2016 WL 11396635 (Mass.Super.) (Trial Pleading)
Superior Court of Massachusetts.
Suffolk County

Joanne MINICH, in her capacity as Guardian of Peter Minich; Felipe Zomosa; and Jeff and Judy Doe, in their capacities as Guardians of Jeffrey Doe, on behalf of themselves and all others similarly situated, Plaintiffs,
v.
Luis S. SPENCER, Robert Murphy; Massachusetts Department of Correction; Commonwealth of Massachusetts, Defendants.

No. SUCV2015-00278.
October 14, 2016.

Second Amended Complaint (with Class Action Allegations)

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I. INTRODUCTION

1. This case involves the prolonged and deliberate misuse of solitary confinement and mechanical restraints on severely mentally ill individuals, civilly committed on an involuntarily basis to Bridgewater State Hospital ("Bridgewater") for "care and treatment." Despite its name, Bridgewater is a prison administered by the Massachusetts Department of Correction ("DOC") that purports to provide care and treatment to both civilly committed mentally ill individuals, not convicted or any crime, and individuals who become mentally ill and are transferred to Massachusetts prisons and who are serving criminal sentences. Defendants in the case are the former Commissioner of the Department of Correction (Luis S. Spencer) and the former Superintendent of Bridgewater (Robert Murphy). The Plaintiffs in this case were all parties in a class action lawsuit seeking injunctive relief ("the equity action") settled with the Commonwealth and a private clinical contractor for Bridgewater in December of 2014.

2. Plaintiffs allege that they were secluded and restrained in violation of their constitutionally protected liberty interests in violation of 42 U.S.C. § 1983, which includes the right to be free from undue restraints and unsafe treatment, and in violation of Mass. Gen. Laws c. 123, § 21 (the Massachusetts "Seclusion and Restraint Law.") Plaintiffs allege, inter alia, that the Plaintiffs were subjected to prolonged and unnecessary restraints in non-emergency situations and subjected to harsh conditions of confinement while in seclusion and restraint, including the denial of exercise, the complete denial of any sensory stimulation, restricted visits from their family and other deprivations. Indeed, over a thirteen month period starting in January 2013, the Plaintiff Minich, a 32 year old man suffering from schizophrenia, was placed into seclusion or restraint for more than 7,200 hours. This rate of seclusion and restraint was more than 1,000 times the national average for psychiatric facilities in 2013. Starting in April 2013, the Plaintiff Zomosa was subjected to seclusion and restraint for more than 500 times the national average.

3. Massachusetts has adopted stringent requirements for the use of seclusion and restraint on individuals with mental illness, in recognition of the serious risks of harm to mentally ill individuals posed by the misuse of seclusion and restraint. In order to prevent prolonged and unnecessary restraint, the Massachusetts Seclusion and Restraint Law establishes both standards for the imposition of restraint and seclusion (emergencies including extreme violence, attempted suicide or personal injury) as well as a check list of procedures that involve, as more fully described herein, review of restraints and seclusion requiring the

personal involvement of both Defendants, designed to ensure that patients are only secluded or restrained when permitted by The Restraint Law Under the Restraint Law, the Defendants Spencer and Murphy had the "responsibility and liability" to ensure that the Restraint Law was properly implemented at Bridgewater.

4. Specifically, Defendant Spencer as the former Commissioner of the Department of Correction was required by the twelfth paragraph of Mass. Gen. Laws c. 123, § 21 to review and sign copies of all restraint forms relating to Plaintiffs within 30 days. He refused to do so in violation of the clear language of the Restraint Law.[1] Had he done so, he would have determined that the three (3) named plaintiffs, as well as the class members they seek to represent, were subject to "undue restraint" in non-emergency circumstances in violation of the Constitution and without compliance with the procedural requirements of the Seclusion and Restraint Law. Defendant Spencer therefore violated a non-discretionary function, clearly established and mandated by statute.

5. The Defendant Murphy, as the former Superintendent of Bridgewater, was required by the ninth paragraph of Mass. Gen. Laws c. 123, § 21 to authorize each instance of the maintenance of Plaintiffs in restraint or seclusion for more than eight (8) hours in any 24-hour period. He violated the statute and the Plaintiffs were subjected to prolonged seclusion and restraint as a result - clearly rising to the level of "undue restraint" under Youngberg v. Romeo, 457 U.S. 307 (1982) - as a result. Again, this was a non-discretionary function, clearly established and mandated by statute. The Defendant Murphy had a non-discretionary duty to assume "responsibility and liability" for the implementation of the requirements of Section 21, including the strict limitation found in the statute itself limiting restraint and seclusion to the occurrence, or serious threat of "extreme violence, personal injury of attempted suicide."

6. The Defendants Murphy and Spencer were fully aware that clearly established law provided that the Plaintiffs had a constitutionally protected liberty interest in freedom from undue restraints and that restraints at Bridgewater were being used for prolonged and unnecessary periods under extraordinarily harsh conditions, including denial of exercise and any form of sensory stimulation. They were personally aware of violations of the Restraint Law and DOC procedures, including violations that had resulted in three patient deaths between 2009 and 2013. Instead of corrective action, they attempted to cover up and delay investigations into the 2009 death. Furthermore, they simply ignored their personal review responsibilities that were mandated under the Seclusion and Restraint Law. As a result, restraint and seclusion took place at more than 100 times the national average at Bridgewater in 2013 and various parts of the Bridgewater facility had to be converted to "overflow" seclusion units to accommodate the large number of patients, including the Plaintiffs, who were being illegally secluded and restrained.

7. As a direct result of the Defendants' actions, the Plaintiffs spent long and unnecessary periods of time either locked in seclusion rooms behind a solid steel door or tied up in mechanical restraints. This isolation, sensory deprivation and inhumane treatment caused them to suffer severe psychological injuries.

8. After the Plaintiff Minich filed suit in March of 2014, the Defendants almost immediately entered into a court approved interim settlement agreement and Mr. Minich was never secluded or restrained at Bridgewater again. This fact demonstrates that his prior prolonged seclusion and restraint was unnecessary. Seclusion and restraint rates for the Plaintiffs Doe and Zomosa also decreased after they filed suit. Following the termination of the Defendant Spencer by former Governor Patrick for Spencer's misconduct related to a Bridgewater abuse investigation, as well as the resignation of the Defendant Murphy, seclusion and restraint levels declined at Bridgewater to a fraction of the levels that were present prior to the time that the initial equity complaint was filed in March of 2014.

9. This case was filed after the settlement of the equity case and after the following events:
● The issuance of a preliminary injunction involving the Plaintiff Doe against the Defendants Murphy, Spencer and The Massachusetts Partnership for Correctional Healthcare, LLC ("MPCH"), in which the court found that the Plaintiff Doe had a likelihood of success on the merits of his claim that he was illegally held in seclusion in non-emergencies;

● Findings by the State Disabled Persons Protection Commission that the Plaintiffs Minich, Zomosa, and Doe had been abused at Bridgewater by the Defendant Murphy as a result of the Defendants' practices in seclusion and restraint;

● The issuance of formal reprimands against the Defendants Spencer and Murphy for misconduct relating to investigations

into the 2009 death of a Bridgewater patient in restraints, Joshua Messier;

● Termination of the Defendant Spencer by former Governor Patrick for misconduct in an abuse investigation relating to Bridgewater;

● Three restraint related deaths since 2009 of Bridgewater patients, all suffering from the same mental health disorder as the Plaintiffs[2];

● The release of statistics from the DOC showing that seclusion and restraint were used at Bridgewater in 2013 at a rate of 100 times the national average and 100 times the rate used at Department of Mental Health facilities.

10. Stated simply, this case concerns the infliction of illegal techniques in non-emergency situations (practices that even the Defendants' expert equates to torture) against mentally ill individuals by state officials.

11. The Plaintiffs, parents, siblings, and guardians of their sons Peter Minich, ("Mr. Minich"), Felipe Zomosa ("Mr. Zomosa"), and Jeffrey Doe ("Mr. Doe"), therefore bring this action on behalf of themselves and all others similarly situated at BSH seeking compensatory and punitive damages under 42 U.S.C. § 1983, Mass. Gen. Laws. c. 123, § 21, the Americans with Disabilities Act, 42 U.S.C. § 12131-12134, and Section 504 of the Rehabilitation Act.

II. THE PARTIES

12. The Plaintiff, Joanne Minich ("Ms. Minich"), is the mother of Peter Minich. Ms. Minich was appointed Guardian of her son on November 13, 2012 by Order of the Suffolk County Probate and Family Court. At the time, Mr. Minich was confined to the Lemuel Shattuck Hospital ("LSH") in Boston, Massachusetts. Ms. Minich resides at 39 Eliot Crescent, Brookline, Massachusetts. Mr. Minich is currently a patient at the Worcester Recovery Center, 309 Belmont Street, Worcester, Massachusetts where he is involuntarily committed.

13. Felipe Zomosa brings this action on his own behalf. While Mr. Zomosa was a patient at the Worcester Recovery Center when the Amended Complaint was filed, as of the date of filing of this Second Amended Complaint, Mr. Zomosa is again involuntarily committed to Bridgewater.

14. The Plaintiffs Jeff and Judy Doe ("the Does") are the mother and father of Jeffrey Doe ("Mr. Doe"), respectively. The Does were appointed Guardians of their son by Order of the Norfolk County Probate and Family Court. Mr. Doe is currently a patient at the Worcester Recovery Center, 309 Belmont St., Worcester, Massachusetts, where he is involuntarily committed.

15. Defendant Luis S. Spencer ("Spencer") is the former Commissioner of Correction for the Commonwealth of Massachusetts and was responsible for the administration of Bridgewater State Hospital at all relevant times. Defendant Spencer held this position between 2012 and 2014, including the time periods that the Plaintiffs were involuntarily committed to Bridgewater. His business address was 50 Maple Street, Suite 3, Milford, Massachusetts.

16. Defendant Robert Murphy ("Murphy" or "Superintendent") is the former Superintendent of Bridgewater State Hospital and was responsible for the day to day administration of correctional services at Bridgewater at all relevant times. Defendant Murphy held this position between 2012 and 2014, including the time periods that the Plaintiffs were involuntarily committed to Bridgewater. His business address was 10 Administration Road, Bridgewater, Massachusetts.

17. Defendant Massachusetts Department of Correction ("DOC") is an agency of the Commonwealth, charged with the care and custody of state prisoners and involuntarily committed patients as Bridgewater. The DOC is responsible for ensuring the safety of its prisoners and involuntarily committed patients in its care, and following adequate procedures for responding to emergencies, including the Restraint Law. The DOC is also responsible for ensuring that adequate health services, including mental health care, are provided to the individuals in its custody. Its address is 50 Maple Street, Suite 3, Milford, MA 01757.

18. The Commonwealth of Massachusetts is also named as a Defendant in this action.

III. JURISDICTION AND VENUE

19. Jurisdiction is conferred upon this Court pursuant to the provisions of Mass. Gen. Laws c. 212, § 4 and c. 214, § 1. Venue in Suffolk County is proper pursuant to Mass. Gen. Laws c. 223, § 1.

IV. STATEMENT OF FACTS

A. Bridgewater State Hospital and the Use of Restraint and Seclusion

20. Bridgewater has a long history of placing mentally ill patients into illegal seclusion and restraint, and illegally using seclusion and restraint as punishment and discipline for severely mentally ill patients. On July 17, 1987, two Bridgewater patients, not serving criminal sentences, filed a Complaint in the Suffolk Superior Court seeking to enjoin illegal seclusion and restraint practices at Bridgewater. O'Sullivan v. Secretary of Human Services, 402 Mass. 190 (1988). After a hearing, the Superior Court entered an order on September 17, 1987, finding that the Defendants' illegal practices created a risk of irreparable harm and issued a preliminary injunction against the Secretary of Health and Human Services, the Commissioner of Correction and the Superintendent, enjoining them from the following:

> (1) restraining a patient except in cases of emergency, as defined in G. L. c. 123, Section 21, third par.; (2) failing to provide constant observation and continuous physical presence, by a specially trained person, for patients in mechanical restraint; and (3) failing adequately to document (in compliance with statutory specifications) the reasons for initiating or continuing any form of restraint.

The Court also enjoined the Defendants from:

> Failing to provide adequate monitoring of a person in that form of restraint which is confinement in a place of seclusion without mechanical restraint, by a person in attendance specially trained to understand, assist and afford therapy to the person in such seclusion. For purposes of this preliminary injunction, the specially trained person may be situated immediately [outside] the room in which the person is secluded without mechanical restraint; in that event, however, if so located, the specially trained person (1) shall be in attendance at a location at all times in full view of the secluded person, and (2) shall be able at all times to observe the secluded person.

See O'Sullivan, 402 Mass. at 192, note 4.

21. On appeal, the Supreme Judicial Court affirmed the injunction. Id. After the issuance of the Superior Court's preliminary injunction (but prior the decision of the Supreme Judicial Court), the O'Sullivan parties entered into an Interim Settlement Agreement ("the Agreement").

22. The first part of the Agreement addressed interim measures for seclusion and restraint since, at the time of the Agreement,

the Superior Court had stayed its order requiring constant observation of patients in seclusion and the Supreme Judicial Court had not yet issued its decision in the O'Sullivan case. The second part of the Agreement concerned the transfer of civilly committed patients directly from the DMH to Bridgewater, which was then a common practice. That part of the Agreement noted that the Commissioner of Mental Health had developed a plan to cease transfer of mentally ill persons to Bridgewater "who have neither a criminal charge pending against them, nor are serving a criminal sentence, nor are awaiting sentencing, except for persons found not guilty by reason of mental illness or mental defect."

23. Under Part E of the Agreement, the Parties specifically agreed that the requirements of the Preliminary Injunction, including that part of the injunction which enjoined the Defendant Commissioner and Superintendent from restraining patients except in emergencies as provided by the third paragraph of the Seclusion and Restraint Law, "shall remain in full force and effect, unless modified or vacated upon proper motion." The O'Sullivan agreement and the underlying preliminary injunction have never been modified or vacated.

24. The Commonwealth of Massachusetts has treated the Agreement as binding and the Agreement is referenced by name in current Department of Correction regulations on seclusion and restraint in effect for Bridgewater. 103 BSH 651.02. Bridgewater's policy on seclusion and restraint is "developed consistent with the requirements" of both the Seclusion and Restraint Law and the O'Sullivan Agreement.

25. As set forth above in Paragraph 3 of the Second Amended Complaint, the Seclusion and Restraint Law imposed strict limitations on the use of restraint at the time that the Plaintiffs were involuntarily committed to Bridgewater. These restrictions were based on the General Court's determination that the use of restraint and seclusion, if misused, had the potential to cause great psychological and physical harm to patients.

26. In addition to the provisions limiting the use of seclusion and restraint to emergencies such as "extreme violence, attempted suicide or personal injury," the Seclusion and Restraint Law mandated that various procedures and reviews take place in order that Bridgewater patients would not suffer psychological or physical harm as a result of improper restraint or seclusion. Violation of these procedures would constitute a violation of the Plaintiffs liberty interests and their right to be free from "undue restraint" under the federal constitution and Massachusetts Declaration of Rights.

27. Many of the protections in the Seclusion and Restraint Law required the personal involvement of the Defendants. Most importantly, under Section 21 of the Restraint Law, the Defendant Murphy "had the responsibility and liability" for implementing all of the provisions of the Restraint Law at Bridgewater. As the Commissioner of Corrections, Spencer had the same oversight responsibilities. Those protections included the following:
a. That Bridgewater patients could only be secluded or restrained in emergencies such as "extreme violence, attempted suicide or personal injury;"

b. That only physicians, as opposed to nurses or other clinicians, could authorize restraint or restraint lasting more than six hours;

c. That the Defendant Murphy had to authorize any restraint lasting longer than eight hours in a twenty four period if he was physically present at the Bridgewater, and to review the restraint upon his return if he was absent;

d. That patients held in seclusion and restraint for more than six hours could have such restraint and seclusion continued only upon orders of a physician "upon personal examination;" and,

e. That all "restraint forms," as well as attachments to the restraint forms (setting for the duration of restraint and the reasons for the restraint), had to be reviewed and signed by the Defendant Spencer within thirty days.

28. At the time of the Plaintiffs' involuntary commitment to Bridgewater, Bridgewater had adopted regulations regarding the use of seclusion and restraint. The Defendants were aware of these regulations and had the duty to ensure that they were followed. Those regulations included, inter alia, the following:
a. That seclusion and restraint may not be used for discipline or punishment. 103 651.02 (M);

b. That Bridgewater "strive[s] to eliminate the use of seclusion and restraint in a manner that is consistent with the mission of this institution and its commitment to provide a safe environment to its patients, staff and visitors." 103 BSH 651.02;

c. That "BSH is also committed to using seclusion and restraint only when there is an imminent risk of a patient physically harming himself or others." 103 BSH 651.02;

d. That seclusion and restraint may only be used in cases of emergency when non-physical intervention would not be effective. 103 BSH 651.02;

e. That seclusion and restraint shall be discontinued as soon as possible and seclusion and restraint "shall" be discontinued as soon as clinically indicated "when it is determined that the emergency that led to the use of seclusion or restraint has been resolved and that that release shall be based on individualized behavioral criteria." 103 BSH 651.02 and 651.10; and,

f. That "Preliminary Interventions," such as de-escalation techniques "must be taken" before a patient is restrained or secluded. 103 BSH 651.03.

29. In addition, the Defendants were aware that the Plaintiffs and other Bridgewater patients had the constitutional right to other protections to minimize the harsh affects of prolonged seclusion and restraint. Those protections included the right to reasonable exercise, the right to adequate food, hygiene and clothing, the right to minimally adequate treatment, the right to safe conditions of confinement and the right to reasonable visitation from family members.

30. Despite the clear language of the Seclusion and Restraint Law, the O'Sullivan settlement Agreement and Injunction, Bridgewater's own regulations and the requirements of the federal and state constitutions, the Plaintiffs were subjected to illegal seclusion and restraint for punitive and disciplinary purposes and were placed into seclusion for prolonged periods of time in non-emergency situations. They were also denied other rights, including the rights referred to in Paragraph 28.

31. These illegal seclusion and restraint practices were not unique to the individually named Plaintiffs and were clearly part of a common scheme and practice. In 2013, Bridgewater patients (numbering between 300 and 350) were secluded for more than 148,000 total hours, more than 400 hours per patient. The comparable hours for approximately 625 patients at five (5) Department of Mental Health ("DMH") facilities was 2,600, or just over 4 hours per patient. Bridgewater patients were therefore secluded and restrained by the Defendants at more than 100 times the rate of patients in DMH facilities and more than 100 times the rate of other psychiatric hospitals in the United States. Between 2004 and 2013, total hours of seclusion and restraint for Bridgewater rose sixteen percent, from 1,215 hours per 1,000 patient days in 2004 to 1,410 hours per 1,000 patient days in 2013.

32. The decision to initiate seclusion or restraint of patients at Bridgewater, including its use with the Plaintiffs, was typically made by correctional officers as a punitive measure and was often accompanied by excessive use of force by correctional officers. Plaintiff Doe, for example, was so tightly restrained that he suffered bruises around his ankles and wrists.

33. Bridgewater has long maintained an "Intensive Treatment Unit" ("ITU") as a separate unit for patients who are forced to endure seclusion and restraint. The ITU has 13 cells with solid steel doors, a window for observation, and a slot for meal delivery on the door of each cell. The design of the ITU is to keep the patient in total isolation; contact with others is limited and usually takes place through the small slot in the door.

34. At all relevant times, patients confined to seclusion in the ITU, including the Plaintiffs, were purposefully deprived of virtually all sensory stimulation. Until the Plaintiffs retained counsel, culminating in a preliminary injunction in the case of Mr. Doe and an eventual class action settlement in the equity action, ITU patients such as the Plaintiffs were deprived of any exercise, adequate clean clothes, adequate showers and hygiene, and reasonable access to visitors and telephone calls. Patients, including Mr. Minich (who is a high school graduate and enjoyed books and art), were routinely denied reading materials even in the face of weeks of seclusion and therefore had nothing to do but stare at the walls, confined to their cells for 24 hours a day. Indeed, the conditions in seclusion and restraint at Bridgewater were more austere and harsh than those

typically found in Special Housing Units in Supermax Prisons. Upon information and belief, Bridgewater used seclusion and restraint during 2012-2014 more than any other psychiatric hospital in the United States.

B. Personal Involvement Of The Defendants In The Deprivation Of The Plaintiffs' Constitutional Rights

35. The Defendant Murphy was personally involved in the deprivation of the Plaintiffs' constitutionally protected liberty interests and freedom from undue restraints in the following ways:
a. As Superintendent of Bridgewater, he had the "responsibility and liability" to ensuring that the protections of the Seclusion and Restraint Law (para. 13), the provisions of the Bridgewater Restraint Regulations and the clearly established requirements of the federal and state constitutions were followed;

b. Murphy was the sole person who could authorize any restraint or seclusion lasting longer than eight (8) hours in a twenty-four hour period if he was physically present at the Bridgewater, and to review the restraint upon his return if he was absent; yet, he never followed this requirement with respect to the restraints and seclusion of the Plaintiffs and other Bridgewater patients;

c. He knew that Bridgewater patients, including the Plaintiffs, were being confined to prolonged seclusion and restraint in situations which did not involve an imminent emergency, yet he failed to exercise his responsibility to stop such illegal and unconstitutional practices;

d. He knew that Bridgewater patients, including the Plaintiffs, were being held in seclusion and restraint for prolonged and unnecessary periods of time (sometimes in excess of 60 days of seclusion or restraints of more than 50 hours) when they were calm, sleeping during daytime hours and compliant and when no emergency requiring their confinement existed, but he failed to exercise his responsibility to stop such illegal practices;

e. He knew that the Seclusion and Restraint Law required that patients held in seclusion and restraint for more than six (6) hours could have such restraint and seclusion continued only upon orders of a physician "upon personal examination," while at the same time being aware that nurses routinely ordered the continuation of seclusion or restraint after six hours in violation of the Seclusion & Restraint Law, including with respect to seclusion and restraint in excess of six hours of the Plaintiffs; yet, he failed to exercise his responsibility to stop such practices.

f. He knew that when physicians did renew seclusion or restraint orders for periods of time when patients, including the Plaintiffs, were in seclusion or restraint for periods of time in excess of six (6) hours, such renewal orders were often given when the physician was "unable to assess" the patient for continued seclusion or restraint. Despite his knowledge of this practice, he failed to exercise his responsibility to stop it;

g. He knew that patients at Bridgewater, including the Plaintiffs, were held in seclusion for prolonged periods of time, including for more than a week or month, without any opportunity for regular exercise or out of cell time, yet he failed to exercise his responsibility to order regular exercise;

h. He knew that patients at Bridgewater, including the Plaintiffs, were confined to seclusion rooms without reading material, television, radio or any other form of sensory stimulation and that such complete sensory deprivation was unnecessary and harmful to them, yet he failed to exercise his responsibility to stop such practices;

i. He was aware that the Seclusion and Restraint Law and Bridgewater regulations required that seclusion and restraint be used as an intervention of the last resort and that under Bridgewater regulations, other techniques, such as de-escalation, had to be attempted before seclusion or restraint was used, yet he knew that such mandatory techniques were not used with Bridgewater patients, including the Plaintiffs, resulting in unnecessary and unlawful seclusion and restraint. He failed to exercise his responsibility to order the use of techniques such as de-escalation as an alternative (and, indeed, a pre-requisite) to seclusion and restraint, as required by the Bridgewater regulations;

j. He was aware that Bridgewater patients, including the Plaintiffs, could be placed on "STS" status, which meant that they could be either confined in a locked room with a solid steel door or a locked door on the Max I or Max II units and that the such isolation would not be considered "seclusion" (despite the definition in Mass. Gen. Laws c. 123, § 21) and could be imposed in non-emergencies and for administrative convenience. Despite this knowledge, he failed to exercise his responsibility to stop this practice;

k. He knew that most instances of seclusion and restraint were usually initiated by correction officers, who would bring a patient to the ITU to obtain a physician's or nurse's order for seclusion or restraint. He knew that Bridgewater correction officers had received inadequate training in mental health and seclusion and restraint and that, because of such inadequate training, patients, including the Plaintiffs, were being placed unnecessarily in harsh conditions of seclusion and restraint for prolonged periods of time. Despite this knowledge, he did nothing to increase training of correction officers until the Norfolk equity action was filed;

1. He knew that there was a history of abuse with respect to Bridgewater seclusion and restraint practices, that seclusion and restraint had been used as a punishment, that three patients since 2009 had died as a result of illegal restraint or seclusion and that the Plaintiffs were therefore exposed to a high likelihood that they would be unlawfully secluded or restraint for punitive purposes, as they were. Despite his knowledge, he did nothing to prevent such abuse and, in fact, was reprimanded by former for Governor Patrick in connection with the Messier death;

m. He knew that, notwithstanding the language of the Seclusion and Restraint Law, Bridgewater patients, including the Plaintiffs, were regularly placed in restraints such as shackles, handcuffs and leg and waist restraints automatically and in non-emergency situations, such as when they were being taken from one unit to another, when they were taken for visits with their families and when they were taken for medical examinations or when they had been confined to the ITU and had to shower. Despite his knowledge that such practices constituted "restraint," he failed to exercise his responsibility to ensure that they took place only in compliance with the Seclusion and Restraint Law;

n. He was aware that when the Plaintiffs were subjected to mechanical restraints, sometimes for periods in excess of 20 hours, they would not be allowed to be toileted in a sanitary fashion, but would be forced unnecessarily to defecate into a bedpan, and then have only one hand released to wipe themselves and that the Plaintiffs would not be permitted to wash this hand and have to use it to feed themselves at mealtime. Despite his responsibility to stop this inhumane practice, he permitted it to continue; and,

o. He had the authority to approve visitation of the Plaintiffs by their relatives during the time that the Plaintiffs were placed in seclusion and restraint. He arbitrarily denied visitation of the Plaintiffs' families at times, and, when visitation was permitted, he allowed such visitation only at the ITU and under circumstances where the Plaintiffs were locked up in a small cell on the ITU, sometimes with their arms and legs shackled, their personal hygiene completely neglected and wearing nothing but a so-called suicide smock.

36. The personal involvement of the Defendant Murphy in the above practices, individually and in the aggregate, caused the Plaintiffs, civilly committed patients who were entitled to care and treatment, to be subjected to prolonged, unnecessary and illegal seclusion and restraint, under conditions that were harsher than those found in Supermax prisons.

37. After the Defendant Murphy's retirement, seclusion and restraint at Bridgewater fell to a fraction of the rate that they had been used under his tenure as Superintendent.

38. As a direct and proximate cause of the Defendant Murphy's actions and inactions, the Plaintiffs suffered substantial psychological as well as physical harm.

39. The Defendant Spencer was the Commissioner of Correction during the time that the Plaintiffs were involuntarily committed to Bridgewater between 2012-2014. As Commissioner, he had the responsibility, in addition to the Defendant Murphy, to ensure that Bridgewater complied with the Restraint Law. Prior to his appointment as Commissioner, he was a senior administrator with the DOC, and his responsibilities included supervision of Bridgewater.

40. The Defendant Spencer was aware that three patients had recently died in restraint related deaths at Bridgewater and that the death of the patient Messier had involved a violation of the Seclusion and Restraint Law and DOC regulations. Despite his knowledge, he attempted to cover up the Messier investigation and was reprimanded by Governor Patrick. He was later terminated by the Governor in the summer of 2014 for delaying action in reviewing a report documenting abuse and physical assault of a patient by a correction officer in a restraint cell. The officer was subsequently charged with assault by the State Police.

41. When the Defendant Spencer became Commissioner of Correction, he would receive quarterly reports of restraint and seclusion at Bridgewater, documenting that restraint and seclusion was used at a rate 100 times higher than national averages. Indeed, the reports revealed that Bridgewater patients received an average of approximately 500 hours of restraint or seclusion in a year.

42. The Defendant Spencer was fully aware that restraint and seclusion was being used improperly for prolonged periods of time at Bridgewater and in non-emergency situations, in direct violation of the Seclusion and Restraint Law, the Bridgewater Restraint regulations and the state and federal constitutions. He was also aware that restraint and seclusion were being used in an abusive fashion and for punishment and discipline.

43. The Defendant Spencer was also aware of the harsh conditions imposed when patients such as the Plaintiffs were subjected to seclusion and restraint, including the denial of exercise and the lack of any form of sensory stimulation.

44. As Commissioner of Correction, the Defendant Spencer had the authority to stop the unconstitutional practices described herein, yet he failed to do so.

45. As set forth above, the Seclusion and Restraint Law mandated that the Defendant Spencer review and sign all restraint forms and attachments of Bridgewater patients within thirty days. The purpose of the review and signature requirement was to ensure that patients at Bridgewater not be subjected to improper restraint or seclusion and that these interventions were personally reviewed at the highest level within the DOC. The statute is clear that the Defendant Spencer could not delegate this responsibility to subordinates or "designees."

46. Despite the clear language of the Restraint Law, the Defendant Spencer simply refused to review and sign Bridgewater restraint forms in a transparent attempt to distance himself on paper from the illegal seclusion and restraint practices that he knew were occurring at Bridgewater during the time that the Plaintiffs were involuntarily committed there.

47. Had the Defendant Spencer properly exercised his obligation to review and sign all restraint forms and attachments, he would have realized (or been forced to do something about the fact) that the Plaintiffs were being subjected to prolonged, unnecessary and illegal seclusion and restraint in violation of the procedural protections in the statute. For example, he would have realized that the Plaintiff Minich was spending more than 75 percent of his time locked up in seclusion and restraint.

48. Indeed, had the Defendant Spencer properly exercised his obligation to review and sign all restraint forms and attachments, given the high rate of seclusion and restraint at Bridgewater, the Defendant Spencer would have had to review and sign almost 50,000 restraint forms in 2013 alone (pursuant to the Seclusion and Restraint Law and Bridgewater regulations, restraint has to be reauthorized every three hours). He would have seen that the Defendant Murphy had never authorized restraint or seclusion for more than 8 hours in a 24 hour period despite the fact that the Defendant Murphy was the sole person under the statute who could authorize continued restraint or seclusion under these circumstances if he was physically present at Bridgewater. He would have seen that, in violation of the Restraint Law, nurses instead of physicians, were authorizing seclusion and restraints beyond six (6) hours.

49. The personal involvement of the Defendant Spencer in the above practices, individually and in the aggregate, caused the Plaintiffs, civilly committed patients who were entitled to care and treatment, to be subjected to prolonged, unnecessary and illegal seclusion and restraint, under conditions that were harsher than those found in Supermax prisons.

50. After the Defendant Spencer's termination, seclusion and restraint at Bridgewater fell to a fraction of the rate that they

had been used under his tenure as Commissioner.

51. The Defendants in this case understood that prolonged seclusion and restraint were extraordinary interventions, posed a high risk of psychological and physical harm to severely mentally ill persons such as the Plaintiffs, and could only be used in full compliance with the law and under circumstances where an emergency existed that could not be addressed with alternative interventions, such as de-escalation.

52. The Defendants understood the risk of severe harm to the Plaintiffs posed by their prolonged seclusions and restraints. The Defendants knew that the Plaintiffs suffered from schizophrenia, a severe biologically based mental illness. With respect to prisoners (as civilly committed mental patients with no criminal record, Plaintiffs enjoyed considerably greater rights), courts and professional associations have long recognized that placing seriously mentally ill prisoners into prolonged isolation places them at particularly high risk for suffering severe injury to their mental health and, as one court put it, can be "the mental equivalent of putting an asthmatic in a place with little air to breathe." The United States District Court in Arizona noted in 1993 that the plaintiffs' and defendants' experts had concurred it was inappropriate to house acutely psychotic inmates in isolation for more than three days. The American Psychiatric Association's Position Statement on Segregation of Prisoners with Mental Illness (2012) states that "[p]rolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential harm to such inmates." The Defendants were charged with knowledge of and responsibility for the deleterious consequences of prolonged seclusion and restraint being illegally used on the Plaintiffs at Bridgewater. As a direct and proximate cause of the Defendant Spencer's actions and inactions, the Plaintiffs suffered substantial psychological as well as physical harm.

C. Prior Proceedings Involving the Plaintiffs and Bridgewater

53. On March 31, 2014, Mr. Minich, through his mother and guardian, filed suit in Norfolk County Superior Court (Civil Action No. 2014-00448) against the Defendants Spencer, Murphy, MPCH, as well as DOC and the Commonwealth of Massachusetts, asserting, inter alia, that he was being held illegally in seclusion and restraint in violation of his federal and state constitutional rights and denied adequate medical and mental health treatment. Shortly after the filing of the Complaint, the parties entered into an agreed Interim Settlement, under which Mr. Minich's prolonged periods of seclusion ended and he was transferred to the Infirmary Unit where he was, from that moment on, never placed in seclusion and restraint again. On June 26, 2014, he was discharged from Bridgewater and transferred to a DMH facility, Worcester Recovery Center ("WRC").

54. On May 5, 2014, Mr. Minich, Mr. Doe, and Mr. Zomosa, through their guardians and best friends, filed an amended class action complaint seeking injunctive relief in asserting claims that 175 patients at Bridgewater, suffering from severe mental illness and not serving criminal sentences, were being unconstitutionally secluded and restrained and denied adequate medical and mental health care.

55. Immediately after the filing of the complaint, Mr. Zomosa's seclusion and restraint decreased dramatically. He was discharged from Bridgewater on May 29, 2014, and transferred to WRC. Unfortunately, he was recommitted to Bridgewater on August 31, 2015, where he remains to this day.

56. On May 15, 2014, the Plaintiff Doe and his guardians filed a request for preliminary injunction in the class action complaint, alleging that he had been secluded in violation of his statutory and constitutional rights. On July 2, 2014, Judge Paul Wilson, Associate Justice of the Superior Court, issued a preliminary injunction enjoining the Defendants from secluding or restraining him in violation of the Seclusion and Restraint Law, finding that Mr. Doe had a likelihood of the success on the merits of his claims that he was secluded in violation of the Restraint Law. Mr. Doe was discharged from Bridgewater on October 15, 2014.

57. On June 18, 2014, Governor Deval Patrick released a plan to reform Bridgewater, which called for the construction of a new DMH facility to house severely mentally ill patients such as the three Plaintiffs. In the short term, the plan called for an additional 130 full-time mental health clinicians at Bridgewater, which would double the number of clinical staff proposed by MPCH in its bid (pursuant to a staffing matrix set by the Department of Correction in requesting proposals), to be funded by

a supplemental appropriation. The plan specifically cited the extent of seclusion and restraint at Bridgewater. The Legislature has only added seventeen new positions as of the date of the filing of this Complaint.

58. On July 11, 2014, the Disability Law Center ("DLC"), the federal designated protection and advocacy organization under the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801 et seq., for Bridgewater, released the results of an investigation into seclusion and restraint practices at Bridgewater. The report concluded that the use of seclusion and restraint did not comply with the law, that its use was not limited to emergencies where there was a likelihood of serious imminent harm, and that even in those instances where it had been used properly initially, it had been continued far beyond the time when a patient poses a likelihood of imminent harm. The DLC also found that, in contravention of clear Bridgewater regulations at 103 BSH 651.02 (M), seclusion and restraint were being used as discipline and punishment. "The frequent and excessive use of restraint is an indicator that a patient's treatment plan is inappropriate or inadequate and that staff are using restrictive practices to replace active treatment." Report at 7. All of the illegal seclusion and restraint practices found by the DLC occurred with the Plaintiffs. The DLC report is attached hereto as Exhibit "B" and its findings and conclusions are incorporated into this Complaint as if set forth in full herein.

59. On December 15, 2014, the parties entered into a Settlement Agreement in the injunctive relief class action case under which the Defendants agreed to reform seclusion and restraint practices at Bridgewater. The Agreement also provided, inter alia, for a comprehensive reform of Bridgewater seclusion and restraint practices, approval of the Agreement by Judge Wilson, a Court Monitor, class certification for all patients at Bridgewater, including those serving criminal sentences, and appointment of the undersigned as Class Counsel. On March 3, 2015, Judge Wilson gave final approval to the Settlement Agreement.

60. On July 27, 2015, after the Court permitted Plaintiffs' request for leave to so file, the Plaintiffs filed their Amended Complaint in order to a) include more specific allegations with respect to the Commonwealth Defendants' liability in this matter; and, b) to add additional causes of action against the defendants under Title II of the American with Disabilities Act ("ADA").

61. On September 14, 2015, the Defendants moved to dismiss the Plaintiff's claims on various grounds, including an argument that the Seclusion and Restraint Law did not provide for a private right of action for the Defendants' violations of the same.

62. Following extensive briefing and oral argument, on May 12, 2016, this Court issued its Memorandum & Order on Defendants' Motion to Dismiss. Among its many denials of the Defendants' various arguments for dismissal of Plaintiffs' Amended Complaint, with respect to Mass. Gen. Laws c. 123, § 21, the Court stated in no uncertain terms that "[the Court] therefore conclude[s] that the Legislature intended that G.L. c. 123, § 21 would create a private right of action."[3]

D. Peter Minich

63. Mr. Minich is a 32 year old mentally ill man suffering from paranoid schizophrenia who was confined to Bridgewater from January 14, 2013 to June 26, 2014. He was initially transferred to Bridgewater for evaluations of his competence to stand trial and criminal responsibility on then-pending charges pursuant to the provisions of Mass. Gen. Laws c. 123, § 15(b). Mr. Minich was found to be incompetent to stand trial on March 20, 2013, and was civilly committed to Bridgewater pursuant to the provisions of Mass. Gen. Laws c. 123, § 16(b), which commitment was for "care and treatment."

64. Mr. Minich has never been convicted of a crime and, until the charges in December 2013, had never been charged with a crime.

65. Mr. Minich was born on XX/XX/1983, to Jan and Joanne Minich. He has an older sister who resides in California with her husband and three children. As a child, Mr. Minich showed great interest in art and athletics. In 2001, Mr. Minich graduated from Wellesley High School.

66. In August of 2003, Mr. Minich was admitted to McLean Hospital with the paranoid ideation that "people were out to get [him]." Mr. Minich was diagnosed with Schizophrenia, Paranoid Type and Polysubstance dependence, in remission. Mr. Minich was subsequently in and out of hospitals.

67. Mr. Minich left McLean after his last admission when his private insurance coverage ended on or about September of 2011. He was transferred to the Lemuel Shattuck Hospital ("LSH") in Boston on September 29, 2011, a facility administered by the Massachusetts Department of Health ("DMH"). At the time of his departure from McLean his diagnosis was Chronic Schizophrenia.

68. On or about December 7, 2012, two LSH staff members contacted law enforcement to report assaultive behavior and requested that charges be brought against Mr. Minich. These staff members were aware of Mr. Minich's mental illness and that he could not be held criminally responsible for his alleged "crimes" based on his severe mental illness.

69. Mr. Minich had no history of assaultive behavior towards others prior to his discharge from McLean and his entry into the Commonwealth of Massachusetts mental health system.[4]

70. On January 14, 2013, the West Roxbury District Court ordered Mr. Minich be transferred to Bridgewater for evaluations of his competence to stand trial and criminal responsibility on the pending charges pursuant to the provisions of Mass. Gen. Laws c. 123, § 15(b). Mr. Minich was found to be incompetent to stand trial on March 20, 2013 by the Brockton District Court. He was sent back to Bridgewater.

71. During his time at Bridgewater, Mr. Minich spent over 6,600 hours in seclusion and over 800 hours (over 33 days in total) in restraint. The exact number of hours Mr. Minich spent in seclusion and restraint are difficult to determine, and are likely much higher than those reported by Bridgewater. Hours spent restrained in his cell are not included. In addition, the Infirmary also has overflow seclusion rooms, and it is unclear how much time Mr. Minich spent in seclusion in that unit.

72. While Mr. Minich was in mechanical restraint, his arms, legs, and sometimes his head were bound to a stationary object such as a bed. Mr. Minich's periods of restraint sometimes lasted over 24 hours. On at least one occasion Mr. Minich was restrained for approximately 41 hours and another time for approximately 34 hours. He would have to defecate into a bedpan and one arm was released for him to use toilet paper to wipe himself. That same arm would be used for Mr. Minich to feed himself while restrained.

73. These periods of seclusion and restraint were severely detrimental to Mr. Minich's mental health. The examples outlined below, taken directly from Bridgewater records, are only a handful of the many abuses of the Restraint Law, Bridgewater regulations and the federal and state constitutions. Because many of the notes and forms from Bridgewater are either completely or partially illegible, it is impossible to know some of the details of Mr. Minich's confinement to Bridgewater. What follows are examples of the legible portions of the Bridgewater records where illegal restraints and seclusion perpetrated upon Mr. Minich.

74. Immediately upon arrival at Bridgewater on January 14, 2013, Mr. Minich was strip-searched by guards, and then illegally placed in the ITU in seclusion This initial seclusion order was in violation of the Restraint Law; no emergency situation existed necessitating Mr. Minich's seclusion.

75. The following day, Mr. Minich was involuntarily medicated with a needle and placed in four-point restraints. The restraint was continued for "questionable seizure activity."

76. For the first several months of his confinement to Bridgewater, Mr. Minich was not assaultive toward others. Mr. Minich's psychotic symptoms increased markedly during his confinement to Bridgewater as a result of his prolonged seclusion. As his time in almost-constant seclusion and restraint continued, Mr. Minich began exhibiting self-destructive and sometimes assaultive behavior.

77. By early March 2013, Mr. Minich began dunking his head in the toilet of his cell, standing on his sink, and threatening to kill himself. For this behavior he was placed in either seclusion or four-point restraints. No efforts were made by DOC staff

to de-escalate these situations, as required by Bridgewater and DOC policy, or otherwise treat the symptoms of Mr. Minich's mental illness.

78. As Mr. Minich's symptoms of mental illness worsened, and as he became increasingly detrimentally affected by his treatment at Bridgewater, Bridgewater began resorting to illegal seclusion and restraint in lieu of any form of mental health treatment. These illegal periods of seclusion and restraint were not the result of the exercise of clinical or professional judgment but instead occurred because of Defendants' blatant disregard of the law.

79. On March 8, 2013, Mr. Minich informed a nurse that he was "sad about being in this place" after he made three (3) attempts in two days to drown himself. He was placed in four-point restraints. No medical treatment was rendered.

80. On March 12, 2013, Mr. Minich's seclusion was continued because a Bridgewater doctor noted that Mr. Minich, a paranoid schizophrenic, was "unable to explain his behavior." He was, in effect, punished for exhibiting symptoms of schizophrenia.

81. On June 19, 2013, Bridgewater employees (without the necessary supervision and oversight of Defendants Murphy and Spencer) developed a plan that was put in place whereby Mr. Minich would be "re-secluded per protocol" every day, regardless of his behavior or whether that there was an "emergency." That plan remained in effect for at least three months.

82. Mr. Minich spent 121 days, from May 28, 2013 to September 29, 2013, in seclusion. During this time, Mr. Minich's was secluded for incidents that occurred days or even months earlier, despite descriptions of Mr. Minich as "calm" or "in good behavioral control."

83. The continuance of Mr. Minich's seclusions were based on prior, resolved emergency situations, and during periods when Mr. Minich presented as "calm" and "in good behavioral control," was in direct contravention of both the Restraint Law and Bridgewater's own policy, which states that seclusion "shall" be discontinued "after the emergency that led to the use of seclusion and restraint has been resolved." 103 BSH 651.10. "Release of the patient from seclusion or restraint shall occur as soon as clinically indicated and shall be based on individualized behavioral criteria...." Id.

84. Between November 9, 2013 and January 9, 2014, some 60 days, Mr. Minich was held in a seclusion room at the ITU, 24 hours a day, for all but 8.5 hours. This seclusion was ordered and continued even when Mr. Minich was calm, compliant and sleeping. He was in seclusion on Thanksgiving and Christmas.

85. Mr. Minich's confinement in seclusion and restraint resulted in an effective cessation in his ability to have appropriate social interactions. He was deprived of virtually any mental stimulus and any physical activity. He was cut off from adequate communication and visits with his mother and father. As a direct result of his lack of human contact, his behaviors and social skills regressed. Bridgewater used this regression to justify more seclusion and restraint.

86. In March of 2014, Mr. Minich was observed by one unidentifiable Bridgewater employee as eating his own feces. During periods of restraint he was urinally incontinent several times, and by January 2014 he was held in seclusion for, among other behavior, drinking toilet water. On at least two occasions in January 2014 he was fecally incontinent after receiving electroconvulsive therapy (ECT). These behaviors were a direct result of his prolonged isolation and other conditions of confinement and are directly attributable to the violation of his statutory and constitutional rights.

87. Mr. Minich continued to be illegally secluded throughout February of 2014. In a nursing note dated February 20, 2014, a Bridgewater nurse noted that Mr. Minich had been secluded on February 7, 2014 for repeatedly standing on the toilet and telling staff that voices were telling him to jump from the sink (a distance of less than four vertical feet). As was the custom and practice at Bridgewater, these actions were not met with treatment or de-escalation practices, as required by DOC seclusion and restraint protocols. 103 BSH 651.03.

88. In her note of February 20, 2014, one nurse stated that Mr. Minich was "medication compliant," that "he had been quiet in his room with no voices noted," and that he "had no reported instances of standing on his toilet/sink or dunking his head." Despite these objective behavioral observations, she ordered: "Continue to seclude and monitor in ITU."

89. Again, on May 18, 2013, the same nurse continued seclusion because Mr. Minich jumped off his toilet, put his head in his toilet, and reported auditory hallucinations. Nonetheless she noted that "Pt is able to be re-directed. Pt medication and meal compliant."

90. In addition to his prolonged seclusion at Bridgewater, Mr. Minich was deprived of adequate clothing (including underwear on many occasions), food, reading and writing material, and virtually any opportunity for human contact. Such deprivation constitutes a denial to access of services and programs offered to other inmates at Bridgewater and services and programs offered to similarly mentally ill patients being treated in the DMH system.

91. Mr. Minich was deprived of any opportunity for regular exercise until he retained counsel and suit was filed in March 2014 (after over a year at Bridgewater). He went outdoors only when he was taken for ECT at Pembroke Hospital, taken to the visiting area (when he was not in seclusion), or taken to Morton Hospital after an injury. Such deprivation constitutes a denial to access of services and programs offered to other inmates at Bridgewater and services and programs offered to similarly mentally ill patients being treated in the DMH system.

92. Mr. Minich was consistently denied reading materials while in seclusion and restraint, even though he is highly intelligent and requested books to read while in isolation. Mr. Minich was punished for experiencing symptoms of his mental illness by withholding any stimulation, leaving Mr. Minich alone in an empty room. These conditions only increased his symptoms. Mr. Minich is also a talented artist and his mother informed Bridgewater of his interest. Bridgewater's website states that it has an art therapy program. Mr. Minich was never given art supplies during his prolonged isolation in seclusion. Such deprivation constitutes a denial to access of services and programs offered to other inmates at Bridgewater and services and programs offered to similarly mentally ill patients being treated in the DMH system.

93. On March 18, 2014, after over a year in Bridgewater, the Defendant Murphy offered to consider giving Mr. Minich crayons when he was in seclusion.

94. Even though he was kept in isolation for more than 75 percent of time in his first thirteen months of confinement at Bridgewater, Mr. Minich's visits from his mother and father were restricted (prior to the time he filed suit) to once a week, and telephone calls while he was in seclusion were limited to one ten minute call every two days. When he was in the ITU, visits from his parents had to be approved in advance by the Superintendent and those visits always took place when he was in a small cell on the ITU (referred to as "the Birdcage"). During many of those visits he was hand, waist, and leg shackled, and had no shoes or socks.

95. Mr. Minich frequently refused food at Bridgewater and lost 40 pounds after his admission. Such weight loss is significant given the dosages of anti-psychotic medication he received, which frequently causes patients to gain weight.

96. Mr. Minich's seclusions and restraints were frequently renewed after six (6) hours by a nurse instead of a licensed physician in violation of the Restraint Law.

97. Mr. Minich's seclusions and restraints were frequently renewed when he was calm, compliant or sleeping during daytime hours in violation of the Restraint Law

98. Mr. Minich's seclusions and restraints were frequently renewed after the nurse or physician was unable to assess him, in violation of the Restraint Law and Bridgewater restraint regulations.

99. By subjecting Mr. Minich to prolonged periods of seclusion in the ITU and excessive mechanical restraints, Bridgewater failed to provide him adequate mental health treatment that could have led to his quick release from Bridgewater and transition to a less harsh, non-correctional setting.

100. During these periods of prolonged seclusion, Defendant Murphy failed to authorize the continued seclusion and restraint of Mr. Minich after he had been in seclusion or restraint for more than eight hours in a twenty four period in violation of the of the Restraint Law, despite the fact that seclusions and restraints of this length happened routinely. Had the Defendant

Murphy properly conducted such reviews and authorizations, he should have realized that Mr. Minich was being illegally secluded and restrained for prolonged periods of time and would have ordered that the seclusion and restraint be discontinued.

101. Simultaneously, Defendant Spencer repeatedly failed to review and sign the restraint forms for Mr. Minich within thirty days of their occurrence in violation of the twelfth paragraph of the Restraint Law. Had the Defendant Spencer performed this duty properly, he should have realized that Mr. Minich was being illegally secluded and restrained for prolonged periods of time and could have ordered that the seclusion and restraint be discontinued.

102. The Defendants were responsible for ensuring that Bridgewater properly implemented the Restraint Law and that mandated procedures, designed to protect Mr. Minich from "undue restraint" were followed. Instead, the Defendants permitted Bridgewater to implement seclusion and restraint in a lawless fashion and the Defendants, in addition to failing to undertake their own individual review responsibilities under the Restraint Law, permitted and fostered systemic abuses of the law that subjected Mr. Minich to "undue restraint" in violation of his federal and state constitutional rights.

103. Mr. Minich was discharged from Bridgewater to the Worcester Recovery Center ("WRC") in June 2014. He has rarely been secluded or restrained at WRC.

104. Mr. Minich's prolonged isolation caused an exacerbation of Mr. Minich's mental illness, most particularly his paranoia and psychosis, and the development of Post-Traumatic Stress Disorder. He now suffers from substantially increased anxiety and increased delusional and paranoid processing. His ability to self-care has suffered, as has his ability to effectively communicate, along with his personal relationships with his family members, have been adversely affected.

105. In addition, a December 2014 investigation conducted by the Massachusetts Disabled Persons Protection Commission ("DPPC") substantiated allegations of abuse of Mr. Minich by the Defendant Murphy. The DPPC specifically concluded that Mr. Minich was placed in seclusion and restraint on occasion when he was not presenting threatening behavior and that the numerous periods of seclusion and restraint for extended durations were so severe that he more likely than not suffered an emotional injury as a result. The DPPC recommended the following action: (1) that the DOC institute policies and procedures that would ensure adherence to the Restraint Law and minimize the use of seclusion and restraint; (2) that the DOC institute policies and procedures that would encourage the use of nonphysical interventions with patients that do not currently present a threat to themselves or others; and (3) that DOC and medical staff be trained in the use of de-escalation techniques. Regarding Mr. Minich's medical records, the DPPC noted that the illegibility of many Bridgewater medical records rendered many records clinically useless and placed the patients at risk.

E. Felipe Zomosa

106. Mr. Zomosa is a 32 year old man with schizophrenia and bipolar disorder. He was civilly committed to Bridgewater for an initial period of six (6) months pursuant to Mass. Gen. Laws c. 123, § 15. His civil commitment was extended for the stated reason of "fixed paranoid delusions." He was originally committed to Bridgewater following an alleged assault of a psychiatrist at Bayridge Psychiatric Hospital in Lynn, Massachusetts. Criminal charges related to that alleged assault were dismissed. Mr. Zomosa has never been convicted of a crime[5].

107. Before entering Bridgewater, Mr. Zomosa graduated from Malden Catholic High School. After high school, he enlisted in the Army; however, he was soon discharged due to increasing depression and deteriorating mental status. He was diagnosed with schizophrenia. Prior to Bridgewater, Mr. Zomosa was close with his family, lived at home with his mother and father, was active with his friends, and enjoyed going to the gym and playing soccer.

108. While at Bridgewater, Mr. Zomosa was repeatedly secluded and restrained in violation of the Restraint Law and held in seclusion or restraint in non-emergency situations.

109. Over the course of his first 12 months at Bridgewater, Mr. Zomosa spent approximately 4,400 hours in seclusion out of

a total of 8,760 hours in the institution, meaning that over half of his time at Bridgewater was spent in seclusion (according to Bridgewater's calculations, he also spent over 337 hours in mechanical restraint, although some of this record is inaccurate). During this time Mr. Zomosa was locked in a room with a solid steel door, deprived of substantially all contact with others, or tied to a bed in four- or five-point restraints, with no knowledge of when his seclusion or restraint would end. Some of these periods of seclusion and restraint spanned months, with only a few scattered hours spent out among the Bridgewater population, before Mr. Zomosa was ordered back into seclusion by the nurses and doctors responsible for treating him.

110. These periods of isolation, seclusion, and restraint were severely detrimental to Mr. Zomosa's mental health. The examples outlined below are only a handful of the many abuses of the law are indicative of the overall excessive, harsh, and illegal treatment of Mr. Zomosa while at Bridgewater, conditions that were known to the Defendants.

111. As was the case with Mr. Minich's records, the exact number of hours Mr. Zomosa spent in seclusion and restraint are difficult to determine, and are likely much greater than those reported by Bridgewater. Hours spent locked or restrained in his cell were not counted in Bridgewater's calculations. In addition, the Infirmary also has overflow seclusion rooms, and it is unclear how much time Mr. Zomosa spent in seclusion at that unit.

112. A large number of the notes and forms from Bridgewater are completely or partially illegible. It is therefore impossible to know some of the details of Mr. Zomosa's confinement to Bridgewater. What follows are examples of the legible portions of the Bridgewater records where illegal restraints and seclusion perpetrated upon Mr. Zomosa.

113. Upon arrival at Bridgewater on April 24, 2013, Mr. Zomosa was instantly secluded in the ITU, despite the absence of any imminent emergency or risk to himself or others upon arrival.

114. The initial seclusion order was illegal, unwarranted, and in violation of the Restraint Law, Bridgewater procedures, was not the result of any clinical or professional judgment, and deprived Mr. Zomosa of his constitutional right to be free from bodily restraint. Mr. Zomosa continued to be held in seclusion for 12 hours upon his arrival at Bridgewater, despite any legally justifiable reason for seclusion.

115. Mr. Zomosa was later transferred to the Max-I unit. However, due to a "verbal altercation" with another patient, Mr. Zomosa was restrained and returned to the ITU on May 7, 2013. Between July 10, 2013 and August 2, 2013, Mr. Zomosa spent less than 24 hours out of seclusion.

116. Mr. Zomosa was secluded during this period for reasons including feeling "scared" and "unsafe," and stating a belief that patients were practicing witchcraft. He was in seclusion on July 15, 2013, as a "time out" because Mr. Zomosa "need[ed] to rest quietly for a while and regain composure."

117. Throughout this period, Mr. Zomosa remained in continued seclusion despite notes describing him as "calm" and "cooperative" or peacefully resting while in seclusion.

118. The continuance of these seclusions under circumstances when Mr. Zomosa presented as "calm" and "cooperative" was in direct contravention of both the Restraint Law and Bridgewater's own policy, which states that seclusion "shall" be discontinued "after the emergency that led to the use of seclusion and restraint has been resolved." 103 BSH 651 - 21. "Release of the patient from seclusion or restraint shall occur as soon as clinically indicated and shall be based on individualized behavioral criteria." Id.

119. On July 10, 2013, after requesting to use the gym facilities because he felt agitated and slamming a door, Mr. Zomosa was secluded and placed in four-point restraints. The basis for the seclusion and restraint was that Mr. Zomosa "was clearly agitated and was likely in need of seclusion." However, subsequent clinical observations indicated that Mr. Zomosa's behavior subsided, thereby reducing or eliminating any arguable "imminent emergency" and necessitating his release from seclusion. Despite these clinical observations and the lack of an identifiable emergency, Mr. Zomosa's seclusion continued.

120. On August 9, 2013, Mr. Zomosa was put into four point restraints after allegedly telling a correctional officer that "I don't know what to do, I think I am going to snap" and taking a "fighting stance." Mr. Zomosa's attempt to express his

feelings of anxiety and frustration were not met with treatment suggestions or de-escalation practices, as required by DOC seclusion and restraint protocols (103 BSH 651.03). Despite the mandatory nature of the de-escalation practices, these practices never occurred.

121. As Mr. Zomosa was continually submitted to the harsh confines of the ITU, the symptoms of his illness intensified and he further deteriorated. For instance, on July 22, 2013, after one of Mr. Zomosa's brief periods free of restraint and seclusion, he was ordered into seclusion for experiencing paranoid delusions. The order, by another Bridgewater clinician, reflects that Mr. Zomosa claimed that "a patient on the unit is practicing witchcraft it scares me" and stated: "I don't feel right." No legitimate clinical treatment options were utilized. Instead, Mr. Zomosa was ordered by at least four corrections officers to submit to being handcuffed. When he did not comply, he was physically forced to the ground by several corrections officers.

122. In August and September of 2013 Mr. Zomosa became increasingly more paranoid, which led to incidents of assaults and confrontations with staff and patients. In response to Mr. Zomosa's agitation, Bridgewater staff punitively employed seclusion and restraint instead of attempting to treat Mr. Zomosa's mental illness. He was repeatedly secluded every three to four days throughout the month and was occasionally restrained. During this time of seclusion and restraint Mr. Zomosa was described as "calm and cooperative," and a nurse recorded in a Progress Note that "no complaints or issues [were] verbalized per unit staff." Nonetheless the seclusion was continued.

123. Mr. Zomosa was placed in seclusion and/or restraints six times in August 2013 for various reasons, many of which had no discernible connection to any immediate emergency. These reasons included being emotional, anxious, lunging at a guard, believing people were following him, and assaulting or threatening to assault a patient.

124. In September 2013, Mr. Zomosa's illegal seclusions continued. Mr. Zomosa spent approximately 17 days in seclusion in September. Mr. Zomosa was sent to the ITU four times for reasons that included "being paranoid and anxious," and for threatening to "snap."

125. Mr. Zomosa was continually subjected to the Bridgewater practice and policy of illegal seclusion nearly every time he exhibited symptoms of his mental illness. Between September 30, 2013, and February 1, 2014, a period of 124 days (2,976 hours), his seclusion was initiated and ordered continued for reasons including being paranoid and delusional, being anxious, and yelling, despite many descriptions of Mr. Zomosa as "calm" and "resting."

126. After February 2014, Mr. Zomosa continued to be secluded in the absence of any imminent emergency. For instance, on February 12, 2014, he was secluded because Mr. Zomosa was "paranoid" and therefore at alleged risk of harm to himself or others. Seclusion for Mr. Zomosa was ordered on February 12, 2014, because, according to the record, Mr. Zomosa was unhappy on the unit and did not think the officers were treating him well.

127. During March and April 2014, Mr. Zomosa's seclusions continued, including one period of seclusion lasting approximately 16 days with very little time, if any, spent outside of seclusion.

128. Mr. Zomosa's seclusions and restraints were frequently renewed after six hours by a nurse instead of a licensed physician in violation of the Restraint Law.

129. Mr. Zomosa's seclusions and restraints were frequently renewed when he was calm, compliant or sleeping during daytime hours.

130. Mr. Zomosa's seclusions and restraints were frequently renewed after the nurse or physician was unable to assess him, in violation of the Restraint Law and Bridgewater Restraint regulations.

131. During these periods of prolonged seclusion, Defendant Murphy repeatedly failed to authorize the continued seclusion and restraint of Mr. Zomosa after he had been in seclusion or restraint for more than eight hours in a twenty four hour period in violation of the of the Restraint Law, despite the fact that seclusions and restraints of this length happened routinely. Had the Defendant Murphy properly conducted such review and authorizations, he should have realized that Mr. Zomosa was being illegally secluded and restrained for prolonged periods of time and could have ordered that the illegal restraints and

seclusions be discontinued.

132. Simultaneously, Defendant Spencer repeatedly failed to review and sign the restraint forms for Mr. Zomosa within thirty days of their occurrence in violation of the twelfth paragraph of the Restraint Law. Had the Defendant Spencer performed this duty properly, he should have realized that Mr. Zomosa was being illegally secluded and restrained for prolonged periods of time and could have ordered that the illegal restraint and seclusion be discontinued.

133. Mr. Zomosa alternated most of his time at Bridgewater between the ITU, where he was constantly secluded, and the Max-I "Overflow" unit. This unit contains locked door seclusion rooms where Mr. Zomosa was forced to reside in non-emergency situations for extended periods. In violation of the Restraint Law, patients confined to Max I were placed in seclusion when there was no emergency at the discretion of untrained staff. Bridgewater did not always follow the observation requirements and other requirements for patients secluded on Max I even though patients are confined behind locked doors and such confinement meets the definition of "seclusion" under the Restraint Law.

134. After he retained counsel in this case, Mr. Zomosa's prolonged isolation ceased and he was discharged to the Worcester Recovery Center on May 29, 2014.

135. The Defendants were responsible for ensuring that Bridgewater properly implemented the Restraint Law and that mandated procedures, designed to protect Mr. Zomosa from "undue restraint" were followed. Instead, the Defendants permitted Bridgewater to implement seclusion and restraint in lawless fashion and the Defendants, in addition to failing to undertake their own individual review responsibilities under the Restraint law, permitted and fostered systemic abuses of the law that subjected Mr. Zomosa to "undue restraint" in violation of his federal and state constitutional rights.

136. Mr. Zomosa deteriorated markedly during his confinement at Bridgewater. His records show a sharp increase in alleged assaultive behavior towards others - often times as a result of his clinically diagnosed paranoid delusional thinking. This deterioration was due in large part to the prolonged periods of isolation that he was subjected to. The deprivation of his freedom of movement, through seclusion and restraint, traumatized Mr. Zomosa and incited feelings of humiliation, demoralization, confusion, and social isolation. As a consequence of his abuse and mistreatment at Bridgewater, he now suffers from Post-Traumatic Stress Disorder.

137. Prior to his confinement to Bridgewater, Mr. Zomosa shared a close relationship with his family and maintained friendships outside of his family. Now he is unable even to attend group therapy, despite an expressed interest, because he is too anxious about being around people.

138. In addition, a December 2014 investigation conducted by the Massachusetts Disabled Persons Protection Commission ("DPPC") substantiated allegations of abuse of Mr. Zomosa by the Defendant Murphy. The DPPC specifically concluded that Mr. Zomosa was placed in seclusion and restraint on occasions when he was not presenting threatening behavior and that his time in seclusion contributed to the decline of his mental status, including increased paranoia, aggressive behavior, and delusions. As a result, the DPPC recommended the following action: (1) that the DOC institute policies and procedures that will ensure adherence to the Restraint Law and minimize the use of seclusion and restraint; (2) that the DOC institute policies and procedures that encourage the use of nonphysical interventions with patients that do not currently present a threat to themselves or others; and (3) that DOC and medical staff be trained in the use of de-escalation techniques. Regarding Mr. Zomosa's medical records, the DPPC noted that the illegibility of many Bridgewater medical records rendered many records clinically useless and placed the patients at risk.

139. Such deprivations suffered by Mr. Zomosa at Bridgewater constitutes a denial to access of services and programs offered to other inmates at Bridgewater and services and programs offered to similarly mentally ill patients being treated in the DMH system.

F. Jeffrey Doe

140. Mr. Doe is a 33 year old man with multiple disabilities. His diagnoses include autism, intellectual disability (previously called "mental retardation"), and schizophrenia. An MRI of his brain taken in 2007 showed volume loss bilaterally in his temporal lobes. Neuropsychological testing revealed wide-spread cognitive impairment including attention and executive functioning abilities, as well as a psychotic process superimposed on top of his existing disorders. The damage to Mr. Doe's brain affects his ability to control his impulses.

141. Despite these disorders, Mr. Doe maintained a healthy relationship with his family. Prior to his transfer to Bridgewater, his parents were able to take him home from LSH on weekends, where he enjoyed playing basketball, going to restaurants, listening to music, and watching soccer on television. He was not assaultive toward his parents or towards other people in the community, and was able to go out in public with his parents.

142. Mr. Doe was first hospitalized at LSH in 2002, a facility administered by DMH. He was hospitalized several times after that, and was in LSH from 2005 to November 2013 when he was transferred to Bridgewater.

143. Mr. Doe has never been convicted of a crime and, until November of 2013, had never been arrested or charged with a crime.

144. On or about November 21, 2013, Mr. Doe was charged with misdemeanor assault and battery on a public employee. Upon information and belief, as was the case with Mr. Minich, the filing of these charges was encouraged and approved by the administrator of LSH, even in the face of knowledge by LSH staff that Mr. Doe would be held incompetent to stand trial and that he would be transferred to Bridgewater for a forensic evaluation, whereupon he could be committed indefinitely even though the crime for which he was charged was highly unlikely to lead to incarceration, even if he were ever held to be competent. Mr. Doe was plainly incompetent to stand trial for any criminal charges. Mr. Doe was civilly committed to Bridgewater for "care and treatment."

145. During his ten (10) months at Bridgewater, Mr. Doe was repeatedly secluded in violation of the Restraint Law which, as explained above, limits seclusion to circumstances involving "emergencies" such as the occurrence or serious threat of extreme violence, attempted suicide, or personal injury.

146. During the first six (6) months of his confinement at Bridgewater Mr. Doe spent almost half of his time in seclusion, approximately 1,532 hours of time in seclusion out of a total of 3,696 hours.

147. The exact number of hours Mr. Doe spent in seclusion and restraint are difficult to determine, and are likely much larger than those reported by Bridgewater. Hours spent by Mr. Doe restrained in his cell on Max I or Max II "transitional units" are not included. In addition, the Infirmary has overflow seclusion rooms, and it is unclear how much time Mr. Doe spent in seclusion at that unit. Hours spent partially secluded in the ITU or other rooms do not appear to be recorded.

148. A large number of the notes and forms from Bridgewater are either completely or partially illegible. It is impossible, as with the other Plaintiffs, to determine many of the details of Mr. Doe's confinement while at Bridgewater.

149. As previously noted, Mr. Doe alternated his time at Bridgewater between the ITU, where he was constantly secluded, and the "MAX-I housing unit - Special Treatment Unit - TL-1" ("Max I"). This unit contains locked door seclusion rooms into which Mr. Doe was placed in non-emergency situations for extended periods of isolation. In violation of the Restraint Law, patients confined to Max I are permitted to be placed in seclusion when there is no emergency at the discretion of untrained staff. Bridgewater does not always follow the observation requirements and other requirements for patients secluded on Max I, even though patients are confined behind locked doors and such confinement meets the definition of seclusion under the Restraint law.

150. Mr. Doe was often deprived of virtually any human interaction or contact with others. When on the Max II unit, Mr. Doe was forced to stay locked inside his room while the other patients were let out of their rooms for the day. Mr. Doe was then allowed to roam the corridor alone until the other patients came back, when he would be forced back into his room.

151. Until he retained counsel and filed suit, Mr. Doe was not taken outdoors for exercise or other outdoor activity, and was

not permitted to practice coping skills or given any other training or assistance that could help calm him down, such as listening to music and playing chess.

152. Mr. Doe was held for prolonged periods of seclusion even when he was calm and compliant, and when the incident leading to the seclusion occurred days or weeks earlier. Most of Mr. Doe's seclusions were initiated by untrained correctional officers and continued for illegal punitive or disciplinary reasons.

153. These periods of isolation and seclusion were severely detrimental to Mr. Doe's mental health. The examples outlined below are only a handful of the many abuses of the law and are indicative of the overall excessive, harsh, and illegal treatment of Mr. Doe while at Bridgewater.

154. Immediately upon arrival at Bridgewater in November 28, 2013, Mr. Doe was placed in seclusion for being "recently increasingly assaultive without warning or provocation" at the previous facility. There was no indication that Mr. Doe was being assaultive upon arrival or that any imminent emergency existed at Bridgewater.

155. Throughout his time at Bridgewater, Mr. Doe was often secluded for symptoms of his disability. Because of his autism and intellectual disability, Mr. Doe was not (and is not) capable of making a "fast" verbal response. However, staff illegally resorted to seclusion when they felt Mr. Doe was not properly or timely responding to them.

156. For instance, just a few days after his arrival, Mr. Doe was placed in seclusion for giving latent responses, being difficult to understand, and placing his hands down his pants.

157. Bridgewater records described Mr. Doe as "non-verbal." He was not capable of reading or writing and could not communicate his wishes, even if he was in pain from a physical injury. He could comprehend instructions on a limited basis, but frequently took time to orally respond, and when he did, his response could be disorganized or incomprehensible.

158. On December 15, 2013, Mr. Doe was secluded for "refus[al] to talk." Throughout his involuntary commitment to Bridgewater, the very symptoms of Mr. Doe's disability were used to justify prolonging seclusion, evidencing a custom and practice at Bridgewater to punish Mr. Doe for exhibiting signs and symptoms of his mental illness.

159. Mr. Doe was often non-responsive to staff when they attempted to perform a risk assessment. To this day, Mr. Doe is frequently non-verbal and has difficulty answering questions quickly. One Bridgewater clinician even noted that Mr. Doe "doesn't understand the process [of risk assessment]." Nonetheless the inability to conduct a "risk assessment" consistently resulted in his continued seclusion, even when Mr. Doe was calm.

160. As in the case of Mr. Minich and Mr. Zomosa, many of the mandated procedures in the Restraint Law were not followed. Mr. Doe experienced periods of seclusion in excess of six hours, with at least one period lasting over a month. Renewal orders were illegally signed by Bridgewater nurses. His seclusions were frequently renewed when Bridgewater staff was unable to assess him because he was resting or sleeping. With no form of stimulation present, there was little Mr. Doe could do but rest or sleep or stare at the walls.

161. In fact, most often seclusion was continued by Defendants when Mr. Doe was described as "resting" or "sleeping." On December 13, 2013, Mr. Doe's seclusion was continued because he was "resting" and on January 1, 2014 because he was "standing, not talking."

162. Seclusion was often continued by Defendants when the risk of harm was clearly no longer present. For instance, on January 10, 2014, Bridgewater records reflect: "No complaints or issues verbalized per unit staff. No internal change in pt's conditions can be concluded at present," yet his seclusion was ordered to continue.

163. On December 23, a note reflects that Mr. Doe "denied hearing voices. He said he is doing well and does not want to harm himself or others... He has been quiet with no issues voiced or noted." Despite this clear indication of the lack of any risk of harm to himself or others, his seclusion was continued. Again on December 26, it was noted that "Patient said that he is doing well. He appears to be better than he was earlier in the week. He has been quiet with no issues voiced or noted."

Nonetheless, as was the custom and practice at Bridgewater, she illegally ordered the seclusion to continue.

164. Mr. Doe was repeatedly secluded for "spitting," a new behavior that he started to engage in while being mistreated at Bridgewater. While "spitting" is an unfortunate behavior, it falls far short of emergencies such as extreme violence, attempted suicide, or personal injury. Moreover, this new behavior, like other new behaviors that Mr. Doe started to exhibit at Bridgewater, was a direct result of the harsh conditions of his confinement and his prolonged isolation.

165. Mr. Doe's inability to understand his mental illness was often held against him. For instance, on May 26, 2014, Mr. Doe was placed in seclusion for spitting on an officer, despite describing Mr. Doe as "calm and cooperative."

166. Mr. Doe was repeatedly secluded by staff in lieu of treatment and as a form of punishment. On February 19, 2014, Bridgewater staff explicitly informed Mr. Doe that due to his past behavior he would not receive the privilege of on-unit time (out of seclusion) : "Pt was informed that due to his recent two assaults he will not receive on-unit time this week." In clear violation of the law, Mr. Doe's seclusion continued based on past behavior long after any emergency was present, as punishment for past behavior.

167. Mr. Doe requires assistance with Activities of Daily Living ("ADL"s), such as taking a shower, eating, dressing, shaving, and toileting (Mr. Doe is often incontinent). Mr. Doe required this assistance while at Bridgewater and was consistently denied such assistance.

168. Acting with conscious indifference, Bridgewater staff often failed to address even Mr. Doe's most basic needs, instead holding his inability to care for himself against him.

169. Mr. Doe was often not able to toilet and feed himself properly because of his disabilities, which resulted in the lack of hygiene in his cell and on his person. In a note dated February 27, 2014, a staff member noted that "there is a severely foul smell when the door [to Mr. Doe's room] is opened." Instead of helping Mr. Doe with his ADLs and cleaning his room, Bridgewater provided no meaningful ADL assistance for Mr. Doe and allowed him to remain in confinement in a cell that smelled of urine and feces, and in clothes covered in food. He was reportedly offered showers "at least weekly," although he required at least daily showers due to his difficulty with eating and toileting.

170. In July 2014, Bridgewater staff noted that Mr. Doe's family had to inform staff that Mr. Doe's fingernails needed to be cut and that he had open wounds on his ankles from being restrained.

171. As a result of his illegal seclusion and restraint, Mr. Doe became depressed and hopeless. He could not comprehend the demands placed on him in the prison environment, the reasons for being punished, and why guards called him "a criminal."

172. Without any form of stimulation or human contact, left alone with his thoughts, Mr. Doe's symptoms only worsened.[6] During the summer of 2014, Mr. Doe's condition continued to deteriorate as a result of the extreme conditions of his confinement, Bridgewater's use of isolation, and the inability of the facility to provide minimally adequate treatment for him.

173. The prolonged use of seclusion and restraint resulted in serious brain damage to Mr. Doe. Mr. Doe began demonstrating problematic behaviors never recorded prior to his time at Bridgewater. He became almost infantile, and was unable to feed himself, insisting that staff feed him. On at least one occasion he was found playing with his own feces. Mr. Doe began spitting, throwing food, throwing his medication, and his assaultive behavior increased.

174. Finally, in September of 2014, after the issuance of a preliminary injunction restraining the Defendants from illegally secluding and restraining him, Mr. Doe was committed to the Worcester Recovery Center. He has rarely been secluded, restrained, or held in prolonged isolation since his transfer there.

175. Unfortunately, Mr. Doe now requires 3:1 (three clinicians to one patient) supervision at most times. Where before there existed the possibility of placing Mr. Doe in a community residence program, that is now impossible. Although he is now clean, shaved, wearing clean clothes, well fed, and physically fit due to daily basketball games, Mr. Doe continues to be damaged due to the deterioration of his mental health while at Bridgewater.

176. Mr. Doe's seclusions and restraints were frequently renewed after six hours by a nurse instead of a licensed physician in violation of the Restraint Law.

177. Mr. Doe's seclusions and restraints were frequently renewed when he was calm, compliant or sleeping during daytime hours.

178. Mr. Doe's seclusions and restraints were frequently renewed after the nurse or physician was unable to assess him, in violation of the Restraint Law and Bridgewater Restraint regulations.

179. During the periods of prolonged seclusion while at Bridgewater, Defendant Murphy repeatedly failed to authorize the continued seclusion and restraint of Mr. Doe after he had been in seclusion or restraint for more than eight hours in a twenty four period in violation of the Restraint Law despite the fact that seclusions and restraints of this length happened routinely. Had the Defendant Murphy properly conducted such review and authorizations, he should have realized that Mr. Doe was being illegally secluded and restrained for prolonged periods of time and could have ordered that the illegal restraints and seclusions be discontinued.

180. Simultaneously, Defendant Spencer repeatedly failed to review and sign the restraint forms for Mr. Doe within thirty days of their occurrence in violation of the twelfth paragraph of the Restraint Law. Had the Defendant Spencer performed this duty, he should have realized that Mr. Doe was being illegally secluded and restrained for prolonged periods of time and would have ordered that the seclusion and restraint be discontinued.

181. The Defendants were responsible for ensuring that Bridgewater properly implemented the Restraint Law and that mandated procedures, designed to protect Mr. Doe from "undue restraint" were followed. Instead, the Defendants permitted Bridgewater to implement seclusion and restraint in lawless fashion and the Defendants, in addition to failing to undertake their own individual review responsibilities under the Restraint law, permitted and fostered systemic abuses of the law that subjected Mr. Doe to "undue restraint" in violation of his federal and state constitutional rights.

182. Bridgewater and its staff subjected Mr. Doe to harsh and inhumane conditions that would "shock the conscience" of a reasonable person. Mr. Doe's confinement and seclusion at Bridgewater deprived him of regular human contact, resulting in a substantial increase in his paranoia, psychotic thought process, and delusional state, and causing Mr. Doe to lose basic self-care skills and regress to an almost infant-like condition. The actions of the Defendants with respect to Mr. Doe's prolonged isolation caused an exacerbation of Mr. Doe's mental illness and caused Mr. Doe to suffer continued physical, emotional, and mental distress.

183. Immediately prior to his confinement to Bridgewater, Mr. Doe was able to enjoy time at home with his family on weekends, where he watched sports with his father, went to restaurants and other public places and played basketball with neighborhood children. He was well liked by his fellow patients. Now, as a direct result of the isolation and inhumane treatment he experienced at Bridgewater, he has not been able to leave the grounds of WRC. Even when Mr. Doe goes outside of the WRC facility (but still inside the fences) with his parents, staff must be with him at all times. He has also become isolated from other patients at the WRC and has limited social interaction.

184. In addition, a December 2014 investigation conducted by the Massachusetts Disabled Persons Protection Commission ("DPPC") substantiated allegations of abuse of Mr. Doe by the Defendant Murphy. The DPPC specifically concluded that Mr. Doe was placed in seclusion on occasions when he was not presenting threatening behavior, that his seclusion was continued when he was not exhibiting the behavioral criteria required under the Restraint Law, and that his time in seclusion contributed to the decline of his mental status. Furthermore, the DPPC concluded that the Defendant Murphy failed to review any restraint documentation with respect to Mr. Doe. Regarding Mr. Doe's medical records, the DPPC noted that the illegibility of many Bridgewater medical records rendered many records clinically useless and placed the patients at risk.

185. Such deprivations suffered by Mr. Doe at Bridgewater constitutes a denial to access of services and programs offered to other inmates at Bridgewater and services and programs offered to similarly mentally ill patients being treated in the DMH system.

G. Facts Relating to Plaintiffs' Claims Under the ADA and Section 504 of the Rehabilitation Act

186. Bridgewater is operated as a medium secure correctional facility. It has different categories of patients. Some patients, approximately 50 in number, are mentally ill prisoners that are transferred to Bridgewater because of their mental illness. Bridgewater also has patients, currently approximately 25 in number who have been found Not Guilty by Reason of Insanity. Patients in these first two categories have often committed or been charged with violent criminal offenses, including murder or rape. Bridgewater also has patients who are undergoing criminal responsibility or competency to stand trial evaluations. The current number of patients in this category is unknown.

187. The vast majority of patients at Bridgewater are severely mentally ill individuals who were initially committed to Bridgewater for competency and criminal responsibility evaluations and were subsequently found to be incompetent or not criminally responsible and are civilly committed to Bridgewater for "care or treatment" based on a finding that they require the "strict security" of Bridgewater. These patients are not serving criminal sentences and enjoy treatment rights that the federal and state constitutions have recognized are more expansive than individuals serving criminal sentences. There are between 175 and 200 patients in this category. All patients at Bridgewater are routinely referred to by Bridgewater correctional staff as "inmates" in both records and in verbal commands.

188. All of the Plaintiffs in this case were civilly committed to Bridgewater for care and treatment. Massachusetts is one of the two states in the country that permits the civil commitment of mentally ill individuals to a correctional facility. Bridgewater staff often refer to these patients as the most severely mentally ill men in the commonwealth because they require the "strict security" of Bridgewater and have therefore been deemed unsuitable for commitment to a DMH facility.[7]

189. Despite their different treatment rights and differing histories of extreme violence among categories of patients, Bridgewater makes no distinction between the civilly committed and those who have been transferred to Bridgewater while serving criminal sentences or those who have been found not guilty by reason of insanity. As a result, Bridgewater has a correctional and not a therapeutic milieu, where the emphasis is control and discipline. Seclusion and restraint decisions are usually initiated by correctional officers, who have the responsibility to maintain control and order in the facility.

190. Bridgewater correctional officers undergo the same training as correctional officers assigned to correctional facilities in the Commonwealth. Most Bridgewater correctional officers have worked at other correctional facilities. They receive little mental health training or training in techniques, such as de-escalation, that reduce the chances that a patient will have to be secluded or restrained.

191. By contrast, staff in DMH facilities receive extensive training, both initially and on-going, in mental health and, in particular, methods to avoid using seclusion and restraint. The type of prolonged seclusion and restraint that the Plaintiffs were subjected to would never occur in a DMH facility. Many staff at DMH facilities receive "trauma informed" training, which can be critical in addressing mental needs of patients with trauma histories, which many Bridgewater patients suffer from - including Plaintiff Minich.

192. The clinical staffing ratio at DMH in-patient facilities are dramatically higher from the staffing ratios at Bridgewater. In disciplines such as nursing, psychiatry, psychology, social workers, licensed mental health workers, DMH has between three to ten times the number of clinicians as Bridgewater. For 300 of the most severely mentally ill men in the Commonwealth, Bridgewater does not even have a psychiatrist on site on nights and weekends (except during one daytime shift).

193. Bridgewater lacks the most basic systems for mental health care, a further disparity between Bridgewater and DMH. Patients at Bridgewater have boilerplate treatment plans with goals and objectives that are unrealistic or irrelevant and professionally inadequate and which involve no family input. DMH has individualized treatment plans that are comprehensive and address the individual needs of each patient and which are drafted and reviewed with input from the patient's family. Bridgewater has no electronic records system unlike DMH and the progress notes of Bridgewater clinicians are frequently illegible, compromising the ability of clinicians to understand the patient's histories.

194. Every DMH patient has an individualized crisis plan designed to anticipate alternatives to seclusion and restraint if patient exhibits inappropriate or even threatening behavior. Bridgewater has highly restrictive visitation procedures which can involve waits of hours before visitors can get through Bridgewater's security "trap" and Bridgewater imposes time limitations on visits. By contrast, DMH welcomes visits from families, allowing them to bring in food for patients and to take patients outside and even off grounds when warranted. Indeed, the Plaintiff Doe's family were routinely permitted to bring him home on weekends when he was committed to a DMH facility. The Minich family frequently brought food for their son when he was committed to a DMH facility. The Plaintiff Minich and Doe both lost 40 pounds during their confinement at Bridgewater.

195. Patients at DMH facilities can participate in a full range of recreational and exercise programs which DMH encourages. By contrast, patient at Bridgewater are routinely denied any form of exercise and there was no program for exercise when the Plaintiffs spent prolonged periods of time in seclusion and restraint.

196. Patients at DMH facilities are assigned a full treatment team which includes a psychiatrist, a psychologist and a licensed professional such as a social worker to maintain contact with the family. As DMH regulations provide: "As part of the treatment of a patient in a facility, there shall be a written assessment of the needs and strengths of the individual and a written, multi-disciplinary treatment plan, which shall be developed with the maximum possible participation of the patient or the patient's legally authorized representative. 104 CMR 27.10(4). Treatment plans are also subject to periodic review, at least quarterly with notice to family. 104 CMR 27.11(1) (2).

197. By contrast, Bridgewater does not provide treatment teams and does not assign patients to a particular clinician. Treatment plans are not multi-disciplinary and not developed with the patient's or his family's input. Rather, the clinician in charge of the patient's care is the clinician who works on the particular unit where the patient is assigned. There is no person assigned to be a liaison with the family and there not even a procedure upon admission where a Bridgewater clinician will speak with a family member so that a reliable history can be obtained. Indeed, it is extraordinarily hard for a family member to reach a mental health professional at Bridgewater to inquire about his loved one, because Bridgewater is so understaffed that its staff do not have time to speak with families on a regular basis.

198. The Bridgewater physical plant, as the Commonwealth has repeatedly recognized, is completely inadequate to treat individuals with mental illness. Mentally ill individuals require space and areas where they can go to be peaceful and quiet. As a result, DMH facilities such as the Worcester Recovery Center are spacious and have specifically designated quiet rooms. Bridgewater is overcrowded and extremely noisy and presents as a prison environment, in stark contrast with the treatment milieu at the Worcester Recovery Center. When the Plaintiffs were secluded and restrained in the ITU, the noise (which frequently includes patients screaming and yelling) was overwhelming.

199. Bridgewater is also a violent facility with an environment which induces fear and terror for patients such as the three Plaintiffs. There are inadequate numbers of trained staff to monitor patients, some of whom have committed acts of extreme violence and are mixed in with profoundly ill civilly committed patients such as the Plaintiffs. Physical altercations between patients or between patients and correctional officers occur routinely, sometimes with fatal results. By contrast, rates of violence are dramatically lower at DMH facilities because of higher staffing ratios, active treatment and training on de-escalation and other techniques.

200. In addition to treatment plans, civilly committed patients at DMH facilities receive far more contact with licensed mental health professionals than Bridgewater patients. Patients at Bridgewater can receive regular therapy from skilled professionals and participate in group therapy led by such professionals. At Bridgewater, "therapy" is virtually non-existent because the staff that is responsible for patients is based on the unit to which the patient is assigned, effectively disrupting any possibly continuity of care.

201. Staff at DMH facilities have plans to focus on ways to keep patients stimulated and engaged so that they can participate in preferred activities. Bridgewater makes no attempt to develop plans so that patients can engage in preferred activities. Bridgewater has no such resources and makes no effort to engage patients with preferred activities. Art and music therapy, available at DMH facilities and which would have benefitted the Plaintiffs Doe and Minich, are non-existent at Bridgewater.

202. DMH has comprehensive regulations to minimize the use of restraint. These regulations are set forth at 104 CMR 27.12 and which are incorporated by reference in this Complaint. They include mandatory staff training on topics such as the impact of restraint or seclusion on individuals with trauma history, the harmful emotional and physical effect of seclusion and restraint on patients and staff and the use of Individual Crisis Plans ("ICPs") and mandatory annual retraining. Bridgewater's training program has none of these requirements. 104 CMR 27.12 (1)(2).

203. In addition, all DMH facilities are required to develop ICPs for all patients that identify "triggers that may signal or lead to agitation or distress of the patient and strategies to help the patient." Bridgewater has only recently (after being sued) begun to adopt a few ICPs, that are inadequate when compared to DMH plans.

204. DMH has far more significant regulatory protections for patients in the area of seclusion and restraint than Bridgewater. Those regulations are set forth at 104 CMR 27.12 (5). Seclusion is defined in far more broad fashion and includes physical intervention of staff or coercive measures, such as threat of restraint or seclusion. By contrast, Bridgewater defines restraint in a manner that is far more limited. Restraint does not include shackling a patient, (which it would under the DMH regulations -104 CMR 27.12 (5)(a)(3)) as occurred with all of the Plaintiffs, or placement on a "transitional" unit, as occurred with all of the Plaintiffs, where they can be confined to locked rooms when other patients are on the corridor or on locked corridors when other patients are in the common area.

205. Likewise, DMH regulations provide for mandatory personal dignity requirements for those subject to mechanical restraint, including access to toileting facilities by staff escort or otherwise. 104 CMR 27.12 5(c)(2). By contrast, Bridgewater patients such as the Plaintiff Minich were routinely forced to urinate or defecate into a bedpan in an unsanitary fashion while restrained.

206. Moreover, the notification and approval for continuation of seclusion or restraint is far more rigorous in the DMH regulations in recognition of the dangers posed by the practice. See 104 CMR 27.12(g).

207. As part of the oversight to ensure compliance with the law and regulations, DMH facilities have both a human rights officer and a human rights committee authorized to hear concerns or complaints of patients. 104 CMR 27.14. One of the roles of the Human Rights Officer is to inform the patients of their rights under the law and to assist them. The existence of a Human Rights Committee is an important mechanism to prevent patient abuse. Bridgewater has no human rights committee or human rights officer.

208. All of the disparities between Bridgewater and DMH facilities were in existence during the Plaintiffs' confinement at Bridgewater. While Mr. Doe and Mr. Minich are no longer at Bridgewater, they are severely mentally ill and can become violent as a manifestation of their mental illness. Because of the current state of the law, these Plaintiffs face the real possibility of return to Bridgewater. This possibility is further evidenced by Plaintiff Zomosa having returned to Bridgewater on August 31, 2015, where he currently remains (having been discharged on May 29, 2014 after he retained counsel in this case).

209. The Plaintiffs suffer from severe mental illness. Because of the severity of their mental illness, they were subjected to discriminatory treatment by being placed at Bridgewater, a correctional facility that denied them of many of the treatment rights available to DMH patients. This discrimination resulted in prolonged periods of unnecessary and illegal isolation, seclusion and restraint; denial of minimally adequate treatment; confinement in unsafe conditions; violation of personal dignity and other deprivations.

210. As severely mentally ill individuals, the Plaintiffs had an even greater need for humane and professionally adequate treatment than those with less severe mental illness. Had the Plaintiffs not been excluded from the services, programs and activities offered to other involuntarily committed mentally ill individuals in the Commonwealth of Massachusetts, they would not have suffered the severe psychological and physical damages that they have incurred as a result of their confinement to Bridgewater. Indeed, instead of receiving treatment at a licensed DMH facility where they would have enjoyed humane and effective treatment, they were sent to prison at Bridgewater because of the severity of their illness.

211. The Plaintiffs are otherwise "qualified individuals" with a disability that limits one or more major life activities under 42 U.S.C. § 12132 of the Americans with Disabilities Act ("ADA"). The Plaintiffs were particularly qualified to receive all of the services available to DMH patients set forth in this section. Had they received such services, they would not have been placed in prolonged seclusion and restraint in non-emergency circumstances and continued in prolonged seclusion and restraint in non-emergency circumstances in violation of their constitutional rights.

212. The Plaintiffs' qualification for such services is further supported by the fact that when they were provided the aforementioned treatment services that DMH patients are entitled to, they were barely secluded or restrained at all and were free from inhumane conditions of confinement.

213. Stated simply, in Massachusetts, the most severely mentally ill men are civilly committed to a prison, rather than a mental health treatment facility even though they are not serving criminal sentences. The Commonwealth's failure to provide these services to the persons who needed them the most - patients such as the Plaintiffs who were severely mentally ill -- was therefore illegal, discriminatory and a violation of Title II of the ADA, 42 U.S.C. § § 12131-12134.

214. The regulations implementing Title II of the ADA requires public entities to "administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d); 28 C.F.R. § 35.152(b)(2) (requiring that those confined to correctional facilities with disabilities are to be housed in the most integrated setting appropriate to the needs under the program access obligation); see also Olmstead v. LC, 527 U.S. 581, 592, 597 (1999) ("Unjustified isolation, we hold, is properly regarded as discrimination on the basis of disability.") Pursuant to 28 C.F.R. § 35.130(b)(1)(ii), the Defendants are prohibited from providing unequal services to individuals with disabilities and may not provide different or separate services to people with disabilities. 28 C.F.R. § 35.130(b)(1)(iv).

215. As outlined herein, however, the practical effect of the Defendants' discrimination against the Plaintiffs is that the Plaintiffs were denied the opportunity to participate in and benefit from a variety of mental health services and activities, or were unnecessarily provided with unequal, ineffective and different opportunities to participate or benefit from the Defendants' classification, security, housing and mental health services on the basis of their severe mental disabilities.

216. Further, as a recipient of federal financial assistance, the Defendants were required to ensure meaningful access by the Plaintiffs to mental health programs and activities while at Bridgewater pursuant to Section 504 of the Rehabilitation Act. Defendants' misplaced reliance on the fact that individuals are supposed to only be committed to Bridgewater when "heightened security" is warranted is belied by the well-established case law. See, e.g., Sch. Bd. Of Nassau Cnty. V. Arline, 480 US 273, 278-288 (1987) (finding direct threat under Section 504, which was codified at 28 C.F.R. § 35.139 for Title II, requires a showing of a "significant risk to the health or safety of others that cannot be eliminated or reduced to an acceptable level by the public entity's modification of its policies, practices or procedures.") Ultimately, the burden on public entities in denying an individual with a disability the opportunity to participate in and benefit from services, programs and activities on the basis of "direct threat" is considered a "heavy burden," and the same would be true of "legitimate safety" criteria. See Lockett v. Catalina Channel Express, Inc. 496 F. 3d 1061, 1066 (9th Cir. 2007); Doe v. Deer Mt. Day Damp, Inc., 682 F. Supp. 2d 324, 347 (SDNY 2010).

217. Given the Defendants' (including the Defendants Commonwealth and Department of Correction) knowledge of the extraordinary seclusion and restraint levels at Bridgewater, (in particular the fact that Bridgewater patients were secluded and restrained at a rate 100 times greater than DMH patients), as well as the fact that virtually none of the programs or services to prevent prolonged isolation offered to DMH patients were offered to Bridgewater patients such as the Plaintiffs, the Defendants acted with deliberate indifference to the rights of the Plaintiffs and in violation of federal and state discrimination laws.

H. Class Allegations

218. Plaintiffs seek certification of the following class ("Class") pursuant to Mass. R. Civ. P. 23(a) and (b) :

> All individuals confined to Bridgewater State Hospital between January 29, 2012 and March 31, 2014 who spent, in the aggregate, more than 60 hours in seclusion in any given consecutive thirty (30) calendar days and/ or more than 15 hours in restraint in any given consecutive thirty (30) calendar days.

219. The members of the Class are so numerous that joinder of all such persons is impracticable, making the disposition of their claims in a class action superior to other available methods for the fair and efficient adjudication of the controversy.

220. Moreover, judicial economy will be served by bringing the Class claims as a class action because doing so will avoid the burden which would otherwise be placed upon the judicial system by the filing of numerous individual lawsuits seeking redress for the Defendants' violations of the Seclusion and Restraint Law during the applicable Class time period.

221. There are commons questions of law and fact involved affecting the parties to the Class in that they have all been subject to prolonged seclusion and restraint while committed to Bridgewater in violation of the Seclusion and Restraint Law, Mass. Gen. Laws c. 123, § 21. Further, because the harsh conditions of confinement and illegal use of seclusion and restraint (as further described herein) suffered at Bridgewater by the named Plaintiffs affected all patients during the applicable Class time period (which corresponds to the two (2) years just prior to the first lawsuit filed by Ms. Minich seeking injunctive relief for her son, Peter), the claims and defenses of the representative parties for substantial violation of the Seclusion and Restraint Law are typical of the claims of the Class.

222. Plaintiffs will fairly and adequately represent and protect the interests of the members of the Class. Further, Plaintiffs have retained and are represented by experienced counsel competent and experienced to handle class action civil rights litigation of the scope contemplated herein.

223. The questions of law and fact with respect to the narrow question of Plaintiffs' private right of action against the Defendants for their violations of the Seclusion and Restraint Law predominate over any questions affecting only individual members with respect to that narrow question. Indeed, the Class is defined in such a way that minimizes any questions affecting only individual members. Using bright line thirty (30) day aggregate hour thresholds that, by the very nature of the number of hours at issue, creates a strong presumption that the individual suffering those prolonged seclusions and/or restraints was doing so unnecessarily and, in fact, in violation of the Seclusion and Restraint statute, dwindles down the need to conduct any individual assessments to practically null (e.g., the Commonwealth's expected argument that the individual was seclusion and/or restrained due to a "clinical decision").

224. Regardless of so called clinical decision-making, all members of the Class will have spent, at a minimum, at least 2.5 days (for every 30) in seclusion and at least 15 hours (for every 30 days) in restraint. In reality, Plaintiffs expect those numbers to far exceed the minimum; however, it cannot be disputed that the Class members' mental health suffered severely as a result of the Defendants' violations of the Seclusion and Restraint Law - even at these minimum class qualification threshold figures.

V. CAUSES OF ACTION

COUNT I 42 U.S.C. § 1983: Freedom from Bodily Restraint; Safe Conditions and Personal Security; Medical Treatment and Minimally Adequate or Reasonable Training (Defendants Murphy & Spencer)

225. Plaintiffs reassert and incorporate the allegations of Paragraphs 1-224 of their Second Amended Complaint as if fully set forth herein.

226. The Defendants Murphy and Spencer have, by act or omission in oversight responsibilities, illegally secluded and

restrained Plaintiffs and imposed harsh and illegal conditions of confinement on Plaintiffs in violation of Plaintiffs' rights to freedom from unreasonable bodily restraint secured by the Constitution and laws of the United States of America.

227. Defendants Spencer and Murphy deprived Plaintiffs of their civil rights by failing to perform the non-discretionary function of review and approval of seclusion and restraint orders as is required by statute. As explained above, the oversight requirements laid out by the Seclusion and Restraint Statute is "clearly established" and was well known to the Defendants Spencer and Murphy.

228. The Defendants Murphy and Spencer's discrimination against the Plaintiffs by their failure to fulfill their oversight responsibilities has resulted in the Plaintiffs suffering from the illegally imposed harsh, excessive, and punitive conditions of seclusion and restraint in violation of Plaintiffs' rights to freedom from bodily restraint, Plaintiffs' rights to safe conditions and personal security, and Plaintiffs' rights receive medical treatment as secured by the Constitution and laws of the United States of America.

229. The Defendants Murphy and Spencer's discrimination against the Plaintiffs by their failure to fulfill their oversight responsibilities has resulted in the Plaintiffs suffering from the illegally imposed harsh, excessive, and punitive conditions of seclusion and restraint in violation of Plaintiffs' rights to receive minimally adequate medical treatment as secured by the Constitution and laws of the United States of America.

230. Defendants Spencer and Murphy directly participated in the deprivation of Plaintiffs' civil rights by failing to review and approve seclusion and restraint orders, breaching duties imposed by Mass. Gen. Laws c. 123, § 21, and other state and local laws, and, through their actions and omissions, including but not limited to their failure to supervise their subordinates, tacitly authorized the conduct of their employees and agents that resulted in the deprivation of Plaintiffs' civil rights.

231. At the time of the alleged violations of Plaintiffs' rights, Defendants Murphy's and Spencer's actions and omissions were conducted under color of state law, as Plaintiffs were all patients of Bridgewater and Defendants were all employees or agents of the Commonwealth of Massachusetts and/or the Department of Correction, employed to perform an essential state function and provide an important oversight role for the use of seclusion and restraint at Bridgewater.

232. Defendants Murphy and Spencer acquiesced to and approved a long standing practice or custom at Bridgewater, as described above, constituting the "standard operating procedure" at Bridgewater, thereby causing and condoning the actions and omissions of their subordinates that deprived Plaintiffs of their clearly established rights.

233. Defendants' reliance on continued seclusion and restraint during Plaintiffs' commitment at Bridgewater, and Defendants' failure to properly review reports and orders pertaining to the seclusion and restraint of Plaintiffs violated their civil rights. Defendants' failure to instruct, encourage, and require their subordinates to make attempts to deescalate Plaintiffs' actions or agitation, treat the symptoms and underlying pathology associated with Plaintiffs' mental illnesses, and train Plaintiffs on how to cope with the symptoms of their mental illness (and their associated emotions, behaviors, and reactions) to ensure that Plaintiffs would remain safe and free from undue restraint, resulted in the deprivation of Plaintiffs' civil rights.

234. Defendants' actions and omissions constituted a deprivation of Plaintiffs' clearly established rights secured by the Constitution and laws of the United States of America and Defendants' actions and omissions caused Plaintiffs to be deprived of their rights. Defendants at all times knew, or should have known, that their acts violated Plaintiffs' clearly established constitutional rights.

235. Defendants' actions of illegal and excessive seclusion and restraint were in violation of 42 U.S.C. § 1983 and evidence a reckless or callous indifference to Plaintiffs' federally protected rights

236. As a result of Defendants' actions and omissions, Plaintiffs have suffered severe, serious, and continuing psychological and physical harm, including trauma, humiliation, demoralization, confusion, and social isolation. Plaintiffs are entitled to recover damages pursuant to 42. U.S.C. § 1983.

COUNT II Mass. Gen. Laws c. 123, § 21 (Defendant Murphy)

237. Plaintiffs, on behalf of themselves and all others similarly situated, reassert and incorporate the allegations of Paragraphs 1-236 of their Second Amended Complaint as if fully set forth herein.

238. Defendant Murphy and his employees and agents admitted, secluded, and mechanically restrained Plaintiffs and the Class in violation of Mass. Gen. Laws c. 123, § 21.

239. Pursuant to paragraph 13 of the Mass. Gen. Laws c. 123, § 21, Defendant Murphy, as Superintendent of Bridgewater, held the "responsibility and liability" for the implementation of the provisions of Mass. Gen. Laws c. 123, § 21 at Bridgewater State Hospital.

240. Defendant Murphy failed to implement provisions of Mass. Gen. Laws. c. 123, § 21, thereby leading to the violation of the requirements and provisions of the law designed to protect individuals such as the Plaintiffs and the Class from undue bodily restraint. These violations include, inter alia:

- restraining Plaintiffs in non-emergencies;
- secluding Plaintiffs for excessive and prolonged periods of time;
- restraining Plaintiffs because "there is no other place for [Plaintiffs] to go;"
- restraining Plaintiffs as punishment;
- continuing restraint when there was no emergency;
- restraining and continuing to restrain Plaintiffs when they were calm and compliant;
- failing to observe Plaintiffs every ten (10) minutes when in seclusion; and
- failing to engage in a meaningful review of Plaintiffs' restraint forms.

241. As a result of Defendant Murphy's actions and omissions, Plaintiffs and the Class have suffered severe, serious, and continuing psychological and physical harm.

242. Plaintiffs and the Class are entitled to damages as a result of Defendant Murphy's failure to implement the provisions of Mass. Gen. Laws c. 123, § 21.

COUNT III Declaratory Judgment: Violation of Mass. Gen. Laws c. 123, § 21; Articles 10 and 12, Massachusetts Declaration of Rights (All Defendants)

243. Plaintiffs reassert and incorporate the allegations of Paragraphs 1-242 of their Second Amended Complaint as if fully set forth herein.

244. Plaintiffs have and had a protected "liberty interest" under Article 10 of the Massachusetts Declaration of Rights which, at minimum, afforded them the right to reasonably safe conditions of confinement, adequate medical care, freedom from unreasonable restraints, and minimally adequate training of Defendants and their employees sufficient to ensure these liberty interests were protected.

245. Plaintiffs have and had a protected "liberty interest" under Article 12 of the Massachusetts Declaration of Rights which, at minimum, afforded them the right to be free of imprisonment and free of deprivation of the privileges and immunities

afforded them by the law of the Commonwealth without judgment by their peers or the law of the land.

246. By engaging in the acts set forth, Defendants have violated the liberty protections due Plaintiffs under Articles 10 and 12.

247. Based on Defendants' repeated violations of Plaintiffs' clearly established rights and the seclusion and restraint practices at Bridgewater, Plaintiffs request the Court issue a declaratory judgment pursuant to Mass. Gen. Laws c. 231A, § 1, declaring that Defendants have violated Mass. Gen. Laws c. 123, § 21 and Articles 10 and 12 of the Massachusetts Declaration of Rights in the following ways:

● By secluding the Plaintiff Doe and Plaintiff Zomosa in a locked corridor with limited human interaction and prolonged isolation when the placement met the definition of restraint under Mass. Gen. Laws c. 123, § 1;

● By forcing Plaintiff Minich to receive visits from his parents while shackled in a steel cage;

● For improperly secluding patients outside of the ITU in locked rooms on Max I and Max II without considering such practice seclusion when the placement met the definition of restraint under Mass. Gen. Laws c. 123, § 1;

● By secluding patients for hours in locked rooms or "counts" without treating or considering such practice seclusion when the placement met the definition of seclusion under Mass. Gen. Laws c. 123, § 1;

● The automatic use of shackles, leg and waist irons, and other forms of mechanical restraint during the transport of patients, including to the shower or toilets, at the ITU;

● By failing to have a physician sign off on each order every three hours after a patient has been in continued restraint or seclusion for six hours pursuant to the seventh paragraph of Mass. Gen. Laws c. 123, § 21;

● For failing to have the Superintendent or his designee approve the seclusion and restraint orders after eight hours of seclusion within a twenty-four hour period pursuant to the ninth paragraph of Mass. Gen. Laws c. 123, § 21;

● For continuing seclusion when clinicians were unable to properly assess the patients in order to renew or extend the seclusion orders;

● For failing to provide adequate medical care and instead punitively subjecting Plaintiffs to illegal restraint and seclusion;

● For failing to provide their employee clinicians and the individually named Defendants with minimally adequate training sufficient to ensure that Plaintiffs' liberty interests were protected;

● By confining Plaintiffs to a correctional facility when they have not been convicted of any crimes, under circumstances where their confinement can be indefinitely continued; and,

● By charging Plaintiffs, whose mental illness plainly prevents them from having the competency to stand trial, with petty crimes in order to remove them from facilities operated by the Department of Mental Health and instead placing them into a correctional facility.

248. Plaintiffs Minich and Doe, both former involuntarily committed patients at Bridgewater that continue to suffer from mental illness and receive treatment, face the possibility of return to Bridgewater in the future. This possibility is further evidenced by Plaintiff Zomosa having returned to Bridgewater on August 31, 2015, where he currently remains.

COUNT IV 42 U.S.C. § § 2131-12134: Violation of Title II of the ADA and Section 504 of the Rehabilitation Act (All Defendants)

249. Plaintiffs reassert and incorporate the allegations of Paragraphs 1-248 of their Second Amended Complaint as if fully set forth herein.

250. The Plaintiffs are otherwise "qualified individuals" with a disability that limits one or more major life activities under 42 U.S.C. § 12132 of the ADA.

251. The most severely mentally ill men in Massachusetts, including the Plaintiffs, are civilly committed to a prison (Bridgewater), rather than a mental health treatment facility. The Commonwealth's failure to provide these services to the persons who needs them the most - patients such as the Plaintiffs who were severely mentally ill -- was illegal, discriminatory and a violation of Title II of the ADA.

252. The regulations implementing Title II of the ADA requires public entities to "administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d); 28 C.F.R. § 35.152(b)(2) (requiring that those confined to correctional facilities with disabilities are to be housed in the most integrated setting appropriate to the needs under the program access obligation); see also Olmstead v. LC, 527 U.S. 581, 592, 597 (1999) ("Unjustified isolation, we hold, is properly regarded as discrimination on the basis of disability.") Pursuant to 28 C.F.R. § 35.130(b)(1)(ii), the Defendants are prohibited from providing unequal services to individuals with disabilities and may not provide different or separate services to people with disabilities. 28 C.F.R. § 35.130(b)(1)(iv).

253. As outlined in this Amended Complaint, however, the practical effect of the Defendants' discrimination against the Plaintiffs in their illegal use of seclusion and restraint on the Plaintiffs in the harsh conditions found at Bridgewater is that the Plaintiffs were denied the opportunity to participate in and benefit from a variety of mental health services and activities, or were unnecessarily provided with unequal, ineffective and different opportunities to participate or benefit from the Defendants' classification, security, housing and mental health services on the basis of their severe mental disabilities.

254. As a recipient of federal financial assistance, the Defendants must ensure meaningful access by the Plaintiffs to mental health programs and activities while at Bridgewater pursuant to Section 504 of the Rehabilitation Act. As outlined in this Amended Complaint, the Defendants failed to provide any access, much less "meaningful" access.

255. The burden on public entities in denying an individual with a disability the opportunity to participate in and benefit from services, programs and activities on the basis of "direct threat" is considered a "heavy burden," and the same would be true of "legitimate safety" criteria. See Lockett v. Catalina Channel Express, Inc. 496 F. 3d 1061, 1066 (9th Cir. 2007); Doe v. Deer Mt. Day Damp, Inc., 682 F. Supp. 2d 324, 347 (SDNY 2010). Here, Defendants cannot show a legitimate "direct threat" excusing them from providing the Plaintiffs with equal access and an opportunity to participate and benefit from the services, programs and activities being offered to other mentally ill individuals in Massachusetts within the DMH system.

256. Given the Defendants' knowledge of the extraordinary seclusion and restraint levels at Bridgewater, (in particular the fact that Bridgewater patients were secluded and restrained at a rate 100 times greater than DMH patients), as well as the fact that virtually none of the programs or services to prevent prolonged isolation offered to DMH patients were offered to Bridgewater patients such as the Plaintiffs, the Defendants acted with deliberate indifference to the rights of the Plaintiffs and in violation of federal and state discrimination laws.

257. Plaintiffs are entitled to damages as a result of Defendants' violation of the Title II under the ADA and Section 504 of the Rehabilitation Act.

COUNT V DECLARATORY JUDGMENT: Violation of Title II of the ADA and Section 504 of the Rehabilitation Act By Civilly Committing Plaintiffs to Bridgewater Based on the Severity of their Disability (All Defendants)

258. Plaintiffs reassert and incorporate the allegations of Paragraphs 1-257 of their Second Amended Complaint as if fully set forth herein.

259. The Plaintiffs suffer from severe mental illness. Because of the severity of their mental illness, they were subjected to discriminatory treatment by being placed at Bridgewater, a correctional facility that denied them of many of the treatment rights available to DMH patients. This discrimination resulted in prolonged periods of unnecessary and illegal isolation, seclusion and restraint; denial of minimally adequate treatment; confinement in unsafe conditions; violation of personal dignity and other deprivations.

260. As severely mentally ill individuals, the Plaintiffs had an even greater need for humane and professionally adequate treatment than those with less severe mental illness. Had the Plaintiffs not been excluded from and denied the services, programs and activities offered to other involuntarily committed mentally ill individuals in the Commonwealth of Massachusetts, they would not have suffered the severe psychological and physical damages that they have incurred as a result of their confinement to Bridgewater. Indeed, instead of receiving treatment at a licensed DMH facility where they would have enjoyed humane and effective treatment, they were sent to prison at Bridgewater because of the severity of their illness.

261. By engaging in the acts set forth herein while under receipt of federal funds, Defendants have violated Title II of the ADA and Section 504 of the Rehabilitation Act. Based on Defendants' repeated violations of Plaintiffs' clearly established rights to full and equal access to programs, services, benefits or opportunities to participate in the same on the basis of the severity of the Plaintiffs' disability, Plaintiffs request the Court issue a declaratory judgment pursuant to Mass. Gen. Laws c. 231A, § 1, declaring that Defendants have violated Title II of the ADA and Section 504 of the Rehabilitation Act in the following ways:

● By civilly committing the Plaintiffs to a prison (Bridgewater) instead of a DMH facility where they can receive proper treatment for their illness on the basis of the severity of their disability;

● In civilly committing the Plaintiffs to Bridgewater, denying the plaintiffs on the basis of their disability the equal opportunity to participate in and benefit from a variety of DMH offered treatment services and activities, such as classification, housing conditions and mental health services, in violation of 28 C.F.R. § 35.130(b);

● In civilly committing the Plaintiffs to Bridgewater, unnecessarily relegating the Plaintiffs with severe mental illness and/or intellectual abilities to unequal, ineffective and different or separate "opportunities" to participate or benefit from DMH offered treatment services and activities in violation of 28 C.F.R. § 35.130(b) on the basis of their disability;

● By segregating and warehousing civilly committed individuals with severe mental illness and/or intellectual disabilities to Bridgewater where they suffered extraordinarily high rates of seclusion and restraint instead of receiving treatment that would have been rendered in the DMH system on the; and,

● By failing to reasonably modify policies, practices and procedures necessary for the Defendants to avoid discrimination on the basis of disability pursuant to 28 C.F.R. § 35.130(b)(7).

WHEREFORE, PLAINTIFFS, ON BEHALF OF THEMSELVES AND ALL OTHERS SIMILARLY SITUATED, PRAY THAT THIS HONORABLE COURT:

1. Order certification of the Class proposed by the Plaintiffs, naming each Plaintiff as a representative of the Class, and appointing undersigned counsel as Class Counsel;

2. Issue judgment in Plaintiffs' favor on all Counts;

3. Award Plaintiffs compensatory damages against all Defendants with respect to Counts I, II and IV;

4. Issue a Declaratory Judgment in accordance with Counts III and V;

5. Award of Plaintiffs' reasonable attorneys' fees and costs, in accordance with 42 U.S.C. § 1988, 28 C.F.R. § 35.175 and other applicable law; and,

6. Order such other and further relief as this Court deems just and proper.

JURY DEMAND

Plaintiffs demand a trial by jury on all issues so triable.

Respectfully submitted,

The Plaintiffs,

By Their Attorneys,

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Dated: *10/13/16*

Footnotes

1 He eventually agreed to review and sign the forms, when threatened with an injunction by the plaintiff Doe's Preliminary Injunction motion, but such agreement was only reached long after the harm to the Plaintiffs had occurred.

2 Inexcusably, between the original filing of this case and filing of the Second Amended Complaint herein, yet another tragic death of a Bridgewater patient relegated to the ITU has occurred. In response, the Disability Law Center ("DLC") (the protection and advocacy group charged with oversight of Bridgewater) issued a scathing report outlining the various failures within BSH that inextricably led to the aforementioned death, and ultimately recommending that BSH be placed into receivership until such time that it can be transitioned out of DOC control and into DMH's hands. A true and accurate copy of the DLC report is attached hereto as Exhibit A, and its findings and conclusions are incorporated into this Second Amended Complaint as if set forth in full herein.

[3] The Court goes even further by inserting a footnote thereafter, stating:

> Moreover, O'Sullivan v. Secretary of Human Servs., 402 Mass. 190 (1988), concerned "an action for declaratory and injunctive relief brought by two patients at Bridgewater... against various state officials, alleging violations of G.L. c. 123, § 21..." Id. at 191. "The Legislature must be assumed to know the preexisting law and the decisions of [the Supreme Judicial] [C]ourt." Worcester, 465 Mass, at 139 (citation omitted). Therefore, if the Legislature had not intended to create a private right of action with the Restraint Law, it could have amended the statute expressly after O'Sullivan to prohibit such claims.

[4] While at McLean, he tried to kiss and touch patients and staff, but was not violent.

[5] A 2012 case pending in Salem District Court for charges of Assault and Battery was dismissed.

[6] As was noted by the court-ordered psychologist conducting the Rule 15(a) evaluation, due to Mr. Doe's disabilities, Mr. Doe does not respond to punishment or negative reinforcement.

[7] As a result of the O'Sullivan settlement agreement, Massachusetts used to have a medium secure Department of Mental Health ("DMH") facility but it was eliminated in the early 2000's.