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✉ 50 Federal Street, 4th Floor • Boston, MA 02110

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☎ Main: 617-482-2773

📠 Fax: 617-451-6383

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March 2, 2023

VIA ELECTRONIC MAIL

Carol Mici
Commissioner
MA Department of Correction Headquarters
50 Maple St.
Milford, MA
carol.mici@state.ma.us

Kristie Marchand
Superintendent
MCI-Framingham
PO Box 9007
Framingham, MA 01701
kristie.marchand@state.ma.us

Request for Reconsideration of Medical Parole Denial – Joann [REDACTED] ([REDACTED])

Dear Commissioner Mici and Superintendent Marchand,

I write on behalf of [REDACTED] to request, pursuant to 501 CMR 17.13(3), reconsideration of Commissioner Mici's February 6, 2023 denial of Ms. [REDACTED] December 2, 2022 petition for medical parole, and that this request be considered expeditiously given Ms. [REDACTED] declining cognitive and physical state.

The Commissioner denied the previous medical parole petition based on the possibility that Ms. [REDACTED] cognition might improve after recovering from COVID and starting a medication trial, but she also recognized that reconsideration was warranted after several weeks. Those weeks have now passed and (1) there has been no improvement in Ms. [REDACTED] medical condition and she has, in fact, continued to deteriorate; (2) Wellpath has recommended not placing her on a medication trial; and (3) the diagnosis of Wellpath psychologist, Dr. Susan Mascoop, of "probable Major Neurocognitive Disorder due to Alzheimer's Disease" has been confirmed by Wellpath psychiatrist, Dr. Susan Richardson, and a new evaluation by Dr. Nicole Mushero, submitted herewith. These facts reaffirm that Ms. [REDACTED] qualifies for medical parole and must be released.

I submit the information below for your consideration and incorporate by reference the full administrative record from Ms. [REDACTED] previous petition.

Brief review of petition and supplements

As stated in her medical parole petition and two supplements, Ms. [REDACTED] has severe mobility issues and dementia, resulting in permanent physical and cognitive incapacitation. She uses a walker, a wheelchair, and Wellpath has assigned an assistant who pushes her wheelchair for her, in recognition of the fact that she cannot do so herself. She can only ambulate a few yards without assistance and sometimes requires assistance to bathe, toilet, dress, eat, and clean her room. Her medical records also indicate that she presents a fall risk and nutrition risk as she consumes less than her bodily requirement. Ex. A, Select Medical Records (highlighting added). Clinicians from Wellpath, DOC's own contracted medical provider, regularly note her dementia, Alzheimer's disease, cognitive issues, chronic confusion, and altered or disturbed thought process. *Id.* Further, Dr. William Weber, a physician with the Beth Israel Deaconess Medical Center, conducted structured cognitive testing of Ms. [REDACTED] on November 10, 2022 and the results support her dementia diagnosis. The assessment is scored out of 30 points, and any score below 23 indicates cognitive impairment. Ms. [REDACTED] scored 17 points on this assessment, strongly corroborating that she has dementia. Dr. Weber opined, based on his examination, that Ms. [REDACTED] memory issues are incapacitating and affect her basic judgment skills.

New evidence of cognitive decline

The Commissioner relies on Wellpath Regional Psychologist Dr. Susan Mascoop's statement that "it is unclear whether or to what extent her COVID diagnosis may have exacerbated her *significant, preexisting cognitive impairments*" (emphasis added), and that medication may slow Ms. [REDACTED] cognitive decline. However, on February 9, 2023, three days after the Commissioner's decision, Wellpath psychiatrist, Dr. Susan Richardson, examined [REDACTED] and determined that: (1) she has a neurocognitive disorder due to Alzheimer's disease; (2) no current medication for Alzheimer's disease can improve cognition; and (3) given her advanced age and frailty, she is prone to experiencing the serious side effects of medication for treating Alzheimer's disease. Ex. A, Select Medical Records at p. 5. Given these findings, Dr. Richardson recommended not placing Ms. [REDACTED] on medication to treat her Alzheimer's disease given the high risk of side effects compared to the minimal benefits. *Id.* Dr. Richardson ultimately opined that "there is no dementia or ADL [activities of daily life] unit for women in the DOC in Massachusetts. Patient [Ms. [REDACTED]] would be much better served in a nursing home setting on a dementia unit where the facility is designed to manage patients with dementia and the staff are specially trained to care for these very challenging patients." *Id.* Dr. Richardson's opinion appears to be the only opinion by Wellpath regarding Ms. [REDACTED] degree of incapacitation, as Dr. Rosenfeld only opined about her life expectancy. Ex. E, Administrative Record at p. 64.

Further, it now appears that Ms. [REDACTED] will remain the Health Services Unit. She seems to be experiencing delusions about her family living in the Laurel Unit, stating that "her Aunts and relatives were at Laurel," that she "[h]opes to get back to Laurel tonight before Mom and Dad show up," and that she "put a deposit on a room in Laurel and that her son would be moving in with her." Ex. A, Select Medical Records at pp. 1, 2. It also appears that she is

struggling with her ADLs. Dr. Rosenfeld stated in the Wellpath Medical Parole Assessment that “there seems to have been a decline in her abilities to perform activities of daily living in terms of needing to be heavily prompted.” Ex. E, Administrative Record at pp. 29, 31. Dr. Mascoop stated in her evaluation of Ms. [REDACTED] that “[s]he has difficulty figuring out how to put on her clothes and requires prompts to do so correctly” *Id.* at p. 24. It also appears that the reason medical staff concerned about her nutrition intake because she has difficulty remembering to eat, and this is why she is prescribed Ensure. *Id.* at pp. 63, 64.

Additionally, Dr. Nicole Mushero conducted a thorough review of Ms. [REDACTED] medical records and wrote a new declaration in support of this request for reconsideration, which is attached here along with their curriculum vitae (CV). Ex. B, Mushero Declaration; Ex. C, Mushero CV. Dr. Mushero is a physician with board certifications in internal medicine and geriatric medicine, and they are employed by Boston University School of Medicine as an Assistant Professor of Medicine where they have worked since 2020. They have expertise and experience in diagnosing and treating elderly patients with complex medical conditions, including cognitive impairment and dementia. Ex. B, Mushero Declaration ¶ 1, 2.

Dr. Mushero opines that Ms. [REDACTED] has a diagnosis of Alzheimer Dementia, which alone is a disabling, irreversible, progressive disease that renders her permanently incapacitated at this stage. Ex. B, Mushero Declaration ¶ 11. Dr. Mushero further notes that patients with a moderate level of dementia, like Ms. [REDACTED] require significant assistance or oversight of activities of daily life given challenges remembering to perform or how to perform basic tasks such as bathing, dressing, and eating, and often lack personal safety awareness. *Id.* Further, Dr. Mushero clarifies that Dr. Mascoop’s own evaluation of Ms. [REDACTED] on January 13, 2023 confirms her dementia diagnosis, and that her 9/30 score on the Montreal Cognitive Assessment (MoCA) indicated “severe cognitive impairment.” *Id.* ¶¶ 5, 6. In addition, with regard to the Commissioner’s assertion that Ms. [REDACTED] cognitive decline may improve as she recovers from her December 2022 COVID-19 infection, Dr. Mushero opines that “it is also common for people with dementia who experience acute illness such as [Ms. [REDACTED] COVID-19 infection]... to never recover their prior cognitive or functional level and that each acute visit leaves them increasingly debilitated.” *Id.* ¶ 6.

Moreover, the Commissioner expressed concerns over Dr. Weber’s qualifications, indicating that he had not included his CV with his evaluation. I have attached Dr. Weber’s CV to this request for reconsideration. Ex. D, Weber CV. Additionally, the Commissioner expressed concerns over Dr. Weber’s statement that Ms. [REDACTED] “appears” to have dementia, rather than making a conclusive diagnosis. Dr. Mushero opines that, even though the Commissioner did not credit Dr. Weber’s findings due to apparent lack of corroboration,¹ “Dr. Weber’s results are incredibly consistent with Dr. Mascoop’s and with what is known about [Ms. [REDACTED] from Wellpath’s own medical records” and, as such, “we can use the medical documentation to provide the collateral needed to establish [Ms. [REDACTED] diagnosis of

¹ When requesting that Dr. Weber be allowed to examine Ms. [REDACTED] Prisoners’ Legal Services requested that he also be able to conduct a collateral interview with another incarcerated woman who helps Ms. [REDACTED] but the Department of Correction’s Health Services denied this request.

dementia which has progressed in severity over the course of time.” Ex. B, Mushero Declaration ¶ 8, 9.

Importantly, the Commissioner misinterprets Dr. Mascoop’s finding that there is no evidence of a confusional or thought disorder as suggesting that Ms. [REDACTED] does not have debilitating dementia. According to Dr. Mushero, “[a] thought disorder typically refers to psychosis or inability to relay thoughts coherently. A confusional disorder can sometimes reference acute conditions such as delirium. Dr. Mascoop primarily references this to establish the reliability of her testing results as people with thought or confusional disorders can be hard to understand simply because of communication difficulties rather than underlying cognitive issues.” Mushero Declaration ¶ 7. Accordingly, the fact that Ms. [REDACTED] does not have a confusional or thought disorder reinforces the reliability of her dementia diagnosis rather than contradicts it.

ADA Fitzgerald’s declaration

The Commissioner’s decision relies on factual assertions about Mr. [REDACTED] medical condition made by First Assistant District Attorney Jennifer Fitzgerald of the Hampden County District Attorney’s Office. Specifically, the Commissioner states that, according to ADA Fitzgerald, Ms. [REDACTED] has not suffered any physical or psychological ailment that is causing her decline, and that symptoms of repeating stories, forgetting names, and repeating conversations are not extraordinary for a person of Ms. [REDACTED] age. ADA Fitzgerald is not qualified to make such medical determinations, and they are not accurate. To the contrary, Dr. Mascoop concluded in her evaluation that her “findings are most consistent with... diagnostic criteria for Probable Major Neurocognitive Disorder due to Alzheimer’s Disease...,” Ex. A, Select Medical Records, which has been confirmed by Dr. Richardson, Ex. A, Select Medical Records at p. 5, and by Dr. Mushero, Ex. B, Mushero Declaration ¶ 11.

Conclusion

Ms. [REDACTED] has severe dementia and mobility issues that render her permanently cognitively and physically incapacitated. Her disciplinary records demonstrate that she has remained disciplinary report-free for the last four years, and that none of the reports she received prior were for violent offenses. Ex. E, Administrative Record at p. 38. MCI-F Superintendent Kristie Marchand also acknowledges that Ms. [REDACTED] presents a “low risk of violence and recidivism,” *Id.* at p. 39, and Ms. [REDACTED] has a Classification Score of only 2, *Id.* at p. 65. These facts support a finding that Ms. [REDACTED] does not pose a risk to public safety. I request that the Commissioner reconsider Ms. [REDACTED] medical parole petition after considering this additional information.

Thank you for your reconsideration of Ms. [REDACTED] petition for medical parole, and please do not hesitate to contact me with any questions or concerns.

Sincerely,



Sarah Nawab, Esq.

Prisoners’ Legal Services of Massachusetts

cc: Tonya Rutherford
Counsel
DOC Legal Division
70 Franklin Street, Suite 600
Boston, MA 02110
tonya.e.rutherford@state.ma.us

Kara Morello-Quinn
Paralegal Specialist
DOC Legal Division
70 Franklin Street, Suite 600
Boston, MA 02110
kara.morello-quinn@state.ma.us

Mitzi Peterson, LICSW
Deputy Commissioner of Clinical Services & Reentry
DOC Health Services Division
50 Maple Street 3rd. Floor
Milford, MA 01757
mitzi.peterson@doc.state.ma.us

Jeff Fisher
Assistant Deputy Commissioner
DOC Health Services Division
50 Maple Street, 3rd Floor
Milford, MA 01757
jeff.fisher@doc.state.ma.us