



**REPORT ON
DR. FRANCESCO
LUPIS
STAFF PHYSICIAN
CONNECTICUT
DEPARTMENT OF
CORRECTION**

Office of the
Correction Ombuds

Executive Summary

The Office of the Correction Ombuds initiated this investigation after receiving multiple complaints involving Dr. Lupis dating back to November 2025. As part of the investigation, the Office reviewed six numbered Security Division investigations involving Dr. Lupis, corresponding facility incident reports, professional licensing and credentialing records, and 27 federal lawsuits naming him as a defendant. The records describe recurring concerns about his professional conduct, medical-record documentation, performance of clinical responsibilities, and treatment of persons in DOC custody.

The Security Division investigations addressed confrontations with patients, inability to reach Dr. Lupis during on-call coverage, derogatory statements about coworkers, inaccurate documentation in a patient's medical record, an arrest involving alleged threats with an axe, and unprofessional telephone communications during a medical emergency. Several investigations resulted in substantiated employee-conduct findings. Other matters were closed without discipline or classified as unsubstantiated, although portions of the underlying records raise questions about how witness accounts and other evidence were evaluated.

The concerns were not confined to patient complaints. Nurses, physicians, advanced practice providers, and supervisors reported offensive communications, disparaging treatment of colleagues, resistance to assigned responsibilities, and conduct that interfered with clinical operations. DOC responded at various points with counseling, supervisory direction, a written reprimand, and repeated distribution of Administrative Directive 2.17. Reports of similar concerns continued.

Complaints received by the Ombuds Office extend into September 2026. They include allegations of discontinuing longstanding medications, inadequate consideration of medical history and specialist recommendations, delayed treatment of a serious knee injury, and retaliation for filing grievances. Their continuation after earlier corrective measures raises a substantial question about whether DOC's response adequately protected patients.

The litigation review identified 27 distinct federal actions naming Dr. Lupis as a defendant. Representative allegations concern delayed specialist care, medication management, pain, and medical accommodations. The confirmed Dixon settlement of \$50,000 and identified court-reporting expenses of \$6,878.14 account for a documented subtotal of \$56,878.14. This amount does not capture the full cost of defending the actions. Neither the filing of a lawsuit nor payment of a settlement establishes liability.

The credentialing review presents additional concerns. Dr. Lupis is employed as a Staff Physician and is not currently board certified. DOC did not supply documentation demonstrating successful completion of the alternative agency competency program described in the supplied job specification. A credentialing roster also records no disciplinary action despite a documented Connecticut licensing reprimand.

The central concern is DOC's response to a recurring body of information from its own investigators, clinical staff, patients, licensing authorities, and litigation records. The documented administrative findings, unresolved clinical concerns, and credentialing discrepancies warrant immediate protective action.

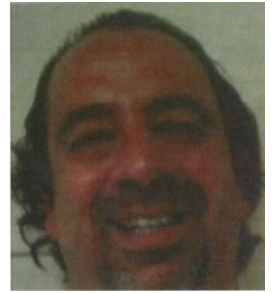
The Office recommends that Dr. Lupis be placed on immediate administrative leave and barred from patient contact pending further independent investigation.

Introduction

Pursuant to Connecticut General Statutes § 18-81qq, the Office of the Correction Ombuds is authorized to investigate complaints concerning the Department of Correction, inspect and monitor correctional operations, review practices affecting persons in custody, and recommend corrective action.

This investigation concerns Dr. Francesco Lupis's treatment of incarcerated persons, workplace conduct, professional qualifications, disciplinary history, and the Department's response to recurring concerns.

The Office reviewed Security Division investigations, facility incident reports, disciplinary correspondence, credentialing materials, professional licensing records, federal court records, and a compiled list of settlements and expenses associated with DOC from 2020 through 2024. The Office also reviewed complaints submitted by incarcerated persons and their family members or representatives.



Dr. Francesco Lupis
Staff Physician

Background

The Office received complaints concerning medical care and provider conduct at Cybulski Correctional Institution from November 2025 through September 2026. The following chronology describes those complaints and the Office's January 2026 facility visit. The complaint allegations have not been independently established by this Office.

November 24, 2025: Knee Injury, Delayed Treatment, and Alleged Retaliation

A representative of an incarcerated person reported that he continued to experience a serious knee injury without a clear treatment plan despite using the grievance process.

The correspondent reported tears involving the ACL, MCL, and meniscus, dependence on crutches, and concerns about blood flow to his foot. She alleged that surgery had been needed since June but had not been scheduled and that there were no scheduled hospital visits or physical therapy.

She further alleged that Dr. Lupis retaliated against the patient and other incarcerated persons with injuries or disabilities who filed grievances about medical care. She requested an investigation into his conduct.

January 21, 2026: Office Visit to Cybulski

The Office visited Cybulski and was informed by the Warden that Dr. Lupis would be escorted from the facility that day. The Office subsequently requested records concerning his conduct and disciplinary history.

June 2026: Reported Return to Clinical Practice

The Office received a complaint reporting that Dr. Lupis had returned to clinical practice at Cybulski. The complainant alleged that Dr. Lupis entered the medical unit stating, "I'm back mother-fuckers."

The complainant also described the discontinuation of longstanding medications and alleged that Dr. Lupis stated, "there is no fucking reason for this medication." When the complainant challenged the change, Dr. Lupis allegedly responded, "I've got MD after my name and you're wearing tans, so I will run circles around you and win every time."

June 23, 2026: Longstanding Medications and Provider Conduct

An incarcerated person reported that Dr. Lupis had discontinued or intended to discontinue longstanding medications, including Gabapentin and Zofran, despite their reported effectiveness in managing chronic pain, nausea, and other conditions following serious injuries.

The complainant described Dr. Lupis as dismissive, argumentative, and unwilling to consider his medical history. He requested review of his treatment, renewal of necessary medications, and intervention concerning the provider's conduct.

July 20, 2026: Scalp Sores or Lesions

An incarcerated person reported persistent sores or lesions on his scalp that had been present while he was housed at Osborn.

He stated that a physician at Cybulski examined the condition and told him that nothing could be done. He reported that a previously prescribed lotion had been effective and alleged that medical staff had failed to address the ongoing condition.

September 4, 2026: Diabetes Medication and Specialist Coordination

An incarcerated person reported that he had received Ozempic since 2022 and had been treated by a diabetes specialist for nearly four years.

He alleged that Dr. Lupis reduced his dosage from 2 mg to 1 mg without adequately discussing the change with him or his specialist. He reported subsequent weight gain and an increase in his A1C and alleged that Dr. Lupis declined his request to restore the prior dosage.

Security Division Investigations

SD-22-102: March 9, 2022, Incident at MacDougall-Walker Correctional Institution

This investigation concerned an exchange between Dr. Lupis and an incarcerated person regarding medication. DOC classified the misconduct allegation as unsubstantiated, citing the absence of audio footage or corroborating witnesses.

A Warden and Deputy Warden identified concerns about Dr. Lupis's conduct before a code was called. The administrative summary described surveillance footage showing Dr. Lupis pointing an outstretched finger toward the incarcerated person's face and potentially escalating the encounter. The video review also did not support Dr. Lupis's account that the incarcerated person entered his office.

An RN described Dr. Lupis as angry and "a little over the top," adding, "I thought he was just overacting a bit."

A CHN stated that Dr. Lupis could have spoken calmly and reported that he instead yelled. She recalled that he may have told the person to "get the fuck out of his office." She further stated, "Honestly, every time I've seen him with inmates, he's never really professional. He yells at'm a lot."

SD-22-291: September 25, 2022, On-Call Coverage

Security Division investigated reports that Dr. Lupis could not be reached while serving as the designated on-call physician, including during an emergency at York Correctional Institution. The investigation also concerned attempted contact from MacDougall-Walker.

Dr. Lupis acknowledged volunteering for on-call assignments but stated that he was unaware of an official policy defining the responsibilities.

The investigation identified the absence of an official policy and a contingency plan for obtaining another provider when the designated physician could not be reached.

SD-22-289 and SD-23-085: Workplace Conduct and Electronic Health-Record Documentation

These investigations concerned a provider-meeting presentation, interactions with coworkers, and documentation in an incarcerated person's electronic health record.

At a September 28, 2022, provider meeting at the Maloney Training Center, Dr. Lupis used coworkers' names alongside fictitious diagnoses and derogatory descriptions.

An APRN described feeling violated and bullied by the use of her name and an offensive diagnosis in front of colleagues without her consent. Multiple attendees corroborated concerns about the presentation.

A Regional Medical Director confirmed that Dr. Lupis described the APRN as "Extremely Psychotic and oh yeah big and fat." Dr. Wright also reported previous disparaging remarks made by Dr. Lupis about two APRNs with whom he worked to other colleagues, supervisors, and incarcerated persons.

Another doctor described progressively harsher comments directed at the APRNs and visible discomfort among attendees. Another Principal Physician characterized some of the language as "unprofessional, offensive and unjustifiable." Another PA who was present described the comments as "unprofessional, unkind, and disrespectful."

The DOC Security Division substantiated a violation of Administrative Directive 2.17, Employee Conduct, concerning the use of coworkers' names with fictitious diagnoses without permission.

In a separate investigation regarding conduct on October 6, 2022, Dr. Lupis recorded that he had filed a complaint against a nurse but acknowledged during his interview that he had not filed it. Security Division characterized the entry as falsified information and substantiated his failure to follow directions governing appropriate documentation.

A written reprimand dated June 7, 2024, addressed both matters and warned that subsequent conduct of this nature could result in more severe discipline.

SD-22-297: November 5, 2022, Arrest

Security Division investigated Dr. Lupis's arrest by the Avon Police Department for disorderly conduct and threatening in the second degree following an incident at his home.

The investigative report states that Dr. Lupis admitted becoming angry, yelling and cursing at his son, retrieving an axe, and threatening him. Dr. Lupis stated that he did not intend to injure his son or break down the bedroom door. The police account and witness statements described circumstances in which his son feared for his safety and called police.

Security Division concluded that Dr. Lupis violated Administrative Directive 2.17, including provisions concerning compliance with law and unprofessional or illegal off-duty conduct that could reflect negatively on DOC.

The investigation was authorized on November 16, 2022. The investigator's report was dated January 4, 2023. Dr. Lupis received formal counseling on February 14, 2023.

SD-23-324: May 1, 2023, Communication with a UConn Operator

This investigation concerned an allegation that Dr. Lupis used profanity and derogatory language during a telephone call with a UConn communications operator regarding an emergency at York.

Dr. Lupis acknowledged saying “fucking idiots” but stated that the comment was directed to his wife after the conversation had ended.

The investigator determined that the telephone connection remained active and concluded that Dr. Lupis violated Administrative Directive 2.17 by failing to communicate professionally and respectfully.

Labor Relations subsequently determined that it could not establish that the comment was directed to the operator. No discipline was imposed.

Facility Incident Reports

WCCI-2025-02-010: Wedge-Pillow Incident

The February 2025 incident package concerns an outburst over missing wedge pillows.

A report completed by a DOC staff member described Dr. Lupis as loud and unprofessional and attributed the statement “I am going to kill someone” to him. Staff reportedly entered the pharmacy and closed the door.

A subsequent review concluded that the available evidence suggested the parties had resolved a possible misunderstanding. As a result, Dr. Lupis received another copy of Administrative Directive 2.17.

WCCI-2025-07-029: Clinical Responsibilities and Professional Conduct

On July 28, a nurse reported that Dr. Lupis said he would not perform off-site-service functions. The nurse also reported overhearing him state, “So you know what, if they want me to do all of this, I’m not seeing any patients, I’m not doing OSS.”

Other records described objections to consult review, order entry, referrals, and participation in the Vivitrol pilot program.

A Regional Chief Operating Officer documented concerns that Dr. Lupis was rude to nursing staff, spent substantial time on Quality of Work Life activities instead of seeing patients, and communicated clinical matters through custody staff rather than appropriate clinical channels.

An August 15 email referenced numerous occasions involving inappropriate language and offensive or disrespectful communications and warned of further corrective action.

The package also described concerns about a patient with sickle cell disease in June 2025. Staff reported that Dr. Lupis changed the patient’s opioid regimen after transfer to Cybulski. The patient subsequently presented repeatedly with severe pain and was transferred to a hospital, where the patient reportedly received treatment for a sickle cell crisis, including pain management and a blood transfusion.

When informed of the hospitalization, Dr. Lupis reportedly responded with profanity and stated that the patient did not belong at Cybulski.

The facility review completed in September 2025 again addressed Administrative Directive 2.17.

Professional Licensing and Regulatory History

Massachusetts

On September 25, 2013, the Massachusetts Board of Registration in Medicine issued an Order of Final Denial of Dr. Lupis's application for a full medical license, finding that he "failed to demonstrate satisfactory proof of good moral character for licensure."

The Board identified three grounds:

"1. Dr. Lupis' performance at State University of New York/Stony Brook University Hospital where he was placed on probation during his postgraduate training for his failure to demonstrate ethical/moral behavior; to be reliable, conscientious, responsible and honest; to react to stressful situations appropriately; to respect the dignity of patients and colleagues; and to keep records completely and accurately. Dr. Lupis was terminated without having successfully completed the terms of his probation;

"2. Dr. Lupis' performance at Flower Hospital in Sylvania, Ohio where he completed postgraduate training and during which time concerns were raised by various attending physicians with regard to Dr. Lupis' reoccurring pattern of unprofessional behavior, including outbursts and verbal hostility towards members of the health care team; patient care issues; and interpersonal issues; and

"3. Dr. Lupis' pattern of being unprofessional in his dealings with Board staff and the Licensing Committee, a committee of the Board."

Connecticut

In a consent order, Dr. Lupis admitted that he failed to diagnose a severed extensor tendon while treating a hand laceration at Westport Urgent Care on December 8, 2014.

His license was reprimanded and placed on probation pending successful completion of approved coursework in hand-trauma management.

DPH subsequently confirmed that he satisfied the consent-order requirements effective October 1, 2016.

Rhode Island

Rhode Island's consent proceeding arose from the same Connecticut hand-injury incident.

The order imposed a reprimand and a \$650 administrative fee and acknowledged satisfactory completion of the required continuing medical education in the original jurisdiction.

This was an additional regulatory action arising from the Connecticut matter, not an additional established patient-care incident.

Michigan

On May 16, 2018, the Michigan Board of Medicine's Disciplinary Subcommittee signed a consent order suspending Dr. Lupis's medical license for a minimum of one day, effective June 15, 2018, with reinstatement subject to specified conditions.

Its administrative complaint referenced the Massachusetts denial, Connecticut disciplinary action, and failure to report adverse licensing action within the required period.

Maryland

The Maryland Board of Physicians imposed a reprimand and probation with terms and conditions on November 22, 2016. The action was reciprocal discipline arising from the Connecticut Board's action. Maryland subsequently terminated the probation on December 19, 2017.

Maine

The Maine Board of Licensure in Medicine entered into a consent agreement accepting Dr. Lupis's voluntary surrender of his medical license on May 9, 2017.

The Board identified his failure to disclose pending allegations before the Connecticut Department of Public Health and Connecticut Medical Examining Board on his license-renewal application as the basis for the action. The outcome was voluntary surrender of his Maine license.

Florida

A June 30, 2017 consent decree permitted Dr. Lupis to voluntarily relinquish his medical license. The agreement also provided that he "agrees never again to apply for licensure as a physician in the State of Florida."

Pennsylvania

On September 19, 2017, Pennsylvania issued Dr. Lupis a public reprimand and placed his medical license on indefinite probation based on disciplinary action taken by another state.

Staff Physician Qualifications and Credentialing

DOC Human Resources confirmed on October 1, 2026, that Dr. Lupis is employed as a Staff Physician.

Human Resources explained that Staff Physicians should have completed residency training and are considered board eligible, while Principal Physicians have completed residency training and passed their boards.

The supplied Department of Administrative Services specification for Staff Physician, class 4660RS, states:

"Incumbents in this class must obtain certification as a specialist in internal medicine within five years of appointment to this class OR demonstrate continued competency and proficiency in the practice of medicine by successfully completing an established agency program."

The Office's inquiry to the American Board of Family Medicine established that Dr. Lupis's certification lapsed in June 2017 and had not been reinstated.

DOC's credentialing flowsheet identifies him as not certified. Its May 31, 2024, roster likewise records "No" for board certification.

DOC has not supplied documentation demonstrating successful completion of an established agency competency program as an alternative means of satisfying the applicable requirement.

On October 1, 2026, the Office expressly asked whether Dr. Lupis had successfully completed such a program. The correspondence reviewed contains no answer.

The credentialing materials contain a separate discrepancy. The May 31, 2024, roster records "No" under disciplinary action despite the documented Connecticut reprimand.

Litigation and Associated Expenditures

A docket report generated from a search of United States District Court for the District of Connecticut records identified 27 distinct federal actions filed from 2020 through 2026 in which Dr. Lupis was named as a defendant.

The following examples are representative of allegations concerning his care of incarcerated persons during his employment with DOC. They are allegations reported in court materials, not findings of liability by this Office.

Dixon v. Lupis, No. 3:20-cv-01754

The plaintiff alleged that defendants “ignored his complaints of pain and immobility” and failed to arrange timely treatment for an Achilles-tendon injury.

The allegations concerned specialist evaluation and treatment, continuing pain, and limitations in mobility. The court permitted identified deliberate-indifference claims to proceed for further development of the record.

The action settled for \$50,000 in August 2024.

Daniels v. Lupis, No. 3:21-cv-00899

The plaintiff alleged delayed access to podiatry for a diabetic foot condition, inaccurate communications about whether a referral had been submitted, and deficiencies in postoperative care and accommodations.

The complaint quoted a September 23, 2020, nursing response stating, “There is no request submitted for Podiatry.”

The plaintiff alleged that the referral was not submitted until October 9, 2020, and that he was not seen by the specialist until February 19, 2021.

Cunningham v. Lupis, No. 3:21-cv-00273

The plaintiff challenged the discontinuation of testosterone therapy and alleged that Dr. Lupis disregarded specialist recommendations.

Statements attributed to Dr. Lupis included, “I’m not sending you for a specialist, you’ll just have to get used to it,” and “if we don’t know about it, we don’t have to treat it.”

Brockett v. Lupis, No. 3:21-cv-00355

The plaintiff alleged that his medication dosage was reduced after an appointment dispute.

He also alleged that Dr. Lupis declined to renew a bottom-bunk pass without examining him, stating that he looked healthy and did not need the accommodation.

Burgess v. Barone, No. 3:23-cv-00967

The plaintiff alleged failures to provide medication and treatment for “daily bleeding and severe pain in his anus and stomach,” as well as failure to provide surgery and therapy that he understood had been scheduled.

Documented Litigation Expenses

A compiled list of settlements and expenses associated with DOC from 2020 through 2024 and the expense workbook document expenditures associated with cases naming Dr. Lupis.

In addition to the \$50,000 Dixon settlement, documents contain 14 court-reporting entries associated by exact docket number with eight cases.

Dixon: \$1,377.65.

Burns: \$565.29.

Castro: \$540.

Cunningham: \$1,408.90.

Burke: \$804.

Collins: \$1,216.

Marston: \$387.

Gojcay: \$579.30.

These court-reporting expenses total \$6,878.14.

The confirmed Dixon settlement and identified expenses account for \$56,878.14. This is a documented subtotal, not the Department's complete litigation cost or an allocation of responsibility solely to Dr. Lupis.

Completeness and Timeliness of Department Records

DOC did not bring several investigative matters involving Dr. Lupis to timely final resolution. The records show prolonged periods between the reported conduct and final disposition, ranging from approximately 16 months to more than three years.

The March 9, 2022, incident was not closed until January 2024, approximately 22 months later. The September 25, 2022, on-call matter reached its reported conclusion in November 2025, more than three years after the incident. The September and October 2022 workplace and documentation matters resulted in a reprimand letter dated June 7, 2024, followed by an August 12, 2024, closure memorandum. The May 1, 2023, telephone incident reached its reported conclusion in September 2024, approximately 16 months later.

Administrative Directive 1.10 establishes an expectation that Security Division investigations ordinarily be completed within 60 business days. Section 9(e) of the September 17, 2020, version requires an investigator whose investigation exceeds that period to submit an extension request to the Director of Security explaining the reasons. It also requires ongoing investigations to be included in monthly status reporting. Section 9(f) provides that Security Division investigations may be closed only after final review by the Commissioner or designee.

The records supplied to the Office do not adequately explain the prolonged timelines or demonstrate compliance with the extension and reporting requirements. They also do not consistently distinguish when investigative work was completed from when disciplinary review and final closure occurred.

The Office therefore finds that DOC's investigation and disposition process was not timely and that the production does not substantiate compliance with the directive's timeliness safeguards. The available dates do not establish whether each delay occurred during investigative work, subsequent review, or both.

These delays impaired timely accountability and the Department's ability to evaluate the effectiveness of corrective measures before additional concerns arose.

Findings

Finding 1. Repeated substantiated employee-conduct violations

DOC investigations substantiated repeated violations of Administrative Directive 2.17, including inappropriate workplace conduct and inaccurate electronic health-record documentation. These findings raise concerns about Dr. Lupis's professional conduct and adherence to employee responsibilities.

Finding 2. Continuing concerns affecting patient care

Reports of refusal to perform assigned clinical duties, delays in care, disputed medication changes, and inappropriate responses to patients with serious medical needs raise continuing concerns about patient care. Although not all allegations have been substantiated, their nature and recurrence warrant independent clinical review and interim restrictions on patient contact.

Finding 3. Unresolved compliance with Staff Physician qualification and credentialing requirements

Dr. Lupis is not currently board certified, and DOC has not documented his successful completion of an established agency competency program as an alternative to the applicable certification requirement. Compliance with the Staff Physician qualification requirements therefore remains unresolved. The credentialing roster also contains information about his disciplinary history that is inconsistent with the documented Connecticut regulatory record.

Finding 4. Weaknesses in DOC investigations, follow-through, and operational controls

Several matters remained unresolved for prolonged periods, demonstrating a lack of timely final disposition. Incomplete records prevent the Office from determining whether investigations complied with Administrative Directive 1.10's completion, extension, reporting, and closure requirements.

DOC's investigations also identified deficiencies in on-call coverage, backup arrangements, reassignment instructions, caseload communication, and electronic health-record expectations. The records provided do not establish that the recommended corrective measures were fully implemented.

Finding 5. Recurring litigation and associated settlements and expenses

A search of U.S. District Court for the District of Connecticut records identified 27 federal actions naming Dr. Lupis as a defendant. The financial review identified a \$50,000 settlement in Dixon and \$6,878.14 in associated court-reporting expenses across identified cases, totaling \$56,878.14.

The litigation reflects recurring allegations concerning Dr. Lupis during his DOC employment. Allegations are not established facts, and a settlement does not establish liability. Nevertheless, the volume of litigation and documented expenditures warrant review alongside DOC's substantiated findings and the complaints received by the Office.

Recommendations

Recommendation 1. Administrative leave and prohibition on patient contact

Place Dr. Lupis on administrative leave and bar him from patient contact pending further independent investigation, including a clinical review of the patient-care concerns identified in this report.

The restriction should encompass in-person and remote encounters, prescribing, patient-specific treatment decisions, and on-call responsibilities. Any return to clinical duties should depend on a documented determination addressing his qualifications, clinical performance, and professional conduct.

Recommendation 2. Qualification and credentialing audit

Determine and document whether Dr. Lupis satisfied the Staff Physician qualification requirements within the applicable timeframe, including certification or successful completion of an established agency competency program.

Resolve the discrepancy in the credentialing roster's treatment of his disciplinary history and document the basis for granting or continuing his clinical privileges.

Recommendation 3. Investigation timeliness and completeness audit

Audit compliance with Administrative Directive 1.10 using the actual authorization, investigative completion, extension, disciplinary, and closure dates for each matter.

Identify missing extension requests, monthly status reports, final approvals, and investigative records. Explain the prolonged periods before final disposition, address any outstanding matters, and establish responsibility for tracking deadlines and corrective action.

Recommendation 4. Written clinical and operational expectations

Establish and enforce written on-call requirements, including response expectations, backup coverage, escalation procedures, and documentation of unsuccessful contact attempts.

Implement the Security Division's recommendations concerning reassignment instructions, caseload communication, and appropriate electronic health-record documentation. Assign responsibility for each corrective measure and verify its implementation.

Investigator Credits

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