

# Two charged in Massachusetts nursing home catastrophe that left 76 veterans dead from COVID-19

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The Massachusetts state attorney general announced last month that two former leaders of a Holyoke veterans home are currently under indictment on charges of criminal neglect in relation to a coronavirus outbreak that led to 76 resident fatalities and more than a hundred positive COVID-19 cases. These deaths at the Holyoke Soldiers' Home facility and the indictments handed down exemplify the stark failure of the US health care system in containing the spread of the disease in nursing facilities across the nation.

Both indictments represent the first criminal case in the country brought against caretakers involved in nursing homes during the COVID-19 pandemic. According to Massachusetts Attorney General Maura Healey, the two individuals, Bennett Walsh and Dr. David Clinton, are facing felony charges and if convicted could face several years or even decades in prison. "We allege that the actions of these defendants during the COVID-19 outbreak at the facility put veterans at higher risk of infection and death and warrant criminal charges," Healey said at a press conference.

Just a day after the investigative report into the deaths was released, Clinton resigned from his post as chief medical officer of the facility, while Walsh had been placed on administrative leave on March 30 and was later fired after the state sent in an emergency response team to oversee the conditions within the resident home.

Soldiers' Home experienced a staggering spike in COVID-19 infections and deaths during the month of April when the pandemic was raging out of control throughout the Northeast US. By April 22, Soldiers' Home had reported 56 deaths caused by the novel coronavirus and 92 residents testing positive. At least 81 confirmed infections among hospital staff had been reported by mid-April, making it the most extraordinary

outbreak of any veteran's facility in the country.

Even before cases began piling up throughout the course of the month, the state-run facility had been placed under investigation in early April when the attorney general's office said it had received a notice of "serious issues with COVID-19 infection control procedures." While mass casualties rose at alarming rates, numerous nurses pointed to the unpreparedness and blatant disregard for safety precautions by hospital administrators as the cause of the spread of disease. Nurses revealed to the media that they were given little to no personal protective equipment and nothing was done to address dangerous staffing shortages.

As the WSWWS noted on the reckless and criminal neglect that prevailed among the hospital administration in the month of April, we wrote: "All evidence points to an attempt by management to hide the outbreak from local authorities, who were only alerted by staff themselves after finding no remediation with their superiors." Walsh had been the superintendent of the facility at the time and Dr. Clinton was its medical advisor.

Members of the Holyoke Board of Health became aware of the outbreak and deaths when a worker made contact on March 27 with Brenda Rodrigues, president of the local branch of the Service Employees International Union (SEIU). Rodrigues described the staff member as "basically in tears" as she related how there had been 11 deaths and that management was acting with reckless indifference.

However, an examination of the timeline of the deadly outbreak in Holyoke shows that it was only when public exposure of the situation by local officials forced their hand that the state offered to investigate the deaths at the Soldiers' Home. While Walsh and Clinton are clearly implicated in the horrific situation that transpired, they were in general compliance with state oversight of

nursing homes.

The indictment levied against the two former officials included charges specifically relating to hospital staff who “wantonly or recklessly” permitted or caused bodily injury and abuse, neglect or mistreatment of an older or disabled person. State investigators paid particular attention to a series of events in late March. Staff members were instructed to combine two dementia wards containing residents that had been infected with the virus with healthy residents. The attorney general’s office said this action increased “the exposure of asymptomatic veterans to the virus.”

Facility administrators decided to consolidate the units because of severe staffing shortages. Healy alleged that Walsh and Clinton were responsible for combining 42 veterans into a single unit that usually accommodates 25 beds. Residents believed to be asymptomatic were placed with nine beds in a single dining room, with only a few feet separating them from each other, according to the office. One employee told investigators that the decision to merge the wards was “the most insane thing I ever saw in my entire life.” Six or seven veterans were also placed in a room meant to only hold four people.

Despite such close proximity of residents, the administrators refused to implement effective quarantine and isolation measures. Residents in the consolidated unit were allegedly allowed to speak to one another, regardless of their COVID-19 status. This reckless decision, concluded the attorney general’s office, demonstrated unsafe infection control procedures and placed dozens of asymptomatic veterans at “an increased risk” of contracting the COVID-19 virus.

The true extent of the disastrous state of the facility’s COVID-19 policies was revealed in a scathing 174-page report released at the end of an Independent Investigation conducted at the direction of Massachusetts Governor Charlie Baker, a Republican. One quoted employee at the facility described the procedures staff had to perform in the most harrowing terms, comparing the resident home to a “concentration camp” where staff members were instructed with moving “unknowing veterans off to die.”

The attorney general’s report outlining the indictment is the second of four investigations into the failures of the facility. This summer, an investigation by a federal prosecutor found that the facility’s leadership team made substantial errors in responding to the outbreak. Healy has confirmed that her office is actively investigating several other facilities that have experienced extraordinary levels of coronavirus-related deaths. Over 6,000 probable or

confirmed deaths have been reported in long-term care facilities in Massachusetts. This is approximately two-thirds of the state’s total reported death count.

Holyoke Soldiers’ is far from an exceptional case but is one of the more grotesque examples of the malign neglect that has characterized the attitude of the government and ruling class toward the lives of the most vulnerable sections of the population. Throughout the pandemic, nursing homes have suffered immensely, housing populations have been proven to be high-risk for the coronavirus. In the United States, an estimated 40 percent of coronavirus cases have been linked to them. At least 77,000 residents and workers have died from the virus in nursing homes and long-term care facilities for adults, more than 35 percent of total deaths nationwide.

Similar patterns of reckless negligence have occurred in several veteran’s homes across the country. At Menlo Park Veterans Memorial Home, a nursing facility in Edison, New Jersey, officials failed to attribute nearly 40 percent of its likely COVID-19 deaths to the virus, according to the New Jersey Department of Health. The department found that 39 residents likely died from the virus in addition to the 62 deaths officially counted.

A New Jersey DHS spokeswoman told media earlier this week that another state-run veteran home in Paramus, New Jersey also had more COVID-19 deaths than the total attributed to the virus. According to New Jersey’s veteran’s agency records, nearly 100 people died at the Menlo facility in April alone, which is about as many as the facility typically loses in a year.



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