Dirk Greineder, MD, PhD.
MCI-Norfolk
P.O. Box 43
Norfolk, MA 02056

December 8, 2020 Update from MCI-Norfolk

The last two weeks have exposed concerning information about how the DOC's failures to anticipate and prepare have caused state prisons to be ravaged by Covid-19 infection with resulting grave consequences for prisoners. It is important to acknowledge that, as a prisoner, I receive no official information from the DOC. However, the prisoner grapevine is, as usual, well informed and surprisingly reliable as concerned prisoners acutely observe and report on personal experiences and events they witness. Every effort has been made to validate facts through direct and independent sources as well to make use of documentation by outside reporters(1).

Norfolk was locked down Tuesday, October 27, 2020 because of symptoms and preliminary positive tests for Covid-19 among select prisoners. Details about the crowded conditions, physical layout and the institution's persistent policy of prompting co-mingling of prisoner workers from all housing units on a daily basis, have been detailed in earlier Updates(2). An important consequence of the 24/7 lockdown was that all prisoners became maximally exposed to each other in the crowded, unventilated tiers while needing to share communal living spaces, bathrooms, showers, and trips to common areas to receive medication, food and use phones. Cells, tiers and housing units thereby revealed themselves to be efficient Covid-19 incubators and sites of transmission(3). Despite admonitions by the SJC that the DOC needed to urgently reduce the prison population to avoid Eighth Amendment and Art. 26 violations against cruel and unusual punishment, the Norfolk population had been reduced by only 2% between April and the October 27 lockdown--1267 prisoners reduced by only 31(4). Amazingly, recent analysis demonstrates that the DOC has released 500 fewer prisoners during the Covid-19 pandemic than during the same time periods in 2016-2019.(5)

Institution-wide testing November 2-5 revealed that many housing units were already heavily infected, with often over two-thirds of prisoners testing positive. As previously reported, positive prisoners were group-isolated in mold-infested dormitories (the condemned Probation Units(6)). Available isolation beds were soon exhausted. Housing units were locked down 24/7, continuing to force maximal cross-contamination among anyone left behind. Many prisoners, although having tested negative the first week in November, began to develop symptoms during subsequent days and weeks. This was evidence that the isolation steps had started too late--and not surprising because of the extensive cross-contamination of units by the routine aggregation of prisoner workers during the preceding months. Prisoners, whether isolated or quarantined in their units, received supportive but no specialized treatment unless sick enough to require evacuation to hospital for assessment or treatment. Cellmates of positive prisoners were temporarily isolated in single cells in the Restrictive Housing Unit ("hole"), tested and, if later positive, moved to group isolation. Overall, 256 (22%) of prisoners at Norfolk tested positive in the first two weeks of November(7).

However, no follow-up testing, temperature checks, oxygen saturation, or symptom checks were conducted in housing units over the next three weeks. Prisoners remaining in units who developed symptoms were not removed from their units, unless specifically reporting severe symptoms or distress. And,

because of the extensive cross-mingling of workers and prisoners in the months immediately preceding the lockdown, the spread of infection throughout Norfolk had been predictable and was no longer controllable. Since movement to group isolation offered most prisoners no substantial benefits but significantly disrupted daily routines, many prisoners tolerated mild to moderate symptoms, often self-medicating with available anti-pyretic medications, but remained in their units. Under the closed-in, crowded lockdown conditions, infection continued to spread rapidly. There was also presumably an invisible pool of prisoners with asymptomatic infections (well documented by studies in the community) who unknowingly spread infection. This should have been anticipated by the DOC and mitigated by aggressive and early follow-up testing. Without such follow-up testing, prisoners had no way to know who needed isolation. Temperature and oxygen saturation checks were not begun until late November and appeared to capture virtually no new cases--strong evidence that waves of infection had already swept through the prisoner community, with many recovering. However, vulnerable, elderly and prisoners with high risk conditions were daily unreasonably subjected to the incubator conditions intrinsic to the infected housing units. Even worse, in a major break of protocol, pulse oximeters were NOT cleaned between use by long lines of prisoners (who also had no hand sanitizer or sinks available near screening sites). Consequently, it is likely that these mandatory screening efforts actually spread infection among prisoners. During November there was a steady stream of prisoners who became so ill that they asked to be taken out for treatment, alarmed by the severity of their symptoms. Many of these ended up evacuated to hospital for detailed assessments, treatment and sometimes hospitalization. There is little doubt that many elderly and vulnerable prisoners suffered significant symptoms and frequently permanent disability from these serious infections(8).

The first follow-up testing was not begun until the week of December 7, 2020. By that time, it is extremely likely that many of the prisoners in housing units had become infected and even recovered. Some had been taken out for observation in group isolation, but a not inconsequential number needed to be sent to hospital for evaluation, treatment and/or hospitalization, including ICU stays. We know that some died, although we may never know exactly how many. The DOC appears to have taken great pains to dissimulate those numbers. As well documented by Deborah Becker of WBUR, the DOC went to great lengths to mask deadly outcomes(9). At least 2 elderly prisoners who died while hospitalized were belatedly "released" on "medical parole" only hours before their deaths(10). This has allowed the DOC to argue that these prisoners should not be counted as prisoner deaths, and indeed they have not been included in the mandatory weekly reports to the Special Master(11). Because of this, it is difficult to accurately confirm prisoner deaths, but it appears that there have been an additional handful of Norfolk deaths linked to Covid-19 during this time. This includes, on December 4, 2020, an elderly and vulnerable prisoner who died too suddenly to be hospitalized. He tested positive and one can only assume that he will be counted in the upcoming reports of prisoner Covid-19 deaths.

The delayed follow-up testing being done in December (both PCR and rapid tests have been administered) is virtually useless and will not discriminate between those previously infected, still vulnerable, or immune. Some previously infected will test positive but are as likely to harbor inert, non-viable viral RNA as live infectious virus (a well established finding). Many others

will test negative, their time of positivity missed by the 5 week delay, regardless whether they were symptomatic or asymptomatic. An unkown number, of course, will never have been infected, although based on prisoner reports, that percentage may be quite low. What is certain is that this delayed testing will not provide guidance to either medical experts or DOC about which individual prisoners are still at risk of future infection. After failing to perform timely follow-up testing, now only antibody testing might unravel this conundrum. Paradoxically, the DOC may have managed to achieve levels of infection indicative of herd immunity by creating extremely high risk environments in the locked down housing units--at unconscionable and considerable risk to the vulnerable.

Evidence of such a possibility is that, as of December 9, 2020, the rate of Covid-19 infection in the community is only 3723/100,000, in spite of the huge ongoing fall surge. Three weeks ago, as of November 18, the Norfolk rate of infection was at 20,880/100,000, 5.6 times the community rate! There can be no doubt that the DOC's neglectful strategy has unnecessarily exposed many prisoners, including many very vulnerable, to excessive risks of Covid infection. This was true as early as August when rates of infection in the DOC were 5 times, and rates of death were 3 times, respectively, the community rates(12). Despite this warning, the continued failure to anticipate and prepare for the inevitable escalation of prison infections has caused unnecessary deaths and permanent disability among this literally captive population.

However, it is quite possible that the DOC did accomplished one of its primary (albeit non-public) objectives: to keep secret the excessive extent of Covid-19 infection in the DOC by deliberately delaying follow-up testing until active waves of infection had stormed through the prisons. This seriously increased risks of long-term disability and death for elderly and vulnerable prisoners, many with multiple underlying risk factors for poor outcomes. One may speculate, however, that this was not the DOC's primary concern.

ENDNOTES

1. Becker D. "2 Mass. Prisoners Hospitalized For Covid-19 Die A Day After Being Granted Medical Parole (WBUR, Nov 30, 2020); Becker D. "Medical Experts Raise Questions About Covid-19 Data From Mass. Jails and Prisons (WBUR, Aug 31, 2020); Strassle C, Jardas E, Ochoa J, et al. "Covid-19 Vaccine Trials and Incarcerated People-The Ethics of Inclusion". N Engl J Med 383:1897-99 (2020); Saloner B, Parish K, Ward JA, et al. "Covid-19 Cases and Deaths in Federal and State Prisons". J Am Med Assoc, 324;602-3 (2020); Jimenez MC, Cowger TL, Simon LE, et al. "Epidemiology of Covid-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons". JAMA Netw Open 3(8):e2018851.doi:10.1001 (2020).

2. Updates (dated May 10 & 20; June 1, 13, & 30; July 15 & 29; August 17; Sept 12; Oct 13 & 31; Nov 30) providing details of conditions at MCI-Norfolk, available at www.realcostofprisons.org/writing.

3. Ibid.

4. www.mass.gov/doc/sjc-12926-special-masters-weekly-report-111820.

5. Lifers' Group Fast Facts: "Falling State Prisoner Numbers: Incidental to Pandemic Court Closure or Real Expedited Release? (Nov 2020); accessible at www.realcostofprisons.org/writing.

6. November 30 Update (see n.2)

7. www.mass.gov/doc/sjc-12926-special-masters-weekly-report-111820.

8. del Rio C, Collins LF, & Malani P. "Long-Term Health Consequences of Covid-19" J Am Med Assoc(JAMA); 324:1723-4 (2020).

9. Becker D. "2 Mass. Prisoners Hospitalized For Covid-19 Die A Day After Being Granted Medical Parole (WBUR, Nov 30, 2020); Becker D. "Medical Experts Raise Questions About Covid-19 Data From Mass. Jails and Prisons (WBUR, Aug 31, 2020).

10. Ibid.

11. www.mass.gov/doc/sjc-12926-special-master-weekly-report-111820.

12. Lifer's Group Fast Facts: "Excessive Rates of Covid-19 Cases and Deaths in Massachusetts State Prisons" August 2020 (accessible at www.realcostofprisons.org/writing). See also Saloner et al and Jiminez et al, n.1.