WITHOUT A RATIONAL PLAN: How and Why the Massachusetts DOC Caused Covid-19 To Ravage State Prisons

A Lifers' Group Report

Prepared by
Dirk Greineder, MD, PhD

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Lifers' Group Inc.
MCI-Norfolk
P.O. Box 43
Norfolk, MA 02056

| Assist | Advocate | Inform |

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Our Mission

To partner with families and other stakeholders to create solutions for sentencing reform, promote meaningful parole opportunities for all lifers, and assist lifers and long-termers to live positive lives both inside and outside of prison

Assist

Improve rehabilitation, self-respect, and the quality of life for all men and women in Massachusetts prisons

Advocate

Coordinate with any organization striving for similar goals in order to provide an effective use of penal and rehabilitative resources

Inform

Operate under sound ethical and democratic principles and share our knowledge with our members and those on the outside on criminal justice and prison reform issues, such as reducing recidivism, improving public safety, and building peaceful and productive relationships with family members, fellow prisoners, supporters, and the community

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FAILURE TO PLAN

From the beginning of the Covid-19 pandemic, it has been clear that prisoners would be and were, in fact, among those at highest risk due to crowded aggregate living conditions. This concern was validated early on by studies showing significantly higher rates of infection and death in prisons nationally and locally (1). In Massachusetts, a June 2, 2020 decision by the Supreme Judicial Court (SJC) did not find constitutional violations in the Massachusetts Department of Correction (DOC) failure to expedite release of prisoners in order to decrease prison crowding. The SJC, however, did alert the DOC that failure to plan ahead to reasonably protect prisoners from infection might result in constitutional violations, especially if the DOC failed to decrease crowding (2).

It is incontrovertible that the DOC chose to ignore this advice and--as we shall see--failed to institute any other viable plan to mitigate Covid-19 infections and deaths in state prisons. By early January 2021, this had resulted in an overall DOC prisoner infection rate over 35% while, even after the winter and holiday surges, the community rate was only 6%. Here at MCI-Norfolk, 41% of prisoners had tested positive (3). Similarly, the prisoner death rate rose to 333/100,000, exceeding the community death rate of approximately 200/100,000 (4). This result is especially surprising because the fraction of the prisoner population aged 70 and older, those most likely to die from Covid, is only one-third that seen in the community (5).

It is fair to argue that the DOC had no plan to deal with the pandemic in prison other than a hope that, miraculously, it would be possible to prevent infection from penetrating prison walls. This futile hope was then further dashed by the DOC's lack of foresight in implementing rational procedures to keep infection out by adequately screening or quarantining guards. This report addresses some of the most serious failings that have led to the staggering rates of infection and death seen in Massachusetts state prisons to date. Many of these issues also have been timely highlighted and discussed in prior reports and in "Updates from MCI-Norfolk", all of which are available for review online (6).

CROWDING

In addressing the major concern about crowding voiced by the SJC, it is clear that the DOC failed to expedite release of even short-term and/or parole eligible prisoners. Additionally, the DOC actively resisted releasing eligible prisoners on home confinement (with or without GPS monitors) even though the SJC ruled that the DOC had that authority (7). Equally troubling is the observation that, by various means including but not limited to reducing access to "earned good time", the DOC released some 500 fewer prisoners April-November 2020 compared to the same periods during the four preceding years, 2016-2019 (8). Although the DOC custody population was reduced by approximately 1000 prisoners during 2020, it is important to remember that there have been virtually no new criminal commitments since April 2020 because

of court closures. Normally this influx would far exceed the observed reduction, confirming that fewer prisoners than normal were released in 2020 (9). By contrast, other states have released large numbers of prisoners, including NJ with over 4000 and California with over 8000 (10)). Here in Massachusetts, reductions in individual prisons have been minimal with no notable effect on crowding. For example, MCI-Norfolk, operating at approximately 97% of capacity on April 4, 2020, the date starting the 24/7 lockdown, saw a reduction of only 34 prisoners (2.6% of a 1267 total) by November, when the pandemic was ravaging the prison (11). The unmitigated crowding was a major contributor that allowed waves of infection to decimate the prison population in November-December. Without preparation or a viable plan, the administration had no effective means to limit the spread.

LOCKDOWN

Once the pandemic took hold in the community in the spring of 2020, the DOC mindlessly implemented its typical universal remedy for any prison crisis: a 24/7 lockdown of all prisoners into cells and tiers. As amply documented in prior "Updates", this lockdown dramatically exacerbated conditions likely to spread infection (12). Prisoners were forced into close, intimate contact with each other 24/7 while sharing communal living space, bathrooms, tight tiers, chow and medication lines, as well as communal closed-circuit ventilation systems. Paradoxically and tragically, these conditions were exquisitely effective means of providing ideal, incubator-like conditions that would maximize the spread of virus once it entered the prison (13).

PRISONER WORKERS DEPLOYED

Initially, the lockdown was complete but within weeks cost-saving expediencies and pragmatic considerations moved the administration to make self-serving adjustments. While most prisoners remained isolated and crammed into tight communal quarters, hundreds of prisoner workers were returned to congregate settings to work in Industries, mainline kitchen, maintenance and janitorial services. Their only PPE were masks. These workers had frequent contact with prison staff who lived in the community and entered the prison daily. A major failing was that prison staff were not routinely tested, creating a steady source of potential infections. Similarly, prisoner workers also were not tested unless reporting symptoms--a serious omission since each worker returned to their original, otherwise quarantined, housing unit each evening. This inexcusable violation of quarantine procedures obviated any benefit derived from the draconian isolation imposed upon all other prisoners. This poorly conceived and deeply flawed strategy set the stage for the eventual efficient distribution of infection throughout the prison population.

TESTING

Another critical misstep by the DOC was the failure to regularly test. Prisoner workers, including unit food handlers and servers, were not screened with testing. The first wide-spread testing was done late May and not repeated until the first week in November. By then, here at Norfolk, many symptomatic cases were springing up and testing revealed multiple housing units with up to three-quarters of prisoners testing positive. Even worse, results were slow to be reported, leaving infected prisoners in prolonged contact with others before they were "isolated" in a dormitory setting. However, even in units

testing negative, many prisoners began experiencing symptoms within days after their negative tests, obviously infected but missed, in these cases, by the marginally premature test. These infected prisoners were not reported or isolated and infection spread rapidly throughout most housing units. The next round of testing did not occur for 5 more weeks. Many symptomatic prisoners had recovered by then and tested negative, thereby never being counted among the infected, even while infection continued to rage through the prison without official accounting or attention.

MASKING

Almost certainly among the most egregious mistakes made by the DOC (other than rebuffing all efforts to reduce crowding) were the decisions made on prisoner mask usage. After the initial lockdown on April 4, during which prisoners were confined to cells 24/7 (except for brief intervals to use communal showers and phones), outbreaks had begun to crop up in several prisons. By late April, the DOC responded appropriately by issuing commercial surgical masks to prisoners with a mandate to wear these in congregate settings. These masks were the standard multilayer, soft masks normally used in surgical theaters, as N95 and other high-efficiency masks were still in short supply in the U.S.. In response to increasing prisoner compliance with masking, and as reported in a study of DOC masking policy, prison rates of infection promptly diminished. By late May new infections were virtually eliminated in all prisons (14). New surgical masks were being issued to prisoners every 2 to 3 weeks until a fateful DOC decision announced on October 14, 2020. On that date the DOC distributed pairs of new home-made, washable masks made by prisoners in Industries based on haphazard templates and designs. Prisoners were required to wear only these new masks, which were the only ones authorized for use. These masks were immediately recognized as poorly designed and likely to have limited effectiveness. They were too big, fitting loosely and made with only a single layer of fabric, a serious flaw which by then had been widely criticized by experts. Too large and without a wire to mold around the nose, the oversize masks leaked air around all margins and typically slipped off the nose, further compromising efficacy.

Despite prisoner complaints, including some grievances, that these masks were inadequate and likely ineffective, the DOC continued to mandate their exclusive use. One grievance was dismissively answered by stating that "...a cloth mask for an inmate in general population is appropriate...". The consequences of this poorly conceived, cost-saving measure were almost immediate: within two weeks case numbers started to climb throughout most prisons, reaching epidemic proportions by the third week (15). This surge has continued well into the new year, by which time it was likely that virtually all prisoners had been exposed (see an analysis of likely infection rates in the January 20, 2021 Norfolk "Update" (16)). Because prisoners have been in 24/7 lockdown quarantine and continuously confined to the same indoor housing units since April, this surge of infections cannot be attributed, as it has been in community surges, to cold weather indoor exposure or changes in the aggregation of prisoners. Rather, it is clear that this ill-conceived penny wise and pound foolish decision by the DOC not to spend trivial sums (probably no more than 50¢ each) to purchase effective surgical masks had devastating impacts upon the prisoner population. Without effective masks and no opportunity to social distance or protect themselves from the ravages of widespread infection, prisoners succumbed to Covid-19 in droves.

SPREAD & ISOLATION

Because of the aforementioned lack of preparation, planning and the failure to reduce crowding, here at Norfolk there was no safe place to isolate prisoners once large numbers tested positive. Desperate, the administration resorted to reopening the previously condemned probation units. This fateful mistake clustered up to 70 infected prisoners into an onerous dormitory setting with double bunks a scant 3 feet apart and no amenities. The building was known to be mold-infested and had a closed-circuit ventilation system that recycled air. Aware that reporting symptoms would cause them to be "isolated" in this dormitory setting that offered neither benefits nor any treatment, kept many prisoners from timely reporting symptoms in order to remain in their housing units--while inadvertently infecting others. Guards rarely reported even blatantly symptomatic prisoners, in part because they had tested negative in early November and because there were so few beds for isolation. Only those complaining of the most serious medical difficulties, often requiring hospitalization, were reported. The remaining prisoners were left in their cells, further spreading infection. Although later on a high-security unit was cleared to be used as a supplemental isolation area, the damage had been done, with Covid-19 infection firmly entrenched at Norfolk. This yielded the documented 41% rate of positive tests by late December even though many unreported symptomatic prisoners tested negative by that time. Norfolk has the most elderly and vulnerable, longest serving prisoner population in the DOC. This group was subject to the many serious medical consequences of Covid-19, including chronic, long-lasting after-effects of infection and even death. In a blatant attempt to dissimulate the number of prisoners dying in custody, the DOC even resorted to releasing some prisoners on "medical parole" only hours before their demise, in order to claim that they were not prisoners at the time of death (17).

MISSTEPS

Multiple other bad decisions and missteps were made, many likely motivated by the desire to save money and maximizing the use of virtually free prisoner labor. A particularly poor choice at MCI-Norfolk was an early decision to stop using costly disposable food trays for meals. Dishwashing machines with cold-sterilization functions had been shut down and washable food tray use discontinued. Without disposable trays, prisoners were required to use individually owned bowls to receive food. This resulted in food servers needing to handle and return prisoners' reusable bowls with every meal, maximizing cross-contamination. Moreover, food servers were not screened or tested for infection. A consequence in my unit, for example, was that delayed test results during the December mass screening caused asymptomatic but infected food servers to continue serving for a week while their tests were pending. During this time they were daily in close proximity with prisoners and handled their bowls during each meal.

Many other troublesome decisions included restricted access to cleaning and disinfection supplies. No effective measures were instituted to provide for systematic sanitation of communal bathrooms, showers and many other shared spaces. Bleach, always contraband in prison, was not accessible. Later, a roving team sprayed some common areas with diluted bleach solution every one or two days, but this had little effect on the crowded tiers and bathrooms. Hand sanitizer, initially not available, was later sequestered in the guards' offices, inaccessible to prisoners in most situations. These and other similar

issues, in conjunction with the underlying close quarters and persistent locking in of prisoners, actively facilitated and encouraged wide-spread infection in prisons. This resulted in frequent tragic outcomes, including deaths as well as burdening substantial numbers of vulnerable and elderly prisoners with well-reported long-term, often devastating and persistent health consequences of Covid-19 (18).

VACCINATION

A particularly deplorable, even tragic consequence of the DOC's lack of prepartion, planning and mitigation of infection in prisons is that had the prison surge of infections been delayed by only a few months, early vaccination would have protected this vulnerable population. Commendably, the Commonwealth Covid-19 task-force included prisoners among the first wave to be vaccinated. This was, in fact, accomplished during January 2021. However, by that time, the majority of prisoners had been exposed and infected before they were ever vaccinated. Thus, lamentably, their deaths or disabling long-hauler Covid-19 disabilities could have been prevented had DOC preparations and policies been effective at delaying the infection surge in prisons.

CONCLUSION

These facts make clear that the DOC's failure to act is inexcusable and directly responsible for the devastation imposed on this literally captive population. Thousands of prisoners have become infected in these crowded quarters, inadequately protected by ineffective masks. In addition to the elderly and vulnerable suffering long-term consequences, all prisoners have been adversely affected by the enforced lockdown and lack of educational, rehabilitative and self-help programs because of the persistently large numbers of infections and high risks.

This lack of foresight and negligent execution is not unique in DOC operations. Similar failings have chronically afflicted operations regarding the use of solitary confinement, disciplinary procedures, the provision of medical and mental health care, and the lack of accountability of DOC staff regarding the need to educate, rehabilitate and re-integrate prisoners back into society. This persistent lack of concern for prisoners' needs leads to dehumanization and debasement of prisoners that, overall, severely impair the ability of prisoners to maintain positive adjustments while in prison but, critically, also once returned to the community after release. In this way, the Department of Corrections not only fails to "correct", but actually exacerbates the risk of recidivism once prisoners are released.

ENDNOTES

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2. Foster & Others v Commissioner of Correction & Others (No.1), SJC-12935, June 2, 2020.

3. www.mass.gov/doc/sjc-12926-special-master-weekly-report-011321.

4. Crimaldi L. "Inmates start getting vaccinated", Boston Globe, 1/23/21, B1.

5. Lifers' Group Fast Facts: "Excessive Rates of Covid-19 Cases and Deaths in Massachusetts State Prisons, August 2020.

6. Norfolk Updates (dated May 10 & 20; June 1, 13 & 30; July 15 & 29; August 17; Sept 12; Oct 13 & 31; Nov 30; Dec 8 & 29; Jan 20, 2021) plus Lifers' Group Fast Facts (see n.5, 8, 14) accessible at www.realcostofprisons.org/writing.

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11. www.mass.gov/doc/sjc-12926-special-master-weekly-report-011321.

12. See n.6.

13. Ibid.

14. Lifers' Group Fast Facts: "For Want of a Reliable Mask: How the Massachusetts DOC Endangered Prisoner Lives and Health To Avoid Paying For Effective Masks During the Covid-19 Pandemic", January 2021.

15. Ibid.

16. See n.6.

17. Becker D. "2 Mass. Prisoners Hospitalized for Covid-19 Die A Day After Being Granted Medical Parole", WBUR, November 30, 2020.

18. del Rio C, Collins LF, & Malani P. "Long-Term Health Consequences of Covid-19" J Am Med Assoc (JAMA); 324:1723-24 (2020); Rubin R. "As Their Numbers Grow, Covid-19 "Long-Haulers" Stump Experts"; JAMA; 324:1381-83 (2020).

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