17 = repeat violations
        - **Note:** Of what appear to be twenty-three living spaces, only six are compliant. In other words, nearly 74% of all living spaces at MCI-Shirley fail to comply with the standards. Every Housing Unit A-1 through F-2, with the lone exception of D-1, have inadequate floor space in all cells, with cells double bunked. All six Cottages fail to comply, with inadequate floor space in all cells.
    - December 19, 2019 report: https://www.mass.gov/doc/mci-shirley-december-4-2019/download

- **Massachusetts Treatment Center**
    - 371 total violations
        - 237 repeat violations
    - 0 cell size / floor space violations
        - **Note:** Despite no space-related violations, the inspector wrote: "Throughout the facility, bathrooms and shower areas were observed to be poorly maintained resulting in unsanitary conditions. The CSP is concerned with the increased risk of disease transmission with the high number of inmates being exposed to such unsanitary conditions."
    - September 26, 2019 report: https://www.mass.gov/doc/massachusetts-treatment-center-bridgewater-september-17-2019/download

- **North Central Correctional Institution – Gardner**
    - 450 total violations
        - 233 repeat violations
    - 30 cell size / floor space violations
        - all 30 = repeat violations
        - **Note:** Of what appear to be thirty-five living spaces, thirty are not compliant. In other words, nearly 86% of all possible housing areas at NCCI-Gardner fail to comply with the standards, with inadequate floor space in all cells and sleeping areas.
    - October 4, 2019 report: https://www.mass.gov/doc/north-central-correctional-institute-in-gardner-september-24-2019/download

- **Northeastern Correctional Center**
    - 248 total violations
        - 127 repeat violations
    - 3 cell size / floor space violations
        - all 3 = repeat violations
        - **Note:** There are eight living spaces in this institution. The three non-compliant areas have inadequate floor space in all cells.
    - October 4, 2019 report: https://www.mass.gov/doc/northeastern-correctional-center-september-30-2019/download

- **Old Colony Correctional Center**
    - 570 total violations
        - 318 repeat violations
    - 9 cell size / floor space violations
        - all 9 = repeat violations
        - **Note:** There appear to be fifteen potential living spaces in this institution, including the New Mans Unit, the HSU, the I.S.O.U., the RHU, the Orientation Unit, a Medical Room, six main housing units, and three dorms. All six of the main housing units, plus two of the dorms and the Orientation Unit, fail to comply with the standards, with inadequate floor space in all cells and inadequate floor space in dorm rooms.
    - January 3, 2020 report: https://www.mass.gov/doc/old-colony-correctional-center-december-13-2019/download

- **Pondville Correctional Center**
    - 38 total violations
        - 14 repeat violations
    - 7 cell size / floor space violations
        - all 7 = repeat violations
        - **Note:** There are only seven housing units in this institution. In other words, 100% of the housing units at Pondville fail to comply with the standards, with inadequate floor space in cells and with cells double bunked.
    - December 20, 2019 report: https://www.mass.gov/doc/pondville-correctional-center-norfolk-december-19-2019/download

- **South Middlesex Correctional Center**
    - 54 total violations
        - 11 repeat violations
    - 0 cell size / floor space violations
    - October 29, 2019 report: https://www.mass.gov/doc/south-middlesex-correctional-center-framingham-october-25-2019/download

- **Souza-Baranowski Correctional Center**
    - 303 total violations
        - 110 repeat violations
    - 16 cell size / floor space violations
        - all 16 = repeat violations
        - **Note:** There appear to be twenty-two living spaces in this institution. Therefore, nearly 73% of all possible housing areas at SBCC fail to comply with the standards, with inadequate floor space in double bunked cells.
            - Additionally, the inspector noted a dead and live bird were observed in the M2 Cell Block unit; a blocked wall vent in cell #12 and cell #24 of J3 South SMU Cell Block; and generally dirty cell #1 of K3 South SMU Cell Block.
    - September 25, 2019 report: https://www.mass.gov/doc/souza-baranowski-correctional-center-september-16-2019/download

County Jails and Houses of Correction

- **Barnstable County Correctional Facility – Bourne**
    - 56 total violations
        - 17 repeat violations
    - 11 cell size / floor space violations
        - all 11 = repeat violations
        - **Note:** There appear to be thirteen living spaces in this institution. Of the twelve Pod living units, only one complied with the standards, i.e. nearly 92% of the living units fail to comply with the standards. All eleven violations involved inadequate floor space with double bunked cells.
    - December 2, 2019 report: https://www.mass.gov/doc/barnstable-county-correctional-facility-bourne-november-20-2019/download

- **Berkshire County Jail and House of Correction – Pittsfield**
    - 85 total violations
        - 41 repeat violations
    - 0 cell size / floor space violations
    - November 13, 2019 report: https://www.mass.gov/doc/berkshire-county-jail-and-house-of-correction-pittsfield-november-8-2019/download

- **Bristol County Dartmouth Women's Center**
    - 10 total violations
        - 8 repeat violations
    - 4 cell size / floor space violations
        - all 4 = repeat violations
        - **Note:** There are only four living spaces in this institution. Therefore, 100% of this facility's living spaces fail to comply with the standards, with inadequate floor space in cells and with cells double bunked.
    - November 13, 2019 report: https://www.mass.gov/doc/bristol-county-dartmouth-womens-center-october-22-2019/download

- **Bristol County I.C.E. Facility – North Dartmouth**
    - 6 total violations
        - 2 repeat violations
    - 2 cell size / floor space violations
        - all 2 = repeat violations
        - **Note:** There are only two sleeping areas in this institution. Therefore, 100% of this facility's living spaces fail to comply with the standards, with inadequate floor space in the dorm sleeping area.
    - November 13, 2019 report: https://www.mass.gov/doc/bristol-county-ice-facility-north-dartmouth-october-22-2019/download

- **Bristol County Jail, Ash Street Facility – New Bedford**
    - 47 total violations
        - 19 repeat violations
    - 0 cell size / floor space violations
    - December 31, 2019 report: https://www.mass.gov/doc/bristol-county-jail-ash-street-facility-new-bedford-december-30-2019/download

- **Bristol County Jail and House of Correction – North Dartmouth**
    - 128 total violations
        - 73 repeat violations
    - 12 cell size / floor space violations
        - all 12 = repeat violations
        - **Note:** Only the HSU cells, Dispatch/Receiving cells, and the EE Unit comply with the standards. All other living areas, or nearly 79% of the living areas in this institution, fail to comply, with inadequate floor space in cells and with cells double bunked, and with inadequate floor space in a dorm room attached to cell block EB Unit, and inadequate floor space in a dorm sleeping area.
    - November 13, 2019 report: https://www.mass.gov/doc/bristol-county-jail-and-house-of-correction-north-dartmouth-october-22-2019/download

- **Bristol County Modular Building – North Dartmouth**
    - 39 total violations
        - 13 repeat violations
    - 4 cell size / floor space violations
        - all 4 = repeat violations
        - **Note:** There are only four sleeping areas in this institution. Therefore, 100% of this facility's living spaces fail to comply with the standards, with inadequate floor space in all dorms.
    - November 13, 2019 report: https://www.mass.gov/doc/bristol-county-modular-building-north-dartmouth-october-22-2019/download

- **Dukes County Jail and House of Correction – Edgartown**
    - 34 total violations
        - 22 repeat violations
    - 8 cell size / floor space violations
        - all 8 = repeat violations
        - **Note:** There are only eight sleeping areas in this institution. Therefore, 100% of this facility's living spaces fail to comply with the standards, with inadequate floor space in some areas, with inadequate floor space and double bunked cells in the Administrative Segregation Unit, with inadequate floor space and double bunked cells in First Floor Unit #1 and Second Floor Unit #3, and with inadequate floor space in a dorm room.
    - December 2, 2019 report: https://www.mass.gov/doc/dukes-county-jail-and-house-of-correction-edgartown-november-26-2019/download

- **Essex County Correctional Alternative Center – Lawrence**
    - 126 total violations
        - 52 repeat violations
    - 0 cell size / floor space violations
        - **Note:** Despite no space-related violations, the inspector wrote: "Throughout the facility, bathrooms and shower areas were observed to be poorly cleaned resulting in unsanitary conditions. The CSP is concerned with the increased risk of disease transmission with the high number of inmates being exposed to such unsanitary conditions."
    - November 25, 2019 report: https://www.mass.gov/doc/essex-county-correctional-alternative-center-lawrence-november-18-2019/download

- **Essex County Correctional Facility – Middleton**
    - 239 total violations
        - 87 repeat violations
    - 9 cell size / floor space violations
        - 7 = repeat violations
        - **Note:** There seem to be forty potential sleeping areas in this facility, only 13 of which comply with the standards. Therefore, nearly 68% of this facility's living spaces fail to comply with the standards, with inadequate floor space in the dorm rooms.
    - November 22, 2019 report: https://www.mass.gov/doc/essex-county-correctional-facility-middleton-november-7-2019/download

- **Essex County Women in Transition – Salisbury**
    - 4 total violations
        - 1 repeat violations
    - 1 cell size / floor space violation
        - 1 = repeat violation
        - **Note:** This facility has seven dorm rooms, and all seven dorm rooms or 100% of this facility's living spaces fail to comply with the standards, with inadequate floor space in all dorm rooms.
    - September 16, 2019 report: https://www.mass.gov/doc/essex-county-women-in-transition-salisbury-september-13-2019-0/download

- **Franklin County Jail and House of Correction – Greenfield**
    - 82 total violations
        - 43 repeat violations
    - 0 cell size / floor space violations
        - **Note:** Despite no space-related violations, the inspector noted dusty ceiling vents in certain showers and cells, and the inspector also noted wall vents blocked in certain cells.
    - November 25, 2019 report: https://www.mass.gov/doc/franklin-county-jail-and-house-of-correction-greenfield-november-20-2019/download

- **Hampden County Jail and House of Correction – Ludlow**
    - 190 total violations
        - 83 repeat violations
    - 0 cell size / floor space violations
        - **Note:** Despite no space-related violations, the inspector noted soap scum on the floor of many showers; a wall vent blocked in certain cells; and twelve out of twenty day room areas have a dirty ceiling with a "black substance observed near air supply outlets."
    - February 13, 2020 report: https://www.mass.gov/doc/hampden-county-jail-and-house-of-correction-ludlow-february-4-2020/download

- **Hampden County Western MA Recovery & Wellness Center – Springfield**
    - 18 total violations
        - 9 repeat violations
    - 0 cell size / floor space violations
        - **Note:** Despite no space-related violations, the inspector noted soap scum on certain showers.
    - January 13, 2020 report: https://www.mass.gov/doc/hampden-county-western-massachusetts-recovery-and-wellness-center-springfield-january-7-2020/download

- **Hampden County Western MA Women's Correctional Center – Chicopee**
    - 11 total violations
        - 0 repeat violations
    - 0 cell size / floor space violations
        - **Note:** Despite no space-related violations, the noted soap scum on certain showers and a wall vent blocked in one cell.
    - January 21, 2020 report: https://www.mass.gov/doc/hampden-county-western-ma-womens-correctional-center-chicopee-january-17-2020/download

- **Hampshire County Jail and House of Correction – Northampton**
    - 71 total violations
        - 25 repeat violations
    - 0 cell size / floor space violations
        - **Note:** Despite no space-related violations, the inspector noted soap scum on certain showers.
    - December 12, 2019 report: https://www.mass.gov/doc/hampshire-county-jail-and-house-of-correction-northampton-december-10-2019/download

- **Middlesex County Jail and House of Corrections – Billerica**
    - 227 total violations
        - 79 repeat violations
    - 1 cell size / floor space violation
        - 1 = repeat violation
        - **Note:** The one space-related violation involved inadequate floor space in all cells of the HUMV Dorm Room. The inspector also noted soap scum on certain showers, mold in certain showers, and blocked wall vents in certain cells.
    - January 30, 2020 report: https://www.mass.gov/doc/middlesex-county-jail-and-house-of-corrections-billerica-january-22-2020/download

- **Norfolk County House of Correction and Alternative Center – Dedham**
    - 131 total violations
        - 67 repeat violations
    - 8 cell size / floor space violations
        - all 8 = repeat violations
        - **Note:** There are twelve potential sleeping areas in this facility, and eight of these areas, or nearly 67% of the sleeping areas here fail to comply with the standards, with inadequate floors space in all cells.
    - January 28, 2020 report: https://www.mass.gov/doc/norfolk-county-house-of-correction-and-alternative-center-dedham-january-16-2020/download

- **Plymouth County Correctional Facility**
    - 152 total violations
        - 77 repeat violations
    - 22 cell size / floor space violations
        - all 22 = repeat violations
        - **Note:** There appear to be twenty-five sleeping areas in this facility, and only the HSU cells, the Booking cells, and GW South comply. In other words, 88% of the sleeping areas here fail to comply with the standards, with inadequate floors space and cells double bunked, and inadequate floor space in dorm areas.
            - Additionally, the inspector noted mold on the ceiling of certain showers; scum on certain showers; and blocked wall vents in various cells.
    - October 8, 2019 report: https://www.mass.gov/doc/plymouth-county-correctional-facility-september-16-2019/download

- **Suffolk County House of Correction – Boston**
    - 631 total violations
        - 287 repeat violations
    - 21 cell size / floor space violations
        - 21 = repeat violations
        - **Note:** There appear to be thirty-three sleeping areas in this facility, and only twelve comply. In other words, nearly 64% of the sleeping areas here fail to comply with the standards, with inadequate floors space in all cells.
            - Additionally, the inspector noted mold in certain showers; scum on certain showers; and blocked wall vents in various cells.
    - November 5, 2019 report: https://www.mass.gov/doc/suffolk-county-house-of-correction-boston-october-15-2019/download

- **Suffolk County Jail – Boston**
    - 265 total violations
        - 140 repeat violations
    - 0 cell size / floor space violations
        - **Note:** Despite no space-related violations, the inspector noted mold on the ceiling of certain showers; scum on certain showers; and blocked wall vents in various cells.
            - Additionally, the inspector wrote: "During the Kitchen inspection, the warewash machine did not reach the appropriate temperature to properly sanitize dishes. The Food Manager stated that staff will manually sanitize the dishes after being washed. Kitchen staff were observed manually using a chemical sanitizing solution to sanitize each item following removal from the warewash machine. The warewash machine has consistently been an issue in past inspections." Also: "The Kitchen was observed to be using a chemical sanitizer that is not approved for use on food contact surfaces."
    - November 7, 2019 report: https://www.mass.gov/doc/suffolk-county-jail-boston-october-24-2019/download

- **Worcester County House of Corrections and Jail – West Boylston**
    - 259 total violations
        - 144 repeat violations
    - 10 cell size / floor space violations
        - all 10 = repeat violations
        - **Note:** There appear to be twenty-six sleeping areas in this facility, and approximately 69% of these sleeping areas fail to comply with the standards, with inadequate floor space in all cells.
    - November 5, 2019 report: https://www.mass.gov/doc/worcester-county-house-of-corrections-and-jail-west-boylston-october-25-2019/download

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

Dated: April 17, 2020

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