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John Dean
Superintendent
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Carol Mici
Commissioner
MA Department of Correction Headquarters
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Petition for Medical Parole of [REDACTED]

Dear Superintendent Dean and Commissioner Mici:

On behalf of Mr. [REDACTED] I submit this request that DOC grant him release on medical parole pursuant to G.L. c. 127, § 119A. Mr. [REDACTED] is permanently cognitively incapacitated due to progressing dementia.

Mr. [REDACTED] will turn 82 years old on [REDACTED]. He is serving a natural life sentence for convictions of indecent assault and battery on a child, kidnapping, and murder committed in 1970. It appears that he may have from and after sentences, however if you determine that Mr. [REDACTED] qualifies for medical parole, it follows that he would be medically paroled from all Massachusetts sentences based on that determination. Mr. [REDACTED] was convicted of a listed offense subjecting him to potential civil commitment, but the medical parole statute makes clear that a grant of medical parole similarly supersedes a potential commitment under the civil commitment statute.¹

Medical Condition

Mr. [REDACTED] has been diagnosed with a number of medical conditions including: dementia, coronary artery disease, glaucoma, hypertension, cirrhosis of the liver, stroke history, hearing loss and pre-diabetes. Ex. A, [REDACTED] assessment; Ex. B, Selected medical records, generally. He is prescribed medications to manage these conditions, in addition to hearing aids for his hearing loss. He had COVID-19 in December 2020 and suffered a stroke in August 2021. Medical records have indicated that his confusion and dementia have worsened since those events.

In March 2022, Wellpath evaluated Mr. [REDACTED] for admission to the Nursing Care Unit,

¹ “**Notwithstanding any general or special law to the contrary**, a prisoner may be eligible for medical parole due to a terminal illness or permanent incapacitation...” G.L. c. 127, § 119A(b) (emphasis added).

(“NCU”) based on his worsening cognitive functioning. Ex. B, p. 1. Medical staff spoke with his employer in the sewing shop who said he had “good days and bad days but often seems out of it.” Ex. B, p. 20. Mr. [REDACTED] was not admitted to the NCU at that time.

In May 2022 Mr. [REDACTED] was hospitalized after he was found confused and unable to get out of bed; at the hospital he was diagnosed with pneumonia and sepsis. Upon his discharge from this hospitalization, nursing notes record that Mr. [REDACTED] was unable to describe the reason for his hospitalization. Ex. B, pp. 3, 9. He was ultimately admitted to the NCU in June 2022 due to worsening cognitive dysfunction that made it impossible for him to independently function in general population. Ex. B, p. 2. In addition to noting his history of confusion and increasing need for direction to complete tasks such as taking medication, Ex. B, p. 1, Wellpath providers have repeatedly noted chronic confusion or a diagnosis of dementia in his medical records. Ex. B, pp. 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 18, 19.

I have met with Mr. [REDACTED] several times over a span of six months or more. Each time he has greeted me warmly but has been unable to say who I am, even generally. Even more notable, Dr. Angeles documented that he was unable to recognize her when she saw him two days in a row. Ex. B, p. 19. On my last visit, I reintroduced myself and asked if he knew what I was there to talk with him about. He smiled and said yes but was unable to recall what it was about when asked to tell me. He has consistently been able to tell me his name and birth date, but not always where he is, and he has never been able to tell me the day of the week or the month or year. On one visit I asked him if he knew who the President is, and he smiled and told me “Obama.”

Mr. [REDACTED] is not prescribed any assistive devices for mobility and is able to walk independently, although slowly and somewhat gingerly, Ex. B, p.13, as would be expected for a man of his age. While Mr. [REDACTED] is able to perform much of his activities of daily living without physical assistance, as noted in several records, he is unable to independently perform many tasks without continual prompting. In fact, that is the very reason that he is now housed in the NCU. Ex. B, pp. 1-2. For example, he needs to be reminded to take the medications used to manage many of his medical conditions, including to minimize the risk of further strokes, and he needs repeated direction to complete tasks, such as following instructions to go to a specific location. *Id.*, see Ex. A. During my last visit with Mr. [REDACTED] in June 2022, the officer who escorted me out of the health services unit remarked that Mr. [REDACTED] appeared to be losing function every day.

Risk to public safety

Mr. [REDACTED] has steadily held employment while in prison, including working in the sewing shop at MCI Shirley until he was transferred to the medical unit earlier this year. DOC conducted a TCU drug screen assessment in 2016, on which Mr. [REDACTED] was assessed to have a low risk of substance abuse. It appears that DOC has not conducted any formal assessment of the risk of violence or recidivism on Mr. [REDACTED] likely due to his sentence structure. Ex. C, Personalized Programming Plan. Mr. [REDACTED] earned his GED in prison in 1975. Documentation shows that Mr. [REDACTED] has been program compliant and DOC has determined that he is not in need of programming for anger or criminal thinking. *Id.*

During Mr. [REDACTED] 50 years of incarceration on this sentence, he has had only ten disciplinary tickets. His most recent disciplinary tickets were in 2016 and none of his

disciplinary offenses in the five decades that he has been incarcerated involve any violent or sexually inappropriate behavior. Medical records also consistently record Mr. [REDACTED] presentation as pleasant and cooperative. Ex. B, pp. 6, 7, 10, 11, 12, 13, 15, 16, 17, 19. At the time of his 2021 classification, Mr. [REDACTED] had an Objective Point Based Score of 1, indicating that, without the application of overrides, DOC's classification system assesses him to be appropriately housed in minimum security. Ex. D, Classification score. I have requested Mr. [REDACTED] 2022 classification documents, in case his scoring has changed since his admission to the NCU and loss of his job and will supplement with those if needed.

It is important to be aware of the significant impact that aging has on a person's risk of recidivism. As stated in a Massachusetts DOC 2020 research report, formerly incarcerated people "55 and older, both male and female, recidivated at the lowest rates, consistent with research on age and recidivism." [MA DOC Three-Year Recidivism Rates: 2015 Release Cohort](#), p. 9. This correlation is consistent when looking at research on the impact of aging on recidivism of those convicted of sex offenses. Findings of an earlier DOC research report were consistent with the 2020 report showing that releasees over 60 had the lowest recidivism rate, [THREE YEAR RECIDIVISM RATES: 2013 RELEASE COHORT](#), p.8; and also found that men released from a sentence for a sex offense recidivated at the lowest rate of any type of offense. *Id.*, Table 10. It should be noted that neither report analyzed recidivism for an age group older than 60. Given that Mr. [REDACTED] is more than 20 years older than that, his risk is reduced even further. A 2017 Vera Institute of Justice report states that "early-release policies are also supported by recidivism research, which demonstrates that age is a significant predictor of re-offending: arrest rates drop to just more than 2 percent in people ages 50 to 65 years old and to almost zero percent for those older than 65." [Aging Out Using Compassionate Release to Address the Growth of Aging and Infirm Prison Populations](#), p. 3.

Medical Parole Plan

Mr. [REDACTED] has family who would like him to come home so they can care for him in his final years. He has a brother, sister, and a sister-in-law, along with nieces, nephews and cousins who are all willing to support Mr. [REDACTED] in his release to the community. Specifically, his youngest brother, Charles [REDACTED] and his wife are able to care for Mr. [REDACTED] in their single-family home at [REDACTED]. The telephone number to reach [REDACTED] is [REDACTED]. The home has three bedrooms and is a single floor home. [REDACTED] and his wife have both worked as nursing assistants, including Mrs. [REDACTED] having worked at a nursing home for years; as a result, both are aware of the type of care that would be needed and feel confident in their ability to provide it and to assist him in accessing medical appointments and public health benefits for which he is eligible. Mr. [REDACTED] would likely be eligible for certain types of home-based services as well to supplement his care. Dr. [REDACTED] opined that Mr. [REDACTED] could be appropriately cared for in a home in the community, so long as he has 24-hour care available to him.

There is a hospital in [REDACTED] along with several medical practices where Mr. [REDACTED] family will be able to assist him in becoming a patient. Because Mr. [REDACTED] is a veteran honorably discharged from military service in the Navy in 1967, he would be eligible for Veterans' benefits, including health care from the Veterans Association, in addition to other public health care benefits. Charles [REDACTED] is also a veteran and himself travels to the VA hospital nearby for his own medical care.

Considering Mr. [REDACTED] advanced age of 82; the relative slowing down and weakening of his body due to age and his various medical conditions; his lack of any violent disciplinary offenses in 50 years; and his permanent cognitive incapacitation from dementia, which both renders him unable to complete most tasks without repeated prompting, and requires him to have 24-hour supervision, Mr. [REDACTED] would not pose a risk to public safety in his current medical condition.

Thank you for your consideration of Mr. [REDACTED] petition.

Lauren Petit

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Staff Attorney

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