December 15, 2014

COMMONWEALTH OF MASSACHUSETTS

NORFOLK, ss. SUPERIOR COURT DEPARTMENT
OF THE TRIAL COURT

JOANNE MINICH, in her capacity as Guardian of PETER MINICH; VILMA and DANIELA ZOMOSA, as Next Friend of FELIPE ZOMOSA; JEFF and JUDY DOE, in their capacity as Guardians of JOHN DOE, on Behalf of Each Named Individual and on Behalf of All Others Similarly Situated,

Plaintiffs,

v.

LUIS S. SPENCER, Commissioner of the Massachusetts Department of Correction; ROBERT MURPHY, Superintendent of Bridgewater State Hospital; MARCIA FOWLER, Commissioner of the Massachusetts Department of Mental Health; MASSACHUSETTS PARTNERSHIP FOR CORRECTIONAL HEALTHCARE, LLC; and the COMMONWEALTH OF MASSACHUSETTS,

Defendants.

Civil Action No. 2014-00448-A

SETTLEMENT AGREEMENT

I. PARTIES AND DEFINITIONS

1. The Parties to this Agreement are plaintiffs Joanne Minich in her capacity as guardian of Peter Minich; Vilma and Daniela Zomosa, as next friend of Felipe Zomosa; Jeff and Judy Doe, in their capacity as guardians of John Doe; the Class Members; and defendants Luis S. Spencer, in his official capacity as Commissioner of the Massachusetts Department of Correction; Robert Murphy, in his official capacity as Superintendent of Bridgewater State Hospital; Marcia Fowler, in her official capacity as Commissioner of the Massachusetts Department of Mental Health; the Commonwealth of Massachusetts; and Massachusetts

Partnership for Correctional Health, LLC (hereinafter, collectively the "Parties" and, individually a "Party").

2. "Action" shall refer to the above-captioned action.

3. "Amended Complaint" shall refer to the Amended Complaint filed in the Action on or about May 1, 2014.

4. "BSH" shall refer to Bridgewater State Hospital, as defined in G.L. c. 125, § 18. Currently, BSH is operated by the Massachusetts Department of Correction as both a secure mental health facility and a medium security correctional facility.

5. "Chemical Restraint" shall refer to the administration of medication to a Patient involuntarily to restrain the Patient. Chemical Restraint shall not include involuntary administration of medication: (a) for treatment purposes consistent with *Rogers v. Commissioner of Dept. of Mental Health*, 390 Mass. 489, 512 (1983); or (b) for other treatment purposes pursuant to a Court-approved substituted judgment treatment plan.

6. "Class Counsel" shall refer to Roderick MacLeish, Jr. of Clark, Hunt, Ahern & Embry and other attorneys who have entered an appearance on behalf of Plaintiffs in this Action as of the date of this Agreement. Roderick MacLeish is lead counsel for Plaintiffs.

7. "Class Members" shall refer to all Patients held at BSH pursuant to the provisions of G.L. c. 123.

8. "DIT" shall refer to the Director of Intensive Treatment Planning at BSH who shall be an employee of MPCH or its successor, if any.

9. "DLC" shall refer to the Disability Law Center, Inc., the entity currently designated as the federal Protection and Advocacy entity for Massachusetts pursuant to 42 U.S.C. § 10801, *et seq*. and 42 U.S.C. § 15041, *et seq*.

10. "DMH" shall refer to the Massachusetts Department of Mental Health, as established by G.L. c. 19.

11. "DMH Commissioner" shall refer to the Commissioner of the Massachusetts Department of Mental Health, as defined in G.L. c. 19, §§ 1, 2.

12. "DMH Directive #14" shall refer to DMH Commissioner's Directive #14 dated May 10, 2001. DMH Directive #14 states the Purpose, Scope, Statement of Principles and Process concerning "Employee Filing of Criminal Complaints in DMH Inpatient Facilities."

13. "DOC" shall refer to the Massachusetts Department of Correction, as established by G.L. c. 27.

14. "DOC Commissioner" shall refer to the Commissioner of the Massachusetts Department of Correction, as defined in G.L. c. 27, § 1.

15. "Emergency" shall refer to incidents such as the occurrence of, or imminent serious threat of, extreme violence, personal injury, or attempted suicide.

16. "Family" shall refer to the Patient and/or family member or significant other of the Patient to whom the Patient permits disclosure of confidential information about himself.

17. "Family Notification" shall mean notice provided to the Family member or other person of the following information concerning the Patient: (a) placement of the Patient in Seclusion and/or Restraint at BSH; (b) any significant physical injury to the Patient at BSH requiring evaluation and/or treatment at an outside medical facility; (c) any significant change in the Patient's medical condition at BSH requiring evaluation and/or treatment at an outside medical facility.

18. "Felipe Zomosa" shall refer to plaintiff Felipe Zomosa.

19. "ICP Plan" shall refer to an Individual Crisis Prevention Plan which shall be age and developmentally appropriate and shall identify triggers and/or environmental factors that may signal or lead to agitation or distress in the Patient. The ICP Plan shall also identify strategies to help the Patient and BSH staff (both correctional and clinical staff) intervene with de-escalation, redirection, or other professionally supported techniques to reduce such agitation or distress to decrease and/or avoid the use of Seclusion and/or Restraint with the Patient. Formulation of the ICP Plan shall solicit input from the Patient. If the Patient is adjudged incompetent, the Patient's legal guardian (if any and if the guardian is known, available for input, and has authority to make ordinary medical treatment decisions) may be consulted. Formulation of the ICP Plan may also include consultation with entities such as DMH and the Patient's Family.

20. "ITU" shall refer to the Intensive Treatment Unit located at BSH.

21. "ITU Director" shall refer to the Director of the Intensive Treatment Unit at BSH, who shall be an employee of MPCH or its successor, if any.

22. "John Doe" shall refer to plaintiff John Doe.

23. "Medical Director" shall refer to the Medical Director at BSH, appointed pursuant to G.L. c. 125, § 18.

24. "Monitor" shall refer to the third party monitor selected by the Parties, as defined herein. The Monitor's duties and responsibilities are set forth in Section XV of this Agreement.

25. "Monthly Report" shall refer to a report concerning each instance of the use of Seclusion and/or Restraint with a Patient during the preceding month. The Monthly Report shall contain the date and time when each such incident started and ended. In lieu of names, the Monthly Report shall identify the Patients involved by their commitment number.

26. "MPCH" shall refer to the Massachusetts Partnership for Correctional Healthcare, one of the defendants in the Action, or its successor, if any.

27. "Notified Family" shall refer to the Family member or other designated person electing to receive Family Notification.

28. "Patient" shall refer to any person who has been admitted or transferred to BSH pursuant to the provisions of G.L. c. 123.

29. "Plaintiffs" shall refer to the individuals named as plaintiffs in the Action, namely Joanne Minich in her capacity as guardian of Peter Minich; Vilma and Daniela Zomosa, as next friend of Felipe Zomosa; Jeff and Dr. Judy Doe, in their capacity as guardians of John Doe; and Class Members.

30. "Peter Minich" shall refer to plaintiff Peter Minich.

31. "Program Mental Health Director" shall refer to the Program Mental Health Director at BSH, who shall be an employee of MPCH or its successor, if any.

32. "Quiet Rooms" shall refer to rooms in designated housing units at BSH that may be made available to a Patient based upon his individual de-escalation needs. Placement of a Patient in a Quiet Room shall be not used as punishment or to circumvent provisions set forth in this Agreement. Voluntary placement of a Patient in a Quiet Room shall be considered Seclusion if the Patient is not permitted to leave the Quiet Room within a reasonable time after his request. BSH will establish procedures to ensure that a Patient who signals his desire to leave a Quiet Room is released as soon as possible but no later than thirty (30) minutes from the time such signal is given.

33. "Restraint" shall refer to the use of bodily physical force, mechanical devices, chemicals, or any other means which unreasonably limits a Patient's freedom of movement.

34. "Risk Assessment Meetings" shall refer to the meetings that occur every weekday morning at BSH among senior staff members, including the Superintendent, Medical Director, ITU Director, and DIT, all as defined herein, or their similarly qualified designees, during which the clinical status of Patients is discussed.

35. "Seclusion" shall refer to confinement of a Patient alone in a room or place of seclusion other than the placement of a Patient in his room for the night.

36. "Specially Trained Observer" or "STO" shall refer to an employee who is designated by the Superintendent or Medical Director, and who has been specially trained to understand, assist, and afford therapy to a person in Restraint.

37. "Superintendent" as used herein shall refer to the Superintendent at BSH.

II. FOCUS OF THIS AGREEMENT

38. The Parties acknowledge and agree that this Agreement is intended to address issues concerning the use of Seclusion and Restraint at BSH, including Plaintiffs' allegations about the purported prolonged, inappropriate, and/or non-emergency placement of Patients in Seclusion and/or Restraint in violation of G.L. c. 123, § 21, and Plaintiffs' inadequate medical and mental health care claims under the state and federal constitutions related solely to the use of Seclusion and Restraint.

III. MATTERS OUTSIDE THE SCOPE OF THIS AGREEMENT

39. As part of this Agreement, Plaintiffs agree to dismiss without prejudice their claims relating to the adequacy of medical care at BSH. The Parties also acknowledge and agree that the matters set forth below in this Section are outside the scope of this Agreement and shall not be addressed under Sections XV and XVII of this Agreement. The Parties do not waive their

ability to raise or otherwise address claims concerning the matters set forth below in a separate action before a court of competent jurisdiction.

40. The Parties disagree as to whether the following practices at BSH constitute Restraint under G.L. c. 123 but agree not to attempt to resolve their differences in this Action or Agreement. Therefore, for the purposes of this Agreement solely, Restraint shall not refer to: (a) the temporary use of mechanical devices with a Patient for safety or security purposes when the Patient is being transported within BSH; or (b) the temporary use of mechanical devices with a Patient for safety or security purposes to prevent injury to Patients as a result of any medical or physical impairment.

41. The Parties disagree as to whether the following practices at BSH constitute Seclusion under G.L. c. 123 but agree not to attempt to resolve their differences in this Action or Agreement. Therefore, for the purposes of this Agreement solely, Seclusion shall not refer to: (a) placement of a Patient in his room on a housing unit for the night at the regular hour of sleep or after 6:30 p.m. upon the Patient's request; (b) temporary placement of a Patient alone in a room for no longer than ninety (90) minutes to await medical assessment and/or treatment; (c) voluntary, temporary placement of a Patient in a room designated by the Superintendent as a Quiet Room; or (d) temporary placement of a Patient in a room for patient and inmate counts and movement. Likewise, the Parties disagree as to whether Seclusion or Restraint orders can be renewed only upon personal examination by a physician or psychiatrist after a Patient has been in Seclusion or Restraint for more than six (6) hours.

IV. USE OF SECLUSION AND/OR RESTRAINT AT BSH

42. The use of Seclusion and Restraint at BSH shall comply with G.L. c. 123, §§ 1 and 21.

43. On or about June 17, 2014, Governor Deval L. Patrick proposed legislative initiatives concerning BSH, including but not limited to House Bill 4367 entitled, "An Act Reforming the Delivery of Forensic Mental Health Services." DOC and DMH support this legislation and, in general, support legislative efforts to improve the treatment of forensic patients.

44. Every order to initiate or continue the use of Seclusion and/or Restraint with a Patient shall identify the grounds for such order, including but not limited to the Emergency necessitating the use of Seclusion and/or Restraint. Reasonable efforts shall be made to ensure that such orders are legible. When required by G.L. c. 123, § 21, ¶ 7, a personal examination of a Patient may include, when deemed clinically appropriate, entrance into the room where the Patient has been placed in Seclusion or Restraint.

45. Restraint or seclusion may only be used if an initial determination has been made and documented in writing that less restrictive alternatives, including strategies identified in the Patient's ICP plan, if any, would be inappropriate or were ineffective under the circumstances. Upon determination of whether Seclusion and/or Restraint orders should be renewed, consideration shall be given to whether less restrictive alternatives should be utilized.

46. Health care staff at BSH shall, unless precluded by emergency circumstances, assess a Patient and shall review such Patient's medical record, if available, for any health history concerns such as cardiovascular, pulmonary, or respiratory disease prior to the time that such Patient is mechanically restrained. In the event that emergency circumstances preclude prior assessment and review, such assessment and review shall take place as soon as practicable thereafter. Health care staff shall regularly monitor vital signs, breathing and circulation, hydration, mental status, oxygen saturation level, skin breakdown, signs of blood clots or

aspiration, and any physical injury to the Patient in Restraints. The Parties shall agree upon a medical consultant who shall review BSH mechanical restraint policies and prepare a report, available to the Monitor and Class Counsel, making recommendations concerning the safe use of mechanical restraints at BSH, especially with regard to any possible medical contraindications to continued placement in such restraints at BSH.

47. The risk status of each Patient in Seclusion and/or Restraint shall be discussed at Risk Assessment Meetings.

48. During at least one Risk Assessment Meeting per calendar month, any Patient shall be identified who: (a) has remained in Seclusion for more than forty-eight (48) continuous hours; (b) has been placed in Restraint for more than twelve (12) continuous hours; or (c) has been placed in Seclusion or Restraint more than three (3) times in a single calendar month.

49. Once per calendar month, the DOC shall provide written notice to the DOC's Director of Behavioral Health Services, the Superintendent, the Medical Director, the Program Mental Health Director, the ITU Director, and the DIT or their designees if a Patient is: (a) placed in Seclusion for more than one-hundred and ninety-two (192) total hours in a single calendar month; (b) placed in Restraint for more than forty-eight (48) total hours in a single calendar month; or (c) placed in Seclusion or Restraint for more than three (3) times in a single calendar month. The DOC's Director of Behavioral Health Services or his/her designee may, based upon his/her evaluation, also meet with BSH clinical staff to review and discuss the Patient's treatment. This provision is in addition to the obligations set forth in G.L. c. 123, § 21.

V. CONDITIONS FOR PATIENTS PLACED IN SECLUSION AT BSH

50. BSH staff shall make necessary efforts to ensure that the personal hygiene of a Patient placed in Seclusion is not compromised. STOs shall notify BSH clinical staff if a

Patient's room becomes unhygienic due to the presence of food, feces, or urine and the room shall be cleaned as soon as reasonably possible thereafter.

51. Unless there is a clinical determination made in writing by the Medical Director, ITU Director, DIT, or physician on duty, based on the risk of the Patient to himself or others, that a Patient requires a safety smock, clean underwear and clothing shall be provided every day to Patients placed in Seclusion. If a safety smock is clinically required, Patients shall be provided a clean safety smock every day. Clean clothing or safety smocks shall be provided more frequently to Patients in the event that such items become unhygienic or soiled with food, feces, or urine. Such items shall not be withheld from a Patient placed in Seclusion as a condition of behaviors unrelated to the above-mentioned clinical determination.

52. Patients placed in Seclusion shall be permitted and encouraged to brush their teeth twice a day. Unless clinically contraindicated, Patients placed in Seclusion shall have the opportunity to shave each day.

53. Patients placed in Seclusion shall be permitted and encouraged to shower daily. If a Patient placed in Seclusion declines to shower on more than two (2) consecutive days, the DOC shall notify the ITU Director or his/her designee and a written plan shall be developed to encourage the Patient to shower.

54. Unless clinically contraindicated, Patients placed in Seclusion for more than twenty-three (23) consecutive hours shall have the opportunity for at least one (1) hour of outdoor exercise during every 24-hour period. If a Patient declines the opportunity for outdoor exercise on three (3) consecutive days, the DOC shall notify the ITU Director or his/her designee and a plan shall be developed to encourage the Patient to engage in outdoor exercise.

55. Unless clinically contraindicated by the ITU Director or his/her designee, Patients placed in Seclusion shall be permitted access to reading materials and such items shall not be withheld as a condition of behavior unrelated to any clinical contraindications.

56. Where clinically indicated, Patients placed in Seclusion shall be permitted access to personal listening devices and other similar items designed to provide stimulation. When clinically indicated and subject to appropriation and receipt of funds, Patients placed in Seclusion shall have access to a television.

VI. CONDITIONS FOR PATIENTS PLACED IN RESTRAINT AT BSH

57. At all times, Patients placed in Restraint shall be positioned in a manner that allows airway access and does not compromise respiration. Patients shall not be placed in Restraint in a face-down position. No locked mechanical devices, such as handcuffs, shall be used as Restraint in an Emergency.

58. Patients placed in Restraint shall have appropriate coverings. BSH staff shall make reasonable efforts to attend to such Patients' personal dignity and their physical and mental comfort, including access to food, drink, toilet or bedpan, and other personal needs. When a Patient placed in Restraint requests to use the bathroom, the request shall be addressed promptly. BSH clinical staff shall also assess the Patient for release from Restraint and the Patient shall either be released from Restraint or, if the underlying Emergency is deemed to still exist, be afforded the opportunity to use a bedpan.

59. Patients placed in Restraint shall be observed by an STO trained to understand, assist and afford therapy to Patients placed in Restraint. Every fifteen (15) minutes, BSH nursing staff shall assess the physical and psychological status, comfort, body alignment,

breathing, circulation, and readiness for release of a Patient placed in Restraint. Every two (2) hours, BSH nursing staff shall take the vital signs of a Patient placed in Restraint.

60. If a Patient placed in Restraint falls asleep, the Patient may be permitted to continue sleeping if BSH clinical staff determines that it is clinically indicated. When the Patient re-awakens, BSH clinical staff shall again assess the Patient for release from Restraint.

VII. VISITATION OF AND TELEPHONE CONTACT WITH PATIENTS PLACED IN SECLUSION AT BSH

61. Unless clinically contraindicated or if the Patient refuses, Patients placed in Seclusion shall be permitted to receive visitors. These visits are subject to the discretion of the Superintendent. Such visits shall occur in a non-contact visiting area within BSH's Administrative Building where attorney-client meetings occur, or in another comparable location where direct, physical contact between the Patient and visitors may not occur. Such visits shall not occur in the cell located in the Administrative Office of the ITU.

62. Unless clinically contraindicated, Patients placed in Seclusion shall have the opportunity to make at least one daily telephone call. Subject to the discretion of the Superintendent, Patients placed in Seclusion may be permitted to make additional daily telephone calls.

VIII. DISCONTINUANCE OF USE OF SECLUSION AND/OR RESTRAINT AT BSH

63. A Patient placed in Seclusion and/or Restraint shall be released from such Seclusion and/or Restraint as soon as possible after the underlying Emergency has ended, as determined by a timely clinical assessment.

64. The inability of BSH clinical staff to speak to a Patient placed in Seclusion and/or Restraint, or such Patient's refusal to speak with BSH staff, shall not constitute grounds, by itself, to continue the use of Seclusion and/or Restraint with such Patient.

65. If a Patient placed in Seclusion is asleep during normal daytime hours, BSH clinical staff conducting a personal examination of the Patient under G.L. c. 123, § 21, ¶ 7 shall attempt to arouse the Patient verbally unless clinically contraindicated. BSH clinical staff shall not be required to wake a Patient placed in Seclusion who is asleep between 9pm and 7am.

66. Patients may not remain in Seclusion voluntarily. If a Patient is released from Seclusion but refuses to leave the ITU, the Patient shall be placed on "Discontinuation Status" and shall remain in the ITU until the Patient is transferred to his housing unit.

IX. ICP PLANS

67. If a Patient is placed in Seclusion for more than one-hundred and ninety-two (192) total hours in a single calendar month, or in Restraint for more than forty-eight (48) total hours in a single calendar month, or placed in Seclusion for more than eight (8) times in a single calendar month, or placed in Restraint for more than three (3) times in a single calendar month, BSH clinical staff shall develop an ICP Plan for such Patient or, if an ICP Plan already exists, review and, if necessary, refine the Patient's ICP plan as deemed clinically appropriate with the goal of reducing or avoiding the further use of Seclusion and Restraint with such Patient. BSH clinical staff shall also review and, where appropriate, modify such Patient's master treatment plan. ICP Plans may also be developed for any other Patients, if necessary. Should BSH receive additional resources, priority will be given to the development of additional ICP Plans.

68. If the Medical Director determines it to be appropriate, the Medical Director or Program Mental Health Director shall authorize BSH clinical staff to consult with clinicians designated by DMH to assist in the development and/or implementation of any individual ICP Plan.

69. Each Patient's treatment team at BSH shall discuss ICP Plans that are developed for that Patient to ensure proper implementation of the Plan.

X. DATA CONCERNING THE USE OF SECLUSION AND/OR RESTRAINT AT BSH

70. BSH staff shall collect and maintain data concerning the use of Seclusion and Restraint at BSH, including any data required by this Agreement.

71. During the first week of each calendar month, BSH staff shall prepare a Monthly Report.

72. A copy of any Monthly Report shall be provided to the Monitor and, upon request, to Class Counsel.

XI. TRAINING ON SECLUSION AND RESTRAINT

73. BSH staff directly involved in the placement of Patients in Seclusion and/or Restraint and/or in the monitoring and assessment of Patients in and/or for release from Seclusion and/or Restraint shall receive training and periodic re-training on Seclusion and Restraint, including as applicable: legal and clinical requirements for Seclusion and Restraint; de-escalation techniques; application and monitoring of Seclusion and Restraint; and approaches to facilitate the earliest possible release from Seclusion and Restraint. Such BSH staff who are correctional employees must demonstrate their competencies in such training. With regard to mechanical Restraint, such BSH correctional staff shall both receive refresher training and demonstrate their competency in mechanical restraint to the DOC on an annual basis, prior to such BSH staff's placement of Patients in Seclusion and/or Restraint and/or in the monitoring and assessment of Patients in and/or for release from Seclusion and/or Restraint.

74. BSH clinical staff will continue to receive annual training on the use of Seclusion and Restraint and on the legal requirements for Seclusion and Restraint. Such BSH clinical staff

who are clinicians (*e.g.*, psychiatrists, nurses, mental health workers) must demonstrate their competencies in such training and/or proper credentialing to the DOC. Such BSH clinical staff shall demonstrate such competencies and/or credentialing prior to their placement of Patients in Seclusion and/or Restraint and/or in the monitoring and assessment of Patients in and/or for release from Seclusion and/or Restraint.

75. DOC, MPCH, or its successor, and DMH shall collaborate to develop a curriculum for trainings in trauma-informed care, Seclusion and Restraint prevention, and de-escalation techniques.

XII. DMH'S ROLE

76. DMH shall be available to assist BSH staff concerning the use of Seclusion and/or Restraint at BSH, including developing alternatives to its use. Such assistance may involve the review of policies or procedures, recommendations to minimize the use of Seclusion and/or Restraint at BSH, or the development of alternatives to the use of Seclusion and/or Restraint.

77. When requested, DMH shall be available to consult with BSH clinical staff concerning the development and implementation of ICP Plans.

78. When requested, DMH shall be available to consult with BSH staff concerning any Patient who is frequently placed Seclusion and/or Restraint at BSH, such as a Patient who has been: (a) placed in Seclusion for more than one-hundred and ninety-two (192) total hours in a single calendar month; (b) placed in Restraint for more than forty-eight (48) total hours in a single calendar month; (c) placed in Seclusion for more than eight (8) times in a single calendar month; or (d) placed in Restraint for more than three (3) times in a single calendar month

79. The DMH Commissioner will reiterate verbally and in writing to DMH employees support for the procedure set forth in DMH Directive #14 and will meet personally

with all facility directors by December 30, 2014 to address the importance of the directive and stress that admissions from DMH facilities to BSH should be avoided whenever reasonably possible.

80. The Chief Operating Officer of each DMH operated facility will keep a written record of each time an employee utilizes the process set forth DMH Directive #14, which record shall include the information about the incident described in ¶ 4(B)(1) of DMH Directive #14. DMH shall make reasonable efforts to determine when DMH employees pursued criminal charges after engaging in the process set forth in DMH Directive #14. DMH will incorporate the requirements of this Paragraph into its procedures for implementing DMH Directive #14.

81. The written records created pursuant to Paragraph 80 above will be provided to the DMH Commissioner or his/her designee. Data collected pursuant to Paragraph 80 above shall be reviewed on a semi-annual basis to identify patterns, if any, or events that led to utilization of the process set forth in DMH Directive #14.

82. Paragraphs 79 through 81 above are not subject to Section XV of this Agreement.

XIII. FAMILY SUPPORT GROUP

83. BSH will take steps to encourage contact between Families and Patients. The Superintendent will establish a Family Support Group whose goal shall be to share ideas with the Superintendent concerning steps that may be taken at BSH to improve the quality of contact between Families and Patients. Meetings of the Family Support Group will take place every other month and/or on such other occasions as agreed upon by the Family Support Group and the Superintendent or his/her designee.

XIV. NOTIFICATION OF FAMILY MEMBERS OF PATIENTS

84. As soon as possible after a Patient's admission to BSH, BSH clinical staff shall speak with the Patient to determine whether he has a Family member or other person whom the

Patient: (a) wishes to have contact with; and/or (b) wishes to be kept informed about the Patient's status at BSH. If the Patient identifies a Family member or other designated person who resides in the community who the Patient wants to receive such information, the Patient will be asked to execute a release permitting disclosure of such information to that designated individual. If the Patient is unable or unwilling to provide such information, BSH clinical staff may also review the Patient's medical and court records to determine whether the Patient has any Family.

85. If a Patient has a legal guardian or has designated a Family member or other person pursuant to Paragraph 84 above, BSH clinical staff shall make reasonable efforts to contact that individual to discuss the Patient's history, admission to BSH, treatment plan at BSH, and related matters within thirty (30) days of the Patient's commitment to BSH.

86. As soon as reasonably possible after BSH clinical staff have identified a Patient's Family member, the DOC shall notify such Family member of BSH's policies concerning visitation and telephone contact, the availability of Family Notification, and the existence and timing of the Family Support Group. Notice provided pursuant to this Paragraph shall include a form for the Family member to return to BSH indicating whether the Family member wishes to receive Family Notification.

87. Subject to permission from the Patient and staffing levels, BSH clinical staff shall: (a) discuss the Patient's current treatment with the Notified Family; and (b) respond to requests for information from the Notified Family.

88. Subject to permission from the Patient and staffing levels, BSH clinical staff shall be reasonably available to communicate with the Notified Family to discuss the Patient's well-being, treatment, and progress.

89. Subject to permission from the Patient and staffing levels, BSH clinical staff shall be available to meet semi-annually with the Notified Family to discuss the Patient's well-being, treatment, and progress, including but not limited to: (a) the Patient's goals and objectives; (b) the Patient's medications and any side effects therefrom; (c) modifications to the Patient's treatment plan; and (d) the amount of time that the Patient has been placed in Seclusion and/or Restraint at BSH. Such meetings may occur by telephone so long as at least one of the two meetings occurs in person if that is the Notified Family's preference.

XV. DLC AS MONITOR

90. The Parties designate DLC as the Monitor. The Monitor will monitor the use of Seclusion and Restraint at BSH in accordance with the terms of this Agreement. The Monitor will monitor whether there has been substantial non-compliance by Defendants with this Agreement. Nothing in this Agreement shall restrict or limit DLC from exercising its independent statutory authority as the designated Protection and Advocacy ("P and A") Agency in Massachusetts, including rights to access materials and/or individuals pursuant to its P and A authority, including 42 U.S.C. §§ 10805 and 15043.

91. The Parties recognize that the Monitor is a material part of this Agreement and agree to cooperate with the Monitor in performing its monitoring functions under this Agreement. If DLC is unwilling or unable to serve as the Monitor at any time while this Agreement is in effect, the Parties shall attempt in good faith to agree upon a replacement Monitor within thirty (30) days, with each Party proposing up to three (3) replacements and the Parties agreeing to select one of the proposed candidates. DLC may also propose possible replacements as Monitor for the Parties to consider. If the Parties still cannot agree in good faith on a replacement, a Party may seek involvement by the Court.

92. The Monitor's monitoring functions under this Agreement shall continue for as long as the Court has jurisdiction to enforce this Agreement.

93. The Monitor's role may be filled by one or more persons at DLC. The Monitor shall not be an employee of any of the Parties.

94. DOC shall provide suitable working space at BSH for the DLC employee(s) filling the Monitor role.

95. The Monitor shall have access to Patient records and Patients with the written consent of the Patient or his legally appointed guardian. Class Counsel shall have reasonable access to Patient records pursuant to 103 DOC 607 (Inmate Medical Records) with the written consent of the Patient or his legally appointed guardian, and to Patients pursuant to 103 MASS. CODE REGS. § 486, *et seq.* (Attorney Access). To the extent required by law for such access to these records, BSH staff shall make reasonable efforts to facilitate consent of the Patients or their legally appointed guardians. Upon notice and request by Class Counsel to the Superintendent, reasonable accommodations shall be made for Class Counsel to briefly meet with those Patients who have previously refused to visit with Class Counsel.

96. The Monitor shall have reasonable access to BSH staff regarding the subject matter of this Agreement, subject to applicable legal privileges, including the attorney-client privilege and medical peer review privilege. BSH clinical staff shall not discuss confidential Patient information unless a written release has been obtained from and provided by the Patient or his legal guardian.

97. Subject to applicable legal privileges, including the attorney-client privilege, medical peer review privilege, or work-product doctrine, the Monitor shall have access to documents, data, and statistical records concerning the use of Seclusion and Restraint at BSH,

including materials collected by DOC and/or MPCH or its successor, if any. Upon request, public records, as that term is defined in G.L. c. 4, § 7(26), regarding the use of Seclusion and Restraint shall be provided to Class Counsel within a reasonable time period. Class Counsel shall also have access to a Patient's confidential medical records upon written authorization by each Patient or his legally appointed guardian.

98. The Monitor shall be free to communicate with Patients and Class Counsel concerning the Defendants' substantial compliance with G.L. c. 123, § 21 and this Agreement, provided the communication does not involve information or documents that were/are confidential pursuant to the provisions regarding peer review confidentiality as set forth in G.L. c. 111, §§ 204-205. In so doing, unless the Monitor has consent from the Patient or his legally appointed guardian, the Monitor shall not disclose any Patient-specific information that was/is: privileged pursuant to G.L. c. 233, § 20B (psychotherapist-patient communications) or G.L. c. 112, § 135B (social worker-client communications); confidential pursuant to G.L. c. 112, § 129A (psychologist-patient communications), G.L. c. 112, § 135A (social worker-client communications), or G.L. c. 112, § 172 (allied mental health or human services professionals communications); or otherwise statutorily protected (*e.g.*, G.L. c. 111, § 70E(b) (patients are entitled to "confidentiality of all records and communications to the extent provided by law"), G.L. c. 123, § 36A (forensic evaluations and commitment petitions and orders are "private except in the discretion of the court"), and G.L. c. 112, § 12CC (governing release of patient-psychotherapist records to patient himself)) from disclosure to anyone not legally entitled to such information.

99. The Monitor shall have access to materials used in the training described above in Section XI of this Agreement, including training material and documentation showing that BSH staff have successfully completed training in Seclusion and Restraint.

100. If the Monitor believes that there has been substantial non-compliance by a Defendant with G.L. c. 123, § 21 or this Agreement, the Monitor shall raise that issue promptly with the Parties and shall identify, in writing, the specific provision of this Agreement for which the Monitor believes there has been substantial non-compliance. The purpose of doing so will be to give the Parties a reasonable opportunity to review, discuss and correct any such substantial non-compliance. Defendants shall provide the Monitor with a written response within thirty (30) days.

101. The Monitor shall be free to inform Patients of their legal rights, including their right to file reports with the Disabled Persons Protection Commission and to retain counsel.

XVI. ATTORNEYS' FEES

102. The Parties agree that any Defendant may seek to negotiate in good faith Class Counsel's claims for reasonable attorneys' fees and costs in connection with this Action under 42 U.S.C. § 1988 and G.L. c. 12, § 11I. If such negotiations are not successful, Class Counsel may bring a motion for attorneys' fees and costs against said Defendant(s) to the Court. Defendant(s) may oppose or otherwise respond to such motion. Nothing in this Agreement waives any Party's arguments in support of or opposition to a claim for attorneys' fees.

XVII. COURT APPROVAL, DISPUTE RESOLUTION, AND ENFORCEMENT

103. This Agreement represents a full and fair resolution of the claims for relief alleged in the Amended Complaint concerning the use of Seclusion and/or Restraint at BSH.

104. For purposes of this Agreement and its approval by the Court, the Parties agree that this Action shall be maintained as a class action under MASS. R. CIV. P. 23 with the class defined as all Patients who were as of the filing of this Action, are now, or may be in the future, held at BSH pursuant to the provisions of G.L. c. 123 during the pendency of this Agreement. The Parties also agree that plaintiffs Joanne Minich and Dr. Judy Doe shall be the class representatives for the Class Members.

105. This Agreement shall be subject to the approval of the Court. The Parties shall jointly file a motion for the Court to approve this Agreement. The Parties shall also cooperate in presenting this Agreement to the Court for approval and/or at any hearing under MASS. R. CIV. P. 23(c). If the Court approves this Agreement, the Parties stipulate that this Agreement shall not be construed as a consent decree. If the Court does not approve this Agreement in all respects, this Agreement shall be null and void and of no force and effect, and nothing herein shall be deemed to prejudice the position of any Party with respect to the Action or otherwise, and neither the existence of this Agreement, nor any of its terms or provisions, nor any of the negotiations or proceedings connected with it, shall be admissible in evidence, referred to for any purpose in the Action or in any other litigation or proceeding, or construed as an admission, presumption, or concession by any Defendant of any liability or the truth of any of the allegations in the Action.

106. This Agreement may be enforced only by the Parties thereto. Nothing contained in this Agreement is intended or shall be construed to evidence an intention to confer any rights or remedies upon any person other than the Parties hereto.

107. If Plaintiffs believe that there has been substantial non-compliance with any provision of this Agreement by Defendants, Plaintiffs, through Class Counsel, shall provide the

Monitor, in writing, the specific reasons and grounds for such belief, including an identification of the specific provision with which such Plaintiff or Class Member believes there was substantial non-compliance. The Parties agree that any minor, incidental, or isolated breach or delay in implementation of a provision of this Agreement shall not constitute substantial non-compliance.

108. The Monitor shall promptly notify the Parties' counsel in writing of any finding that the Monitor shall make concerning Defendants' substantial compliance or substantial non-compliance with this Agreement. Any such finding shall be in writing and may be cited or otherwise used in a subsequent proceeding. The purpose of doing so will be to inform the Parties and to give Defendants a reasonable opportunity to review, discuss, and correct any alleged substantial non-compliance. Plaintiffs, through Class Counsel, shall also make reasonable efforts to meet promptly and in good faith with Defendants to attempt to resolve the alleged substantial non-compliance.

109. If the efforts to resolve the alleged substantial non-compliance are not successful, Plaintiffs, through Class Counsel, and Defendants may jointly or individually seek relief from the Court to effect substantial compliance with this Agreement, but not through a petition for contempt.

110. If the Court determines that there has been substantial non-compliance by Defendants with a provision of this Agreement at any time during the period of the Agreement, the Court may enter an order consistent with equitable principles that is designed to achieve substantial compliance with such provision(s) of this Agreement, but not an order of contempt.

111. If Plaintiffs, through Class Counsel, contends that Defendants have not complied with an order entered by the Court under the preceding Paragraph, Plaintiffs may, after

reasonable notice to Defendants, move for further relief from the Court to obtain compliance with the Court's prior order. In ruling on such motion, the Court may apply equitable principles and may use any appropriate equitable or remedial power available to it.

112. The term of this Agreement and the jurisdiction of the Court shall commence upon the date of approval by the Court and shall extend for two (2) years from said date of approval. The Court's jurisdiction shall terminate at the end of the two (2) year period with respect to any provision of this Agreement for which there is no outstanding determination that any Defendant is in substantial non-compliance. If the Court determines that there has been substantial non-compliance by any Defendant with a provision of this Agreement at any time during the two (2) year period of this Agreement, the Court's jurisdiction with respect to such provision or provisions relating thereto shall continue for the remainder of the two (2) year period or for a period to be ordered by the Court of not more than two (2) years from the date of the Court's determination of substantial non-compliance by any Defendant.

113. The Court shall be the sole forum for the enforcement of this Agreement. The Parties agree not to seek termination of or otherwise challenge this Agreement or any order approving this Agreement during the period of time that the Court retains jurisdiction. Nothing in this Paragraph shall limit the Parties' rights to challenge or appeal any finding as to whether there has been substantial non-compliance by any Defendant, or any order entered by the Court pursuant to this Section.

114. Subject to the provisions set forth in this Section, this Agreement shall expire at the end of two (2) years from the date of approval by the Court and the Action shall be dismissed with prejudice. Such dismissal with prejudice shall not operate to prevent a Patient from filing an action alleging ongoing violations of law, provided that: (a) the Patient and Class Counsel

were not reasonably aware of such violations during the pendency of this Agreement; (b) the Patient and Class Counsel exhausted the dispute resolution procedures set forth in this Section; or (c) the dispute resolution procedures were ongoing at the time of the dismissal.

XVIII. APPROPRIATIONS AND RECEIPT OF FUNDING

115. The Parties acknowledge that Defendants' ability to fulfill their obligations under this Agreement is subject to appropriations by the Legislature, receipt of funds, and any collective bargaining agreements.

116. In order to implement and comply with this Agreement, DOC and DMH shall submit budget requests as needed and will, consistent with Art. 63 of the Massachusetts Constitution, make their best efforts to obtain the funding necessary to implement and comply with this Agreement.

117. If the Parties' efforts to resolve any disagreement as to whether there is sufficient funding to fully implement this Agreement are unsuccessful, either Plaintiffs or Defendants may invoke the dispute resolution procedures in Section XVII of this Agreement.

118. Plaintiffs do not waive any claim that compliance with the requirements of G.L. c. 123, § 21 or Federal constitutional law may be mandatory regardless of lack of funding or collective bargaining agreements. Defendants reserve the right to assert the non-appropriation or non-receipt of funds or failure to collectively bargain successfully as a defense to any request for a remedial order from the Court.

XIX. NO WAIVER OF MONETARY CLAIMS OR CLAIMS OUTSIDE THE SCOPE OF THIS AGREEMENT

119. Nothing in this Agreement shall constitute a waiver by any Plaintiff or Class Member of any individual claim against any Defendant in a court of competent jurisdiction for monetary damages or concerning matters outside the scope of this Agreement. Defendants agree

that for the purposes of the statute of limitations, any action filed by plaintiffs John Doe, Peter Minich, and/or Felipe Zomosa for monetary damages shall be treated as if the cause of action first accrued on March 31, 2014 in the case of Peter Minich and on May 1, 2014 for the purposes of John Doe and Felipe Zomosa. Defendants agree that plaintiffs John Doe, Peter Minich, and Felipe Zomosa shall be able to file any claim for monetary damages in any court of competent jurisdiction after execution of this Agreement, subject to any applicable notice requirements. In any such action by these three Plaintiffs, Defendants shall not raise as a defense the failure of these three Plaintiffs to seek monetary damages in this Action and Defendants shall waive the defenses of res judicata, issue preclusion, and collateral estoppel with regard to this Action.

XX. NO ADMISSION OF LIABILITY

120. Nothing in this Agreement shall be construed in any way as an admission by any Defendant of any liability or wrongdoing whatsoever. Each Defendant specifically disclaims any liability or wrongdoing whatsoever on the part of itself, its agents, and employees.

XXI. MISCELLANEOUS

121. This Agreement sets forth the entire agreement between the Parties hereto, and fully supersedes any and all prior agreements or understandings between the Parties hereto pertaining to the subject matter hereof.

122. This Agreement shall be deemed to be made and entered into in the Commonwealth of Massachusetts and shall in all respects be interpreted, enforced, and governed under the laws of said Commonwealth. The Parties expressly acknowledge that any subsequent changes to such laws, including changes or amendments to G.L. c. 123, § 21 or any other relevant statute, shall govern and apply to the Parties and this Agreement.

123. This Agreement may not be relied upon as precedent in any future claim and shall not in any way be construed as an admission, presumption, or concession by any Defendant of any liability or wrongdoing whatsoever.

124. Each Party represents and acknowledges that each Party is and has been represented by its own counsel. Each Party further represents and acknowledges that, in executing this Agreement, no Party relies or has relied upon any representations or statements made by any other Party or its counsel other than the promises and representations set forth in this Agreement.

125. Should any part, term, or provision of this Agreement be declared or be determined by any Court to be illegal or invalid, the validity of the remaining parts, terms, or provisions shall not be affected thereby and said illegal or invalid part, term, or provision shall be deemed not to be a part of this Agreement.

126. Except as otherwise stated, this Agreement shall only be amended, revoked, changed, or modified through a written agreement executed by all the Parties. No waiver of any provision of this Agreement will be valid unless it is in writing and signed by the Party against whom such waiver is charged.

127. This Agreement is the result of an arm's-length negotiation. Since all Parties contributed substantially, materially, and cooperatively in drafting this Agreement, it shall not be more strictly construed against one Party than any other.

128. This Agreement may be executed in a number of identical counterparts, all of which shall together constitute one Agreement, and such execution may be evidenced by signatures delivered by facsimile transmission or other electronic means.

Joanne Minich in her capacity as Guardian of Peter Minich

Joanne Minich
Joanne Minich

12/17/14
Date

December 15, 2014

Vilma Zomosa and Daniela Zomosa as Next Friend of Felipe Zomosa

Vilma Zomosa

12-17-2014
Date

Daniela Zomosa

12/17/2014
Date

Jeff Doe and Judy Doe, in their Capacity as Guardians of John Doe

Jeff Doe Jeff Doe
Jeff Doe

12/17/2014
Date

Judy Doe
Judy Doe

12/17/2014
Date

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December 15, 2014

CAROL HIGGINS O'BRIEN, Commissioner of the Massachusetts Department of Correction and on behalf of VERONICA MADDEN, Superintendent of Bridgewater State Hospital

Carol Higgins O'Brien
Signature

12-18-14
Date

MARCIA FOWLER, Commissioner of the Massachusetts Department of Mental Health

Signature

12-18-14
Date

Commonwealth of Massachusetts

M. Patrick Moore Jr.
Signature

12-18-14
Date

[NAME] M. Patrick Moore Jr.
[TITLE] Deputy Legal Counsel
Office of the Governor

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December 15, 2014

Massachusetts Partnership for Correctional Healthcare, LLC

Deana Johnson
General Counsel

12/19/14
Date

Counsel for Massachusetts Partnership for Correctional Healthcare, LLC

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