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April 7, 2022

VIA ELECTRONIC MAIL

Commissioner Carol Mici
Department of Correction
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Milford, MA 01757
carol.mici@doc.state.ma.us

Superintendent Stephen Kennedy
Old Colony Correctional Center
One Administration Road
Bridgewater, MA 02324
stephen.kennedy@doc.state.ma.us

Re: Supplementation to the Medical Parole Petition of [REDACTED]

Dear Commissioner Mici and Superintendent Kennedy:

I write to supplement the April 14, 2022 medical parole petition of Mr. [REDACTED] with additional information and documentation regarding Mr. [REDACTED]'s medical condition, and to direct your attention to deficiencies in the supporting materials transmitted by Superintendent Kennedy to Commissioner Mici. I submit the following as supplementation to this petition and administrative record:

I. Additional Information Regarding Mr. [REDACTED]'s Permanent Cognitive and Physical Incapacitation

As stated in his medical parole petition, Mr. [REDACTED] is permanently cognitively incapacitated due to dementia, and permanently physically incapacitated due to several physical impairments, including severe arthritis, and visual and auditory impairments. Since his petition was filed, PLS has received additional information regarding the extent of Mr. [REDACTED]'s incapacitation:

In early March of 2022, a prisoner in Mr. [REDACTED]'s unit who interacts with him daily informed us that Mr. [REDACTED]'s cognition and ability to walk had significantly deteriorated in the month since our prior visit. The prisoner is part of a prayer group that includes Mr. [REDACTED]

and reported that Mr. [REDACTED] is no longer able to recite passages from the Quran, a skill that he retained even as other aspects of his memory and cognition steadily deteriorated. He also noted that Mr. [REDACTED] more frequently appears disheveled (for example, with his clothes improperly buttoned), indicating his diminished ability to care for his own needs.

We also spoke with Mr. [REDACTED]'s companion, who lives in Mr. [REDACTED]'s unit. The companion reports that DOC assigned him to walk with Mr. [REDACTED] due to his fragile physical condition and susceptibility to falls. The companion walks with him three times a day to the chow hall to pick up Mr. [REDACTED]'s meals, which requires travelling up and down stairs. According to the companion, Mr. [REDACTED] slips at least three or four times during each trip, requiring the companion to catch and stabilize him. The companion carries Mr. [REDACTED]'s tray and other items for him because Mr. [REDACTED] cannot do so himself. The companion also reported that Mr. [REDACTED] is unable to stand for even short periods of time. He accompanies Mr. [REDACTED] to the medication line several times a day, where they must wait in line for up to 30 minutes at a time. Mr. [REDACTED] is often forced to sit on the floor while waiting because he cannot remain standing, and staff do not provide chairs for him to sit on.

Mr. [REDACTED]'s physical incapacitation has also been noted by staff. After noticing that it takes more than 30 minutes for Mr. [REDACTED] to walk from his unit to the canteen, staff gave Mr. [REDACTED]'s companion permission to pick up his canteen bag. During several of our visits to see Mr. [REDACTED] correctional officers have disclosed that Mr. [REDACTED] is a fall risk and that he walks extremely slowly.

Mr. [REDACTED]'s companion provided the following details regarding his cognitive impairment: Mr. [REDACTED] does not remember the companion's name although the two interact constantly and the companion's name is posted on Mr. [REDACTED]'s door. He cannot recall events that occurred within the past few days, or even conversations that occurred just a few hours prior. Mr. [REDACTED] also will not remember to take his medication without reminders from his companion.

II. Deficiencies in the Materials Transmitted by the Superintendent to the Commissioner

A. *Medical Parole Evaluation*

Although cognitive impairment is a central basis for Mr. [REDACTED]'s eligibility for medical parole and is referenced at length in his petition, there is no discussion of cognitive impairment in the February 12, 2022 Wellpath Medical Assessment by FNP-C Ihuoma Arikibe and Medical Director Dr. John Straus.¹ It does not appear as if DOC has provided

¹ While Mr. [REDACTED] does not seek medical parole based on terminal illness, it is noteworthy that Dr. Straus and FNP-C Arikibe used the wrong standard for their assessment of terminal illness. They state that "there is no concrete evidence that [Mr. [REDACTED]] has less than 18 months to live." However, the statutory definition of terminal illness does not require "concrete" evidence, but rather that a licensed physician identify "a condition that appears incurable . . . that will *likely* cause the death of the prisoner in not more than 18 months . . ." M.G.L. c. 127 § 119A(a) (emphasis added).

neurocognitive testing to identify and determine the severity of Mr. [REDACTED]'s cognitive condition for the purpose of evaluating medical parole eligibility. Indeed, Mr. [REDACTED]'s medical records from the past year suggest that DOC has never administered such testing to him, despite clear signs of age-related cognitive decline.

Given the deficiencies in this evaluation, PLS arranged for Mr. [REDACTED] to undergo a neurocognitive evaluation for dementia by Dr. Nicole Mushero, a physician and Assistant Professor at Boston University School of Medicine with board certifications in internal medicine and geriatrics. Dr. Mushero's evaluation, which is appended as Exhibit A, notes that Mr. [REDACTED] screened positive for significant cognitive impairment that is likely to be mixed Alzheimer's and Vascular dementia. Dr. Mushero also found that Mr. [REDACTED] has multiple physical impairments, including severe arthritis, visual impairment, and coronary artery disease severely and permanently limit his physical functioning.

B. Medical Parole Release Plan

Under *Buckman v. Commissioner of Correction*, the Superintendent of the facility in which the petitioner is incarcerated bears the burden of preparing or procuring a medical parole release plan and transmitting it to the Commissioner. 484 Mass. 14, 32 (2020). Here, the materials transmitted by the Superintendent do not contain a medical parole plan or any indication that the DOC has initiated release planning. We noted in Mr. [REDACTED]'s petition that his brothers reside in [REDACTED] and are willing and able to care for him, but there is no evidence that DOC has reached out to them. Mr. [REDACTED]'s brother [REDACTED] resides at [REDACTED] and his phone number is [REDACTED].

As *Buckman* made clear, it is the responsibility of the DOC, not the petitioner, to initiate a "collaborative process" between the prisoner, healthcare providers, reentry staff to formulate and recommend a release plan to the Commissioner, and the "superintendent ultimately bears the burden of producing or procuring these documents arising from the collaborative process." 484 Mass. at 32. No such documents were provided to the Commissioner here, which make it impossible for the Commissioner's to render a decision that comports with *Buckman*.

C. Risk Assessment

The Superintendent is also responsible for preparing and transmitting to the Commissioner an "assessment of the risk of violence that the prisoner poses to society." M.G.L. c. 127 § 119A(c)(1); *see also* 501 CMR 17.05; *Buckman*, 484 Mass. at 32. Here, the supporting documents provided by the Superintendent to the Commissioner include a September 2021 Classification Report, a January 2015 Texas Christian University Drug Screening, and an August 2010 Risk Assessment. A risk assessment that is almost twelve years old is not an evaluation of the prisoner's current level of risk to public safety. In addition, the assessment appears to be incomplete, with data missing from several sections. In addition, the documents transmitted by the Superintendent do not include a Personalized Program Plan, which typically includes a risk level and details regarding program

involvement. The Commissioner therefore has little to no information about Mr. [REDACTED]'s participation in programming, which is relevant to an assessment of risk. A decision that does not rely on a complete and current assessment of risk will not comport with the requirements of *Buckman*.

Please do not hesitate to contact me about Mr. [REDACTED]'s petition. I can be reached via email at alin@plsma.org or phone at (617) 502-6832 ext. 6832.

Sincerely,

/s/ Ada Lin

Ada Lin
Legal Fellow

Cc:

VIA ELECTRONIC MAIL

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VIA FIRST CLASS MAIL

[REDACTED]
Old Colony Correctional Center
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Bridgewater, MA 02324

Nicole Mushero, M.D. Ph.D.

85 East Concord St

Section of Geriatrics, Department of Internal Medicine

Boston University School of Medicine

Patient: [REDACTED]

1. My name is Nicole Mushero. I am a physician and am board-certified in internal medicine and geriatric medicine and am employed by Boston University School of Medicine as an Assistant Professor of Medicine. I have expertise and experience in diagnosing and treating patients with complex medical conditions including cognitive impairment.
2. I have been asked to review the physical and mental condition of [REDACTED] (DOB [REDACTED]) who is incarcerated at Old Colony Correctional Center (OCCC) to assess the extent of his incapacitation. My conclusions are based on a physical examination of Mr. [REDACTED] done at OCCC on March 26, 2022 and my review of his medical records.
3. I understand that a prisoner must be permanently incapacitated or terminally ill in order to qualify for medical parole and that permanent incapacitation is defined as “a physical or cognitive incapacitation that appears irreversible, as determined by a licensed physician, and that is so debilitating that the prisoner does not pose a public safety risk.”
4. In assessing incapacitation, I have considered whether Mr. [REDACTED] suffers from identifiable diseases or disabilities, the extent to which such diseases or disabilities substantially limit major life activities and, in particular, restrict his mobility and the activities in which he can engage, and whether the diseases or disabilities are irreversible.
5. All opinions expressed in this statement are held by me to a reasonable degree of medical certainty.

6. Cardiovascular disease: The patient has known severe coronary artery disease (CAD) including a myocardial infarction (NSTEMI) in April 2009 where a stent was placed. Despite being on the appropriate medical regimen to control disease (Plavix, metoprolol, lisinopril, simvastatin and isosorbide monohydrate to control symptoms) he continues to have unstable angina—this means that he has chest pain from lack of blood flow to his heart at rest and this severely limits his ability for any type of physical activity. During the course of my interview with him he developed chest pain and shortness of breath requiring a dose of medication (nitroglycerin) to relieve his symptoms.
7. Arthritis: While medical records only note arthritis in his R knee on my exam Mr. [REDACTED] has severe arthritis in multiple joints in his body. His hands have swelling consistent with severe arthritis and he is not able to make a fist or grasp things tightly due to the pain and swelling there. This limits his ability to dress himself and he is dependent for assistance with dressing and grooming ADLs. He is also dependent for administration of as needed medications for chest pain relief as he is unable to open the bottle of medication himself. I evaluated his gait which is extremely unsteady—he currently uses a cane as ambulatory aid but even with this aid his gait was unsafe and he had to use the wall or furniture to balance himself. It is noted by the patient and in his medical record that he falls frequently which is further evidence of his gait instability. He was unable to walk more than a few feet without stopping due to a combination of imbalance and pain.
8. Cognitive impairment: Prior to my evaluation there was concern for cognitive impairment due to multiple people in Mr. [REDACTED] life noting instances of forgetfulness such as getting lost in a facility in which he has lived since 2003, forgetting the name of the prisoner aid who helps him daily and making non-sensical statements such as a family member living to be 142 years old. His medical records indicate difficulty relaying his own medical history but he has not previously been diagnosed with cognitive impairment and it is unclear if this has been assessed.
I evaluated him for cognitive impairment during our meeting using two cognitive screening tools. The first test is the Rowland Universal Dementia Assessment Scale (RUDAS) which is a validated dementia screening instrument scored out of 30 points, with less than 24 points meeting criteria for cognitive

impairment. Mr. [REDACTED] scored 16/30 (please see attached documentation). On memory recall he could recall only 2/4 words at five minutes. He also had severe difficulty understanding directions or following tasks as exemplified by inability to reason around the judgement task or perform the praxis. This combined with his functional impairment (needing support with IADLs and ADLs) means that Mr. [REDACTED] meets criteria for a diagnosis of dementia. Additionally, I did another test (the mini-cog, another validated dementia screening tool which includes a three-word recall and clock draw) which includes having the person make a clock which Mr. [REDACTED] was unable to do correctly (see attached documentation). Notably Mr. [REDACTED] is unable to put all of the numbers in for a clock or keep the numbers within the clock face, these are common errors for people with cognitive impairment. He was asked to place the hands at ten minutes past 11 which you can also see he has not been able to do. The sheet also includes a request for him to write his name, demonstrating that it is his.

For both of these tests Mr. [REDACTED] screened positive for cognitive impairment which raises the strength of the assessment. Even more striking, for someone with Mr. [REDACTED] educational background it is expected that they will perform better than average on testing such as this which Mr. [REDACTED] failed to do highlighting the extent of his cognitive impairment.

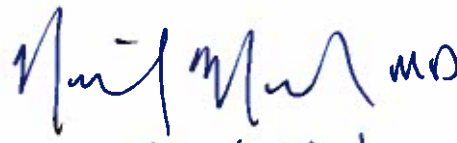
Given his history it is likely that he has a mixed Alzheimer's and Vascular dementia although it would require further neuropsychiatric testing to fully elucidate the type of dementia. Regardless of the type, however, dementia is an irreversible and progressive neurological condition which will worsen with time. It is expected that Mr. [REDACTED] will become more confused, forgetful and physically weaker as the dementia progresses.

9. Visual impairment: according to medical records from June 2021 he has only light perception in his R eye vision and diminished vision in his left eye due to primary, open angle glaucoma.
10. Mr. [REDACTED] has several other medical problems including hypertension, although this seems generally well controlled, a seizure disorder with last known seizure 5/21/21 on medications to prevent future seizures, acid reflux disease or GERD for which he takes medications and severe hearing loss for which it is recommended he wear hearing aids.

11. In summary, Mr. [REDACTED] has multiple disabling medical conditions including severe arthritis, coronary artery disease, visual impairment with blindness in one eye and dementia. All of these conditions severely limit Mr. [REDACTED]'s physical functioning. Dementia alone is a disabling, irreversible disease which renders Mr. [REDACTED] permanently incapacitated. His physical function is further limited by cardiac ischemia and difficulty walking and using his hands due to arthritis.

12. I have reviewed the medical parole plan prepared for Mr. [REDACTED]. The plan anticipates that he will live with his brother, with other family available for assistance in care. It is my opinion that this medical parole plan is adequate to provide for Mr. [REDACTED] continuing care in the event that he is released on medical parole.

Signed under the penalties for perjury.

 MD
Nicole Mosher 3/31/2022



Abderrahman
T. D. M. J. C.

R U D A S

The Rowland Universal Dementia Assessment Scale: A Multicultural Cognitive Assessment Scale.
(Storey, Rowland, Basic, Conforti & Dickson, 2004). International Psychogeriatrics, 16 (1), 13-31

Date: 3/26/22

Patient Name: Abdel Salim

Item	Max Score
Memory	
1. (Instructions) I want you to imagine that we are going shopping. Here is a list of grocery items. I would like you to remember the following items which we need to get from the shop. When we get to the shop in about 5 mins. time I will ask you what it is that we have to buy. You must remember the list for me. Tea, Cooking Oil, Eggs, Soap Please repeat this list for me (ask person to repeat the list 3 times). (If person did not repeat all four words, repeat the list until the person has learned them and can repeat them, or, up to a maximum of five times.)	
Visuospatial Orientation	
2. I am going to ask you to identify/show me different parts of the body. (Correct = 1). Once the person correctly answers 5 parts of this question, do not continue as the maximum score is 5.	
(1) show me your right foot ✓	1
(2) show me your left hand ✓	1
(3) with your right hand touch your left shoulder ✓	1
(4) with your left hand touch your right ear ✓	1
(5) which is (indicate/point to) my left knee ✓	1
(6) which is (indicate/point to) my right elbow	1
(7) with your right hand indicate/point to my left eye	1
(8) with your left hand indicate/point to my left foot	1
	<u>5</u> ..5
Praxis	
3. I am going to show you an action/exercise with my hands. I want you to watch me and copy what I do. Copy me when I do this . . . (One hand in fist, the other palm down on table - alternate simultaneously.) Now do it with me: Now I would like you to keep doing this action at this pace until I tell you to stop - approximately 10 seconds. (Demonstrate at moderate walking pace).	
Score as:	
Normal = 2 (very few if any errors; self-corrected, progressively better; good maintenance; only very slight lack of synchrony between hands)	
Partially Adequate = 1 (noticeable errors with some attempt to self-correct; some attempt at maintenance; poor synchrony)	
Failed = 0 (cannot do the task; no maintenance; no attempt whatsoever)	<u>0</u> ..0
Visuoconstructional Drawing	
4. Please draw this picture exactly as it looks to you (Show cube on back of page). (Yes = 1)	
Score as:	
(1) Has person drawn a picture based on a square? <u>(five sided outer edge)</u>	<u>0</u> ..0
(2) Do all internal lines appear in person's drawing?	<u>0</u> ..0
	
(3) Do all external lines appear in person's drawing?	<u>0</u> ..0
	
	<u>0</u> ..0
Judgment	
5. You are standing on the side of a busy street. There is no pedestrian crossing and no traffic lights. Tell me what you would do to get across to the other side of the road safely. (If person gives incomplete response that does not address both parts of answer, use prompt: "Is there anything else you would do?") Record exactly what patient says and circle all parts of response which were prompted.	
.....	
.....	
Score as:	
Did person indicate that they would look for traffic? (YES = 2; YES PROMPTED = 1; NO = 0)	<u>0</u> ..0

Memory Recall

1. (Recall) We have just arrived at the shop. Can you remember the list of groceries we need to buy?
(Prompt: If person cannot recall any of the list, say "The first one was 'tea'." (Score 2 points each for any item recalled which was not prompted – use only 'tea' as a prompt.)

honey
dove

Tea	2
Cooking Oil	✓.....2
Eggs	2
Soap	✓.....2

4/8

Language

6. I am going to time you for one minute. In that one minute, I would like you to tell me the names of as many different animals as you can. We'll see how many different animals you can name in one minute.
(Repeat instructions if necessary). Maximum score for this item is 8. If person names 8 new animals in less than one minute there is no need to continue.

- | | | | |
|---------|--------|---------|---------|
| 1. | bird | 5. | lamb |
| 2. | donkey | 6. | giraffe |
| 3. | horse | 7. | snake |
| 4. | fish | 8. | |

7/8

TOTAL SCORE =

16/30

