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SJC-12725

JOSEPH BUCKMAN & another[1] vs. COMMISSIONER OF CORRECTION & others.[2]

Suffolk. October 4, 2019. - January 28, 2020.

Present: Gants, C.J., Lenk, Gaziano, Lowy, Budd, Cypher, & Kafker, JJ.

Parole. Imprisonment, Parole. Commissioner of Correction. Regulation.

Civil action commenced in the Supreme Judicial Court for the county of Suffolk on February 19, 2019.

The case was reported by Cypher, J.

Ruth Greenberg (John Reinstein also present) for the plaintiffs.

Mary C. Eiro-Bartevyan (Bradley A. Sultan & Richard E. Gordon also present) for the defendants.

Pamela Alford, Assistant District Attorney, for district attorney for the Norfolk district.

The following submitted briefs for amici curiae:

Jeffrey G. Harris for Committee for Public Counsel Services.

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[1] Peter Cruz.

[2] Department of Correction (department); Superintendent, Massachusetts Correctional Institution (MCI), Norfolk; and Superintendent, MCI, Shirley.

Chauncey B. Wood & Donna M. Cuipylo for Massachusetts Association of Criminal Defense Lawyers.

Tatum A. Pritchard for Disability Law Center.

Mary Price, of the District of Columbia, David Milton, & Rebecca Schapiro for Prisoners' Legal Services of Massachusetts & another.

GANTS, C.J. As part of the comprehensive criminal justice reform legislation enacted in 2018, the Legislature established a medical parole program for prisoners in State and county custody who are terminally ill or permanently incapacitated. See G. L. c. 127, § 119A, inserted by St. 2018, c. 69, § 97. In January 2019, counsel for prisoners Joseph Buckman and Peter Cruz filed separate petitions for medical parole on their behalf. Citing Department of Correction (department) policy, the superintendent for each prisoner informed counsel that the petition was incomplete, returned the petition for the resubmission of the required information, and refused to review it as submitted.[3] On February 19, 2019, Buckman and Cruz brought

[3] The superintendent at MCI, Norfolk, informed counsel for Buckman that the petition was incomplete because the medical parole plan that was submitted failed to include "documentation that medical providers qualified to provide the medical services identified in the medical parole plan are prepared to provide such services." The superintendent at MCI, Shirley, informed counsel for Cruz that the petition was incomplete because the medical parole plan that was submitted failed to include "documentation that medical providers qualified to provide the medical services identified in the medical parole plan are prepared to provide such services," and because the petition referenced medical records in the possession of the department but did not include a written diagnosis and prognosis by a licensed medical provider.

an action in the county court, seeking certiorari review of the superintendents' decisions pursuant to G. L. c. 249, § 4, and asserting claims for mandamus, injunctive, and declaratory relief. They argued that, under § 119A, a superintendent is required to accept a written petition for medical parole and make a recommendation within twenty-one days of its receipt, regardless of whether the superintendent believes the petition is incomplete or inadequate.

The single justice reserved and reported the case to the full court, posing three questions concerning the interpretation of the medical parole statute:

> "1. Whether, for purposes of G. L. c. 127, § 119A, a written petition for medical parole of a prisoner must be considered by the superintendent of the facility where the prisoner is incarcerated, regardless of the superintendent's view as to the completeness or adequacy of the petition.
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> "2. Which party bears the burden of preparing or procuring '(i) a medical parole plan; (ii) a written diagnosis by a physician licensed to practice medicine under [G. L. c. 112, § 2]; and (iii) an assessment of the risk [for] violence that the prisoner poses to society.' G. L. c. 127, § 119A.
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> "3. Whether the Commissioner of Correction [(commissioner)], on receipt of the petition and the superintendent's recommendation as to release of the prisoner, must provide notice to the prisoner of the recommendation, as well as a copy of the recommendation and any supporting or related materials."

After the case was reported, the Secretary of the Executive Office of Public Safety and Security (EOPSS) promulgated

administrative regulations pursuant to G. L. c. 127, § 119A (h), that govern the medical parole application process and that replaced the department policy that was in effect at the time the superintendents found the written petitions to be incomplete. We consider the reported questions in light of these regulations.[4,5]

After careful examination of the plain language of the statute, and its legislative history and purpose, we answer the reported questions as follows:

> 1. Under G. L. c. 127, § 119A, a written petition for medical parole of a prisoner must be considered by the superintendent (or sheriff, where the prisoner is in custody in a house of correction) of the facility where the prisoner is incarcerated, regardless of the superintendent's (or sheriff's) view as to the completeness

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[4] The single justice reported this case on April 3, 2019. An emergency version of the Executive Office of Public Safety and Security regulations was in effect from May 1, 2019, until they were formally promulgated on July 26, 2019. The final regulations retained the requirements for a petition for medical parole set forth in the department policy that are challenged here.

[5] Cruz suffered from end stage renal disease as well as other chronic illnesses, and died on September 9, 2019, during the pendency of this appeal. There has been no motion to substitute plaintiffs, nor any request for an executor to continue the case on Cruz's behalf, but Buckman suffices as a plaintiff in this case. Regardless, we exercise our discretion to address the merits of this case where it concerns important legal issues about the application of the medical parole statute that are, due to the terminal illness or debilitating physical condition of potential plaintiffs, likely to be capable of repetition but to evade review. See Pembroke Hosp. v. D.L., 482 Mass. 346, 351 (2019).

or adequacy of the petition.[6]

2. The superintendent (or sheriff) bears the burden of preparing or procuring "(i) a medical parole plan; (ii) a written diagnosis by a physician licensed to practice medicine under [G. L. c. 112, § 2]; and (iii) an assessment of the risk for violence that the prisoner poses to society." G. L. c. 127, § 119A.

3. The commissioner, on receipt of the petition and the superintendent's (or sheriff's) recommendation as to release of the prisoner, is not required to provide the prisoner with the recommendation, but is required to provide the prisoner with all supporting documents submitted by the superintendent (or sheriff) with the recommendation.

To the extent that the regulations promulgated by the Secretary of EOPSS (secretary) conflict with the answers to the reported questions, the regulations are hereby declared void.[7]

Background. 1. The statute. We look first to the language of the statute. Under G. L. c. 127, § 119A, medical release is limited to two narrow categories of

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[6] Although the reported questions do not address the medical parole process for prisoners committed to the custody of a house of correction, we hold that the answers to these questions are the same regardless of whether a prisoner submits a petition to the superintendent of a correctional facility or to a sheriff because the language of the statute establishes essentially the same process regardless of where an individual is incarcerated. Compare G. L. c. 127, § 119A (c), with G. L. c. 127, § 119A (d).

[7] We acknowledge the amicus briefs submitted by the district attorney for the Norfolk district, the Committee for Public Counsel Services, the Massachusetts Association of Criminal Defense Lawyers, Prisoners' Legal Services of Massachusetts and Families Against Mandatory Minimums, and the Disability Law Center.

prisoners: those with "permanent incapacitation," that is, "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"; and those with a "terminal illness," that is, "a condition that appears incurable, as determined by a licensed physician, that will likely cause the death of the prisoner in not more than [eighteen] months and that is so debilitating that the prisoner does not pose a public safety risk." G. L. c. 127, § 119A (a).

Because those eligible for medical parole are so ill, whether physically or cognitively, the statute does not require that a written petition for medical parole be submitted by the prisoner; it may also be submitted on his or her behalf by the prisoner's attorney or next of kin, a medical provider at the correctional facility, or even a member of the department's staff. G. L. c. 127, § 119A (c) (1). If any of these persons submits a written petition, the superintendent (or, where the prisoner is in the custody of a house of correction, the sheriff) "shall consider" the prisoner for medical parole, and "shall review the petition and develop a recommendation as to the release of the prisoner." Id. The superintendent must consider the petition promptly -- the statute provides that the superintendent "shall" transmit the recommendation to the

commissioner "not more than [twenty-one] days after receipt of the petition." Id.

"Whether or not the superintendent recommends in favor of medical parole," the superintendent must transmit four documents to the commissioner with his or her recommendation: (1) the petition itself; (2) "a medical parole plan;" (3) "a written diagnosis by a physician licensed to practice medicine"; and (4) "an assessment of the risk for violence that the prisoner poses to society." Id. "Medical parole plan" is the only one of these four items statutorily defined in § 119A (a). It is

> "a comprehensive written medical and psychosocial care plan specific to a prisoner and including, but not limited to: (i) the proposed course of treatment; (ii) the proposed site for treatment and post-treatment care; (iii) documentation that medical providers qualified to provide the medical services identified in the medical parole plan are prepared to provide such services; and (iv) the financial program in place to cover the cost of the plan for the duration of the medical parole, which shall include eligibility for enrollment in commercial insurance, Medicare or Medicaid or access to other adequate financial resources for the duration of the medical parole."

G. L. c. 127, § 119A (a). Once the commissioner receives the petition and recommendation, he or she is required to notify the interested parties -- the prisoner, the person who petitioned for medical parole (if it was not the prisoner), the district attorney of the jurisdiction where the prisoner's offense occurred, and, if applicable, the victim or the victim's family -- "that the prisoner is being considered for medical parole."

G. L. c. 127, § 119 (c) (2). Any of the parties who receives notice "shall have an opportunity to provide written statements" to the commissioner. Id.[8]

The statute requires the commissioner to issue a written decision, accompanied by a statement of reasons, "not later than [forty-five] days after receipt of a petition." G. L. c. 127, § 119A (e). Under the statute, "[i]f the commissioner determines that a prisoner is terminally ill or permanently incapacitated such that if the prisoner is released the prisoner will live and remain at liberty without violating the law and that the release will not be incompatible with the welfare of society, the prisoner shall be released on medical parole." Id. In essence, in deciding whether to allow medical release, the statute requires the commissioner to make three determinations: (1) is the prisoner "terminally ill" or "permanently incapacitated"? (2) if released, will the prisoner live and remain at liberty "without violating the law"?[9] and (3) is the

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[8] If the prisoner was convicted of and is serving a sentence for murder, the district attorney or victim's family may request a hearing. See G. L. c. 127, § 119A (c) (2).

[9] Where the commissioner determines that the prisoner suffers from "permanent incapacitation" or a "terminal illness," the commissioner has already determined, based on the definition of those statutory terms, that "the prisoner does not pose a public safety risk." G. L. c. 127, § 119 (a). Because we recognize the possibility that a prisoner who does not pose a public safety risk may nonetheless violate the law, we do not

prisoner's release "incompatible with the welfare of society"? Id. If the commissioner determines that the answer to the first two questions is "yes," and the answer to the third is "no," "the prisoner shall be released on medical parole." Id. Once the commissioner determines that the prisoner shall be released, the parole board imposes the terms and conditions for medical parole. G. L. c. 127, § 119A (f).

2. Legislative purpose. Because we consider the language of a statute in the context of the Legislature's purpose in enacting it, we examine the legislative history of the medical parole statute to discern its purpose.

Prior to the enactment of the medical parole statute, Massachusetts was one of only a handful of States without a statutory "compassionate release" or "medical parole" program.[10]

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equate "does not pose a public safety risk" with "will live and remain at liberty without violating the law," but instead note their close interrelationship.

[10] Testimony of Representative Hannah Kane, Joint Committee on the Judiciary, Hearing on Sentencing and Correctional Services (June 19, 2017), https://malegislature.gov/Events/Hearings/Detail/2662 [https://perma.cc/Y72U-J8QB] ("forty-seven out of fifty-two corrections systems in the United States offer some procedure" for medical parole). A June 2018 report by Families Against Mandatory Minimums states that forty-nine States (now including Massachusetts) and the District of Columbia currently provide for compassionate release. See Price, Families Against Mandatory Minimums, Everywhere and Nowhere: Compassionate Release in the States 8 (June 2018), https://famm.org/wp-content/uploads/Exec-Summary-Report.pdf [https://perma.cc/N768-G73R].

The only way a dying prisoner could obtain release was to seek executive clemency from the Governor on the basis of a "terminal illness" or a "severe and chronic debilitating medical condition."[11] See Office of the Governor, Executive Clemency Guidelines § 4.3.3 (Dec. 10, 2015) (guidelines). See also 120 Code Mass. Regs. §§ 900.00 (2017). To petition for commutation of a sentence on the basis of a medical illness, a prisoner had to produce a "a written diagnosis from at least one licensed physician" and "a detailed medical treatment plan setting forth how the petitioner will receive care" upon his or her release. Guidelines, supra at §§ 4.3.3.1, 4.3.3.3. When the medical parole statute was enacted in April 2018, the executive clemency process had proved to be almost invariably an exercise in futility for prisoners; "[s]ince 2000, 769 inmates [had] requested commutations . . . from the [S]tate Parole Board, but only one request [had] been approved by a sitting governor." With Aging Prison Population, Massachusetts Looks to Possible Cost-Saving, Compassionate Fix, Boston Globe, May 20, 2018.

The Massachusetts prison population, however, was growing increasingly older and more costly to incarcerate. The over-all

[11] There are two types of executive clemency -- pardons and commutations. A petition on the basis of medical illness would be a petition for a commutation. See generally Office of the Governor, Executive Clemency Guidelines § 2 (Dec. 10, 2015).

State prison population in Massachusetts dropped from 11,409 in 2011 to 9,207 in 2018, but the number of incarcerated individuals age fifty and over increased by approximately twelve percent during that same time period.[12] In 2015, the proportion of prisoners age fifty-five or older to the total number of prisoners in custody in Massachusetts was the highest in the country.[13] And the population was trending older. In 2016, 24.5 percent of the criminal population was age fifty or older, in 2017 it was 25.8 percent, and in 2018 it was 26.6 percent.[14]

Older inmates both are more susceptible to chronic medical conditions and typically experience the effects of age sooner than individuals outside of prison.[15] As a result of their greater health care needs, older prisoners generally cost more to incarcerate, with the cost of providing health care to older

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[12] Department of Correction, Inmate and Prison Research Statistics, January 1 Snapshot by Age, https://public.tableau.com/profile/madoc#!.

[13] McKillop & Boucher, Pew Charitable Trusts, Aging Prison Populations Drive Up Costs, (Feb. 20, 2018), https://www.pewtrusts.org/en/research-and-analysis/articles/2018/02/20/aging-prison-populations-drive-up-costs [https://perma.cc/V47B-MJEW].

[14] Inmate and Prison Research Statistics, supra.

[15] L.M. Maruschak, M. Berzofsky, & J. Unangst, United States Department of Justice, Bureau of Justice Statistics, Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12, at 2, 5 (rev. Oct. 4, 2016).

prisoners reported as nearly three times the cost for a typical adult prisoner.[16] In 2018, the cost to incarcerate an individual at one of the State's medium security prisons, Massachusetts Correctional Institution, Norfolk, averaged $51,811 per year, while the cost to care for an individual at the Lemuel Shattuck Hospital Correctional Unit averaged $320,037.[17] Older and ill prisoners also need specialized housing. The 2011 Corrections Master Plan developed by the Division of Capital Asset Management found that "[d]ue to an aging incarcerated population," the Commonwealth would need to add beds over the next decade for "sub-acute or long-term patients [who] are typically not suitable to be housed in the general population due to their vulnerability and the disproportionate consumption of staff resources."[18] The report noted that without enough sub-acute beds, "these chronically ill inmates frequently occupy infirmary beds," hampering the ability of the department and

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[16] J. Anno, C. Graham, J.E. Lawrence, & R. Shansky, United States Department of Justice, National Institute of Corrections, Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates, at 30 (2004).

[17] Department of Correction, Research and Planning Division, Prison Population Trends 2018, at 2, 4 (Mar. 2019).

[18] Division of Capital Asset Management, Corrections Master Plan, DOC 0801ST1, Final Report, at 11 (Dec. 2011) (Corrections Master Plan).

sheriffs to provide acute, short-term crisis care to inmates.[19]

It was with these trends in mind -- the aging prison population, the rising cost of health care, and the fact that elderly and infirm prisoners are "considered among the least likely to re-offend when released" -- that "the [L]egislature decided to include language for a medical parole program within An Act relative to criminal justice reform."[20] Although the focus was on cost savings, there was also a human element to the legislation. Speaking on behalf of the Harm Reduction Caucus, Representative Mary S. Keefe, after recognizing the "tremendous economic benefits in terms of money that would be saved," added, "more to the heart, . . . this is . . . the compassionate thing to do."[21] See Representative Claire D. Cronin, co-chair of the Joint Committee on the Judiciary, Floor Speech, Formal Session of House of Representatives, April 4, 2018 (criminal justice reform bill "create[s] a mechanism for compassionate medical release for ill inmates who pose no public safety threat").

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[19] Corrections Master Plan, supra at 11.

[20] Brownsberger, Extraordinary Medical Release in the Criminal Justice Package (June 30, 2018), https://willbrownsberger.com/extraordinary-medical-release [https://perma.cc/K9SJ-MLPW].

[21] Testimony of Representative Mary S. Keefe, Joint Committee on the Judiciary, Hearing on Sentencing and Correctional Services (June 19, 2017), https://malegislature.gov/Events/Hearings/Detail/2662 [https://perma.cc/Y72U-J8QB].

3. The regulations. The medical parole statute requires the secretary to "promulgate rules and regulations necessary for the enforcement and administration of this section." G. L. c. 127, § 119A (h). The final regulations were formally promulgated on July 26, 2019, and are, in relevant part, similar to the earlier department policy that was in effect at the time Buckman's and Cruz's petitions were deemed incomplete.

The regulations, if valid, effectively answer each of the three reported questions. As required by § 119A (c) (1), a superintendent must consider a written medical parole petition upon its receipt, and the petition may be submitted not only by a prisoner or his or her attorney, but also by a prisoner's next of kin, a medical provider of the correctional facility, or a member of the department's staff. 501 Code Mass. Regs. § 17.03(2) (2019). However, the regulations require that the petition be accompanied by four documents: (1) "a medical parole plan developed by the petitioner"; (2) "a written diagnosis accompanied by a signed affidavit on letterhead from a licensed physician or a medical provider identified by the petitioner, if not a medical provider utilized by the [d]epartment"; (3) a release form to permit release of the petition and all supporting documents to other criminal justice agencies and the appropriate district attorney; and (4) a release form to permit the department and parole board to assess

the proposed medical parole plan. 501 Code Mass. Regs. § 17.03(3). If any of these four accompanying documents are not submitted, or if the medical parole plan does not include specific information required by the regulations, then the petition "shall be considered incomplete" and returned to the petitioner for resubmission. 501 Code Mass. Regs. § 17.03(5).

Thus, under the regulations the petitioner bears the burden of preparing or procuring a medical parole plan and a written diagnosis by a licensed physician. Moreover, the regulations introduce the concept of an "incomplete" petition -- treating the medical parole plan and written diagnosis as required elements of a "complete" petition, and mandating that the superintendent return any submission that fails to include these documents or fails to sufficiently fulfill the requirements of a medical parole plan.

With respect to the third reported question, the regulations provide that upon receipt of the petition and recommendation, the commissioner shall notify the interested parties identified in § 119A (c) (2) that the prisoner is being considered for medical parole. See 501 Code Mass. Regs. § 17.07(1). Under the regulations, the prisoner is entitled to receive nothing more than this notice. 501 Code Mass. Regs. § 17.07(3). In contrast, upon request, the relevant district attorney may receive a copy of the medical parole petition, the

medical parole plan, and all supporting documents; the victim, or the victim's family, may receive a copy of the medical parole petition and "the most recent clinical assessment of the prisoner prepared by the [d]epartment's or [s]heriff's medical provider." Id. But according to regulation, none of the interested parties may receive the superintendent's recommendation. Id.

Discussion. 1. Standard of review. Because the regulations, if valid, provide answers to each of the reported questions, we must determine whether the relevant regulations are valid or void. Where, as here, a statute authorizes the secretary of an executive department to "promulgate rules and regulations necessary for the enforcement and administration" of the statute, G. L. c. 127, § 119A (h), and where, as here, the regulations are duly promulgated, they "are presumptively valid," Craft Beer Guild, LLC v. Alcoholic Beverages Control Comm., 481 Mass. 506, 520 (2019), quoting Pepin v. Division of Fisheries & Wildlife, 467 Mass. 210, 221 (2014). But a department or agency does not have the authority to promulgate a regulation for the enforcement or administration of a statute that "is contrary to the plain language of the statute and its underlying purpose." Massachusetts Teachers' Retirement Sys. v. Contributory Retirement Appeal Bd., 466 Mass. 292, 301 (2013), quoting Duarte v. Commissioner of Revenue, 451 Mass. 399, 408

(2008).

In determining whether an administrative agency's regulation is valid, we look first to the language of the statute and, where it speaks clearly on the topic in the regulation, we determine whether the regulation is consistent with or contrary to the statute's plain language. See Craft Beer Guild, LLC, 481 Mass. at 520. Where the statute relevant to the regulation is ambiguous or where there is a gap in the statutory guidance, we determine whether the regulation may "be reconciled with the governing legislation." Id., quoting Taylor v. Housing Appeals Comm., 451 Mass. 149, 154 (2008). In doing so, "we accord 'substantial deference' to the agency charged with interpreting and administering the statute in question, and do not invalidate regulations unless 'their provisions cannot by any reasonable construction be interpreted in harmony with the legislative mandate.'" Craft Beer Guild, LLC, supra, quoting Taylor, supra. "But deference does not suggest abdication; '[a]n incorrect interpretation of a statute . . . is not entitled to deference.'" Craft Beer Guild, LLC, supra at 512, quoting Commerce Ins. Co. v. Commissioner of Ins., 447 Mass. 478, 481 (2006). With these principles in mind, we now answer the reported questions by determining whether the relevant regulations are valid or void.

2. The initiation of the petition process. The first

question asks whether a superintendent may reject a petition for incompleteness, which causes us to confront the underlying question of what exactly is required by statute to initiate the petition process -- i.e., what begins the twenty-one day clock for the superintendent?

Section 119A (c) (1) plainly states that "[t]he superintendent . . . shall consider a prisoner for medical parole upon a written petition," and, "the superintendent shall, not more than [twenty-one] days after receipt of the petition transmit the petition and the recommendation to the commissioner" (emphasis added). It is clear from the language of the statute that the Legislature did not consider the medical parole plan or written diagnosis to be a document that the prisoner was required to submit in order to initiate the petition process. The Legislature clearly refers to the petition as a separate document from the medical parole plan and written diagnosis. If the medical parole plan and written diagnosis were considered part of the petition, then the Legislature would not have needed to require the superintendent to transmit these documents to the commissioner along with the petition. See G. L. c. 127, § 119 (c) (1).

The Legislature certainly could have provided that, upon receipt of the petition, the medical parole plan, and the written diagnosis of a licensed physician, the superintendent

would have twenty-one days to transmit a recommendation; but that is not what the statute provides. "[W]here the language of a statute is plain and unambiguous, it is conclusive as to the legislative intent." Sharris v. Commonwealth, 480 Mass. 586, 594 (2018), quoting Thurdin v. SEI Boston, LLC, 452 Mass. 436, 444 (2008). The receipt of the petition alone triggers the twenty-one day deadline.

It is equally plain that the regulation requiring the medical parole plan and the written diagnosis to be submitted with the petition is inconsistent with the legislative purpose of the statute. In medical parole cases, where a petitioner might be terminally ill, there is a need for an expeditious administrative process -- which the Legislature has determined should not exceed sixty-six days -- so that a prisoner may promptly be released or appeal from the denial of the petition. The preparation of a medical parole plan, as defined in the statute, would be a formidable task for even a young and healthy prisoner, given a prisoner's limited access to the world outside prison. See, e.g., 103 Code Mass. Regs. § 483.10 (2018) (limiting number of preapproved adult visitors prisoner may have, and noting that list of preapproved visitors may only be revised upon request twice per year); 103 Code Mass. Regs. § 482.06(3)(c) (2017) (limiting prisoner's telephone access to fifteen preauthorized telephone numbers, five of which are

reserved for attorneys). For a prisoner whose condition meets the definition of physical incapacitation or terminal illness, the preparation of a medical parole plan would be nearly impossible without substantial assistance from an attorney or relative. But permanently incapacitated and terminally ill prisoners are unlikely to have the financial resources needed to retain an attorney, and not all are fortunate enough to have relatives willing or able to provide such help. Such prisoners, under the regulations, are given one recourse -- if a prisoner provides a written diagnosis and completes the release forms, then he or she "may request assistance through parole staff assigned to the institution" in completing the medical parole plan documents. 501 Code Mass. Regs. § 17.03(3)(d)(2).[22] But the regulations do not require parole staff to provide such assistance, nor do they establish any timeline for doing so.

Therefore, the regulations cannot be reconciled with the speedy process enshrined in the statute. If the medical parole plan and written diagnosis were required to be submitted with the petition to set the twenty-one day deadline in motion, then it might take months for a physically incapacitated or

[22] Even this assistance is limited. The regulations do not permit parole staff to provide the prisoner assistance in obtaining a plan for the "proposed course of medical treatment following any release on medical parole," even though that is a required part of the medical parole plan. 501 Code Mass. Regs. §§ 17.03(3)(d)(2), 17.03(4).

terminally ill prisoner to be able to prepare an adequate medical parole plan and obtain a written diagnosis, if he or she could do so at all before he or she died, frustrating the very purpose of the statute.

The regulation that essentially makes a medical parole plan and written diagnosis required elements of a "complete" petition also gives the superintendent nearly unbridled discretion to delay a petition by determining it to be "incomplete." For prisoners with little time left to live, a superintendent's delay may be the equivalent of a denial. But the statute does not authorize a superintendent to deny a petition; only the commissioner has that authority. See G. L. c. 127, § 119A (e).

Where the statute provides that the superintendent "shall consider a prisoner for medical parole upon a written petition," G. L. c. 127, § 119A (c), and where the petition is separate and distinct from the medical parole plan and the written diagnosis of a licensed physician, we answer the first reported question by declaring that a superintendent must consider a written petition for medical parole regardless of his or her view of the completeness or adequacy of the petition. To be sure, a more complete submission is preferable, but by requiring nothing more than that the petition be "written," the Legislature intended to make the petition process as accessible as possible and to prevent superintendents from refusing to accept petitions based

on form over substance. As long as the petition is written and is unambiguously a petition for medical parole for a particular prisoner, signed by a person authorized to make such a petition, the superintendent must accept and review the petition upon its receipt, and may not return it for incompleteness.[23]

To the extent the secretary's regulations are contrary to the plain language and purpose of the statute, they are hereby declared void. See Noe, Sex Offender Registry Bd. No. 5340 v. Sex Offender Registry Bd., 480 Mass. 195, 210 (2018) (regulations violated enabling statute where in clear conflict with both text and purpose of statute); Spaniol's Case, 466 Mass. 102, 111 (voiding regulations "not in harmony with the legislative mandate"). Specifically, the following regulatory provisions are void in their entirety because they cannot be reconciled with the answer to the first question: 501 Code Mass. Regs. § 17.03(5) (incomplete petitions shall be returned); 501 Code Mass. Regs. § 17.06(5) (same for county correctional

[23] We recognize that a prisoner will need to execute the medical release forms required by the regulations once the petition is received, but these release forms are separate and distinct from the petition itself. Section 119 (c) (1) requires a superintendent to consider a prisoner for medical parole where a written petition has been submitted by a prisoner's next of kin, a medical provider at the correctional facility, or a department staff member. Because none of these persons, in the absence of separate legal authority, could execute a medical release on behalf of the prisoner, the Legislature could not have intended a medical release to be a required element of a "complete" petition.

facility custody); and 501 Code Mass. Regs. § 17.06(8) (incomplete petitions transmitted by sheriff to commissioner shall be returned to petitioner).

3. Which party bears the burden? The second reported question asks which party bears the burden of producing a medical parole plan and procuring a written diagnosis. The answer is in some ways dictated by our analysis supra -- where the petitioner need not submit the medical parole plan or the written diagnosis to begin the process, the Legislature could not have intended that the petitioner bear the burden of preparing or procuring those documents during the twenty-one day time frame the superintendent has to formulate his or her recommendation. Pragmatically, the only way that a superintendent can meet his or her statutory obligation to transmit with the recommendation "(i) a medical parole plan; (ii) a written diagnosis by a physician licensed to practice medicine . . . ; and (iii) an assessment of the risk for violence that the prisoner poses to society," G. L. c. 127, § 119A (c) (1), is to bear the burden of causing them to be prepared or procured.

Moreover, there is no dispute that the statute properly places the burden to make an "assessment of the risk for violence that the prisoner poses to society" on the superintendent. Id. Where the statute plainly gives the

superintendent the responsibility to prepare the risk assessment, it is reasonable to infer that the Legislature also intended the superintendent to prepare or procure the other two documents that are required to be transmitted with the recommendation.

The department contends that placing this burden on the superintendent would be "unworkable" within twenty-one days, and that the Legislature could not have intended to require the superintendent to develop a medical parole plan where he or she might recommend against release. We recognize that preparing a medical parole plan and procuring a written diagnosis within twenty-one days of receipt of a petition places a formidable burden on a superintendent. But the superintendent is in a far better position to meet this burden than a permanently incapacitated or terminally ill prisoner.

While incarcerated, prisoners are entirely dependent on the department for access to health care services. The department's contract health care provider maintains records of all on-site medical care provided to prisoners, as well as records of treatment at outside medical facilities. See 103 DOC § 607.02 (2019) ("The inmate medical record shall include documentation of all inmate visits or contacts with medical, mental health, or dental treatment staff. The inmate medical record shall also contain all reports, records, entries, orders, and written

documentation concerning the inmate's medical, mental health, and dental care"). A prisoner's medical records are considered the property of the department's health services division, and a prisoner must sign a release form to access them. See 103 DOC § 607.05(1), (7).

Apart from possession of the prisoner's medical records, the department also has staff who are dedicated to developing individual reentry plans. Each correctional institution has an institutional reentry committee, which includes medical staff and "a medical/mental health discharge planner" who is required to "schedule appointments with [c]ommunity [p]roviders" and to assist prisoners in signing up for MassHealth. See 103 DOC § 493.03 (institutional reentry committee); 103 DOC § 493.07 (medical, mental health, and substance abuse treatment). The regulations already provide that, once a prisoner submits a medical parole petition, a written diagnosis, and release forms, he or she "may request assistance through parole staff assigned to the institution in completing [portions of the medical parole plan]." 501 Code Mass. Regs. § 17.03(3)(d)(2). It takes no more time to help the superintendent prepare such a plan than it would to help the prisoner to do so. And, to the extent that this obligation may require the allocation of additional reentry resources, the Legislature would have recognized that such a reallocation is well justified economically, given the enormous

cost savings that may accrue to the department from the medical release of permanently incapacitated or terminally ill prisoners.

In effect, by enacting § 119A, the Legislature intended to trigger a collaborative process whereby the health care provider for the institution, reentry staff, and the prisoner (or his or her attorney or next of kin) work together to prepare a medical parole plan for the prisoner and obtain a written diagnosis by a licensed physician. The prisoner, to the extent that he or she is able, has every incentive to cooperate, because he or she needs a medical parole plan and written diagnosis that will convince the superintendent to recommend medical parole and the commissioner to approve it. But the superintendent ultimately bears the burden of producing or procuring these documents arising from the collaborative process. To require the petitioner -- often the prisoner -- to formulate a medical parole plan and obtain a written diagnosis from a licensed physician would place that formidable burden on someone who claims to be permanently incapacitated or terminally ill, and who may suffer from dementia, mental illness, or cognitive limitations. We infer that the Legislature did not intend to place this burden on those so poorly able to bear it. Therefore, in answer to the second reported question, we conclude that the superintendent bears the burden of preparing

or procuring a medical parole plan, a written diagnosis by a licensed physician, and an assessment of the prisoner's risk of violence.[24]

To the extent that the secretary's regulations conflict with this answer, they are hereby declared void. Specifically, the following regulatory provisions are void in their entirety because they cannot be reconciled with the answer to the second question: 501 Code Mass. Regs. § 17.03(3) (petition to be accompanied by medical parole plan and written diagnosis developed by petitioner); 501 Code Mass. Regs. § 17.06(3) (same for county correctional facility custody); 501 Code Mass. Regs. § 17.03(4) (medical parole plan to be developed by petitioner); and 501 Code Mass. Regs. § 17.06(4) (same for county correctional facility custody). The following regulations are void in part to the extent that they declare that the medical parole plan or written diagnosis by a licensed physician must be provided by the petitioner: 501 Code Mass. Regs. § 17.02

[24] Because we hold that the superintendent, rather than the petitioner, bears the burden of producing a medical parole plan and procuring a written diagnosis from a licensed physician, we need not decide whether the regulations that impose this burden on a prisoner who claims to be terminally ill or physically incapacitated are in violation of the Americans with Disabilities Act, 42 U.S.C. §§ 12101 et seq. (ADA), or art. 114 of the Amendments to the Massachusetts Constitution. See Crowell v. Massachusetts Parole Bd., 477 Mass. 106, 112 (2017) (ADA requires parole board to make reasonable accommodations for prisoners with disabilities to give them access to benefits of State program).

(definition of multidisciplinary review team); 501 Code Mass. Regs. § 17.04 (review conducted by multidisciplinary review team); and 501 Code Mass. Regs. § 17.09 (review by parole board).

4. Documents required to be provided to the prisoner. The third reported question asks whether the commissioner, upon receiving the recommendation of the superintendent, must provide the prisoner with a copy of the recommendation and of any supporting materials. As noted, § 119A (c) (2) does not require the commissioner to provide the interested parties with anything other than notice that the prisoner is being considered for medical parole release. The regulations expressly prohibit any interested party from receiving the superintendent's recommendation before the commissioner makes a final decision. 501 Code Mass. Regs. § 17.07(3).[25] Buckman argues that his statutory entitlement under § 119A (c) (2) of "an opportunity to submit written statements" to the commissioner will be "meaningless" if he does not receive a copy of the

[25] A prisoner would obtain a copy of the recommendation if his or her petition for medical release were denied and the prisoner petitioned for relief under G. L. c. 249, § 4 (civil action in nature of certiorari). Under the department's regulations, where such an action is brought, a prisoner may request, and receive within fifteen business days, the entire administrative record in the case, which would include the superintendent's recommendation. See 501 Code Mass. Regs. § 17.14.

recommendation. We recognize that, without knowing whether the recommendation favors or opposes release, and without receiving a copy, a prisoner cannot effectively support or confront the superintendent's recommendation. However, the recommendation is just that -- a recommendation. The ultimate decision belongs solely to the commissioner, who renders a decision de novo and need give no deference to the recommendation of the superintendent. Where the Legislature clearly understood that the commissioner would receive a recommendation from the superintendent, but required the commissioner to do nothing more than provide notice, we conclude that the department's regulations protecting the recommendation from disclosure are not so inconsistent with the plain language or purpose of the statute as to warrant a finding of invalidity. See Taylor, 451 Mass. at 154 (deferring to agency's interpretation of statute unless regulations cannot be harmonized with agency's legislative mandate).[26]

[26] We recognize that the Committee for Public Counsel Services in its amicus brief contends that G. L. c. 127, § 119A, creates a constitutional liberty interest by mandating medical parole under the circumstances set forth in the statute, and that prisoners who are physically incapacitated or terminally ill are therefore entitled to due process protections. The prisoners, in their complaint, alleged that their right to procedural due process would be violated if the commissioner made a final determination of their petition for medical parole "without providing reasonable notice of the information on which that decision is based." But the prisoners did not brief

The documents accompanying the recommendation, however, require separate analysis. The regulations provide that, upon request, the relevant district attorney may obtain all "supporting documents" furnished to the commissioner, apart from the recommendation itself. See 501 Code Mass. Regs. § 17.07(3). The regulations are silent regarding the access of the prisoner to such "supporting documents." To be fair, when the regulations were promulgated, the department assumed that the medical parole plan and the written diagnosis would be furnished by the prisoner, and therefore reasonably would have understood that the prisoner already had a copy of these documents. However, that understanding cannot survive this opinion. Having concluded that the Legislature intended that the superintendent bear the burden of preparing or procuring the prisoner's medical parole plan and written diagnosis, we also conclude that the Legislature intended that the prisoner receive a copy of these documents.

As to other supporting documents, where a district

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whether, as a matter of constitutional due process, they are entitled to notice of the superintendent's recommendation regarding release on medical parole. Therefore, we do not address whether the prisoners are entitled as a matter of constitutional law to notice of the superintendent's recommendation. See Craft Beer Guild, LLC, 481 Mass. at 510 n.5, citing First Nat'l Bank of Boston v. Haufler, 377 Mass. 209, 211 (1979) (declining to review issue "not briefed and argued before us").

attorney, upon request, can obtain all supporting documents, including the assessment of the prisoner's risk for violence, it would be fundamentally unfair, and therefore arbitrary and capricious, for the department's regulation to deprive the prisoner of access to those same documents upon request. We can find no justifiable basis for a regulation that would allow a district attorney, having seen the risk assessment, to submit a written statement to the commissioner arguing that the risk assessment underestimates the prisoner's current risk for violence, but would deprive the prisoner, who would not have seen the risk assessment, of the opportunity to argue that the risk assessment overstates his or her current risk for violence. See Salisbury Nursing & Rehabilitation Ctr., Inc. v. Division of Admin. Law Appeals, 448 Mass. 365, 374 (2007), quoting Purity Supreme, Inc. v. Attorney Gen., 380 Mass. 762, 776 (1980) (regulation is arbitrary or capricious where there is "absence of any conceivable ground upon which" it may be upheld).

The prisoner does not require a copy of the recommendation to be able to marshal his or her facts in support of the petition for medical parole, but he or she does need a copy of the supporting documents in order to examine and, if necessary correct, the accuracy of the information in those documents. The unfairness of depriving the prisoner of access to these supporting documents is magnified by the regulation that

provides, "No subsequent petitions may be submitted following the [c]ommissioner's denial of medical parole, unless the prisoner experiences a significant and material decline in medical condition." 501 Code Mass. Regs. § 17.14(4). This limitation on a prisoner's ability to submit subsequent petitions, the legality of which we do not address in this opinion, rests on the premise that the commissioner's denial was based on fair and accurate information regarding the physical or mental condition of the prisoner and the risk, if any, posed by his or her release. Unless the prisoner has a meaningful opportunity to challenge the fairness or accuracy of that information in his or her written statement to the commissioner, there can be little confidence in that premise. A regulation granting the district attorney access to all supporting documents but denying that same access to the prisoner is fundamentally unfair and cannot be harmonized with the agency's legislative mandate.

Conclusion. We answer the reported questions as follows:

1. Under G. L. c. 127, § 119A, a written petition for medical parole of a prisoner must be considered by the superintendent (or sheriff, where the prisoner is in custody in a house of correction) of the facility where the prisoner is incarcerated, regardless of the superintendent's (or sheriff's) view as to the completeness or adequacy of the petition.

2. The superintendent (or sheriff) bears the burden of preparing or procuring "(i) a medical parole plan; (ii) a written diagnosis by a physician licensed to practice

> medicine under [G. L. c. 112, § 2]; and (iii) an assessment of the risk for violence that the prisoner poses to society." G. L. c. 127, § 119A.
>
> 3. The commissioner, on receipt of the petition and the superintendent's (or sheriff's) recommendation as to release of the prisoner, is not required to provide the prisoner with the recommendation, but is required to provide the prisoner with all supporting documents submitted by the superintendent (or sheriff) with the recommendation.

To the extent that the regulations promulgated by the secretary conflict with the answers to the reported questions, they are hereby declared void. Specifically, the following regulatory provisions are void in their entirety because they cannot be reconciled with the answers to the reported questions: 501 Code Mass. Regs. § 17.03(5) (incomplete petitions shall be returned); 501 Code Mass. Regs. § 17.06(5) (same for county correctional facility custody); 501 Code Mass. Regs. § 17.06(8) (incomplete petitions transmitted by sheriff to commissioner shall be returned to petitioner); 501 Code Mass. Regs. § 17.03(3) (petition to be accompanied by medical parole plan and written diagnosis developed by petitioner); 501 Code Mass. Regs. § 17.06(3) (same for county correctional facility custody); 501 Code Mass. Regs. § 17.03(4) (medical parole plan to be developed by petitioner); and 501 Code Mass. Regs. § 17.06(4) (same for county correctional facility custody). The following regulations are void in part to the extent that they require the medical parole plan or written diagnosis by a

licensed physician to be provided by the petitioner: 501 Code Mass. Regs. § 17.02 (definition of multidisciplinary review team); 501 Code Mass. Regs. § 17.04 (review conducted by multidisciplinary review team); and 501 Code Mass. Regs. § 17.09 (review by parole board).

So ordered.