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).

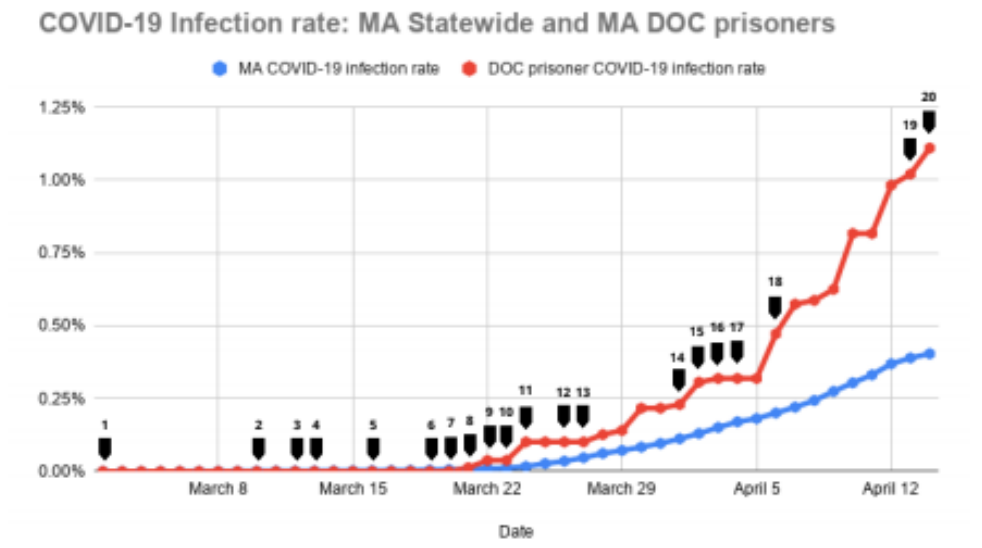
[6] As discussed *infra*, the low rate of testing in prison guarantees that identified cases greatly understate the actual number.

[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.

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Respectfully Submitted,

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[114] See BMC Decl. ¶¶ 16-23.