COMMONWEALTH OF MASSACHUSETTS

PLYMOUTH, ss.

TRIAL COURT DEPARTMENT
BROCKTON DISTRICT COURT
DOCKET NO. 15 IQ 0001

REPORT ON THE INQUEST INTO THE DEATH OF JOSHUA K. MESSIER

On Monday, May 4, 2009, Joshua K. Messier, committed to Bridgewater State Hospital (BSH) pursuant to G.L. c. 123, § 6(a), died during the process of being placed into four point restraints following his assault upon a correctional officer. Attorney General Maura Healy appointed Martin Murphy as a Special Assistant Attorney General and through him, on January 2, 2015, requested an inquest pursuant to M.G.L. c. 38 et. seq.

In accordance with the statutory mandate, an inquest was held from March 9th through March 13th of this year to determine "when, where, and by what means [Joshua Messier] met his death...and all material circumstances attending the death, and the name...of any person whose unlawful act or negligence appears to have contributed" to the death of Joshua Messier. See G.L. c. 38 s. 10. Twenty-two witnesses were examined and nine volumes of exhibits were introduced consisting of more than 5000 pages of material. The targets of the inquest are John Raposo, Derrick Howard, George Billadeau, and Daniel Kerr.

Pursuant to the mandate of G.L. c. 38 s. 10, the Court issues the following report.

FINDINGS OF FACT

I. Messier's Admission to Bridgewater State Hospital

Messier was admitted to BSH on April 1, 2009, from the Dudley District Court, pursuant to G.L. c. 123, § 15(b), for further evaluation of his criminal responsibility for three counts of assault and battery, following an initial evaluation by Dr. Hanya H. Bluestone, Ph.D. The victims of the alleged assault and batteries were employees of the Harrington Memorial Hospital, located in Southbridge, MA, the location where the assaults occurred and where Messier had been admitted, on March 26, 2009, for psychiatric treatment following an unprovoked attack on his father and mother.

Messier, born July 16, 1985, was twenty-three years of age at the time of his death. Prior to his freshman year at UMASS Dartmouth, he had no prior psychiatric history. In his freshman year of college, Messier, then 18 years of age, began having auditory hallucinations. On March 26, 2004, Messier was admitted to Marlborough Hospital after experiencing auditory and visual hallucinations, including command hallucinations to kill his parents. He was diagnosed with schizophreniform disorder and polysubstance abuse. Messier's psychiatric history includes other admissions to Westwood Lodge Hospital, Pembroke Hospital, Harrington Memorial Hospital, Spring Harbor Hospital (located in Maine), and Worcester State Hospital, his lengthiest hospitalization (approximately 1.5 years).

Messier's admission to Worcester State Hospital on June 21, 2007, pursuant to G.L. c. 123, §§ 7 & 8, followed his admission to Harrington Memorial Hospital, in March of 2007, and, as stated in the Barbara McElroy G.L. c. 123, § 15(b) report, was "secondary to increase in psychotic behaviors (paranoia and auditory hallucinations), medication non-compliance, and aggression toward family members (allegedly assaulted sister and mother)." The Worcester State Hospital discharge plan indicates that Messier's hospitalization at the hospital was marked by more than seventy documented assaults. The natures of the assaults are not identified. Messier was discharged from the Worcester State Hospital in October of 2008, following a positive response to medication treatment, a reported decrease in hallucinatory activity, and two months of assault-free behavior.

Following this discharge, Messier resided with his family. Messier was admitted to Harrington Memorial Hospital on February 22, 2009, following an incident where he broke china in response to hearing voices. He was discharged on February 25, 2009, but readmitted on March 13, 2009, after his mother called 911 because he was experiencing auditory hallucinations and punching himself in the face with his hand. He was discharged on March 18, 2009. Following unprovoked attacks on his parents, he was readmitted on March 26, 2009.

According to the McElroy report, because of the history of assaultive behavior, upon Messier's admission to Bridgewater State Hospital, Messier was admitted to the Intensive Treatment Unit of the hospital. On April 7, 2009, because of observed behavioral stability, Messier was moved to a less restrictive observation unit, which is designated as B1. The McElroy report also states that during the period of the G.L. c. 123, § 15(b) observation, "Messier did not engage in any self-injurious behaviors or suicide attempts. He [] remained behaviorally stable and ha[d] not required any additional

transfers to the ITU. He ha[d] not engaged in any aggressive or assaultive behaviors toward staff or other patients." And he was compliant with medication treatment.

The McElroy report is dated April 17, 2009. The report concludes that, although Messier did not lack a substantial capacity to appreciate the wrongfulness of his criminally charged conduct at the time of his assaults upon the Harrington Memorial Hospital staff, he likely was experiencing psychiatric symptoms that prevented him from conforming his conduct to the requirements of the law.

Messier was returned to the Dudley District Court on April 17, 2009. Although Messier's family had posted the $500 bail set on the complaint charging him with the Harrington Hospital assaults, Messier was returned to Bridgewater based upon a petition pursuant to G.L. c. 123, §§ 7 and 8 filed with the Brockton District Court. See G.L. c. 123, § 6(a)("No person shall be retained ... at Bridgewater state hospital except ... during the pendency of a petition for commitment..."). The petition, dated April 17, 2009, was signed by the Bridgewater medical director, Robert Diener, M.D., stating that Messier was "mentally ill, and is not the proper subject for commitment to any facility of the Department of Mental Health, and that the failure to retain him in strict security would create a likelihood of serious harm to himself or others."

Following his return to Bridgewater State Hospital, Messier engaged in a fistfight with another patient on April 20, 2009, and was taken to the ITU and held in seclusion, but not restraints, for approximately 30 hours. He was then returned to Unit B-1. On May 3, 2009, Messier assaulted another inmate and was taken to the ITU and again held in seclusion. He was discharged to Unit B-1 at approximately 10:10 AM on the morning of his death.

II. Non-Medical Evidence

Except for Messier's alleged assault upon Officer Christopher Rego in the staff room of the B1 Unit and what occurred during the movement of Messier after he left the B1 Unit and was moved across the courtyard to the ITU, a distance of approximately six hundred and six feet, the actions of the correctional officers (1) following Messier's assault upon Rego, (2) immediately prior to placing Messier into posey restraints,[1] (3)

[1] A posey restraint is a term used to describe soft restraints made of leather or rubber material. The term stands in contrast to metal restraints such as handcuffs or leg irons. Rubber poseys were used to restrain Messier.

during the application of posey restraints, and (4) following the placement of the restraints, were captured on six separate video cameras. The videos are identified as 1 B1 Rm Cor S, 3 B1 Foyer, 6 B1 T Area, 13 ITU Cell 13, 15 ITU 4 Point M, and 16 ITU Room Cor.

The Court finds as follows from its review of the one hour seventeen minute and forty-seven second compilation of videos and statements of involved personnel.

The 3 B1 Foyer video shows Messier walking unescorted into the foyer/trap room of building B1 through the entrance/exit doorway from and to the complex courtyard. Messier was returning from the Administration Building where he had visited with his mother, Lisa D. Jaskueka-Messier. The video shows Messier proceeding across the foyer to the window of a guard room, also referred to as the trap room, apparently gaining the attention of Officer Jose Varela, the trap room officer, briefly stopping at the trap door located to the right of the room, and then, as the trap door, also referred to as the Sally port/unit door, began to open, proceeding through the doorway. Messier walked through the open doorway at approximately 9:09:30 PM, and the 6 B1 T Area video picks up Messier walking unescorted down a corridor of the B1 Unit.[2]

At 9:09:32 PM, Messier is out of camera view. At the point where Messier is out of camera view, Messier had entered the correctional officers' staff room, a room off-limits to Messier, located along the corridor route that Messier had been traveling. In that

2 According to Rego's civil deposition testimony, the usual practice would have been, at that time of night, for the officer opening the trap door to alert B1 officers that Messier was in need of an escort, and the escorting officer would then unlock Messier's room to allow him to enter. According to Rego, all patients on B1 are locked in their room after 8:30 PM. Rego further stated in his deposition that it would have been general practice for an officer to escort Messier from the visiting room to the trap door. Once through the trap door, an officer assigned to the B1 unit would take over the escort. Varela, in his written report, states that he was working the trap, allowed Messier to enter the unit, and told Messier to see the "floor officer's [sic]" to let him into his room. Billadeau, in his deposition, stated that unless a patient like Messier is designated as being special security status, the patient is not required to be escorted between the visiting room, across the yard area, and into the B1 Unit, but the patient would be under the observation of the yard officer, who is physically in the yard area, as the individual travels from the Administration Building to the B1 Unit Building. Billadeau also states in his deposition that there is no policy on escorting a patient to his cell and a patient may be allowed to walk to his cell and remain outside waiting for an officer to unlock the cell door.

room were Officer Rego and Sergeant John Pupek, each seated at a desk. According to statements made by Rego and Pupek to State police and in civil deposition testimony, Pupek, knowing that Messier was returning from a visit by his mother, asked Messier how the visit was. Rego attributed, in his civil deposition testimony, the inquiry by Pupek as a method to de-escalate the situation. According to Pupek, Messier, who had a troubling look on his face and a blank stare, did not respond, but proceeded over to Rego and, with a closed fist, struck Rego on the side of the head. As both Rego and Pupek rose to their feet, Messier again stuck Rego in the head. Rego then ordered Messier to "cuff up," a term used to instruct inmates to turn around and place their hands behind their back to be handcuffed. Messier failed to comply and instead again assaulted Rego. Rego then began to throw punches back at Messier to defend himself. According to Pupek, Rego struck Messier 3-5 times, hitting Messier's head and shoulder area.

The 6 B1 T Area video does show, at approximately the 9:09:44 PM mark, Messier appearing to quickly exit from the staff room and move further down the hallway in the direction that he had been traveling. Rego quickly exits the side room and grabs the back of Messier's sweatshirt. Rego appears to swing Messier around and the two end up falling against a corridor chair that was positioned against the wall to the left of the staff room doorway oriented as one would enter the staff room. The 3 B1 Foyer video shows seven correction officers, each moving quickly as they pass through the foyer door leading to Messier's location. The first correctional officer passes through the doorway at 9:10:11 PM and the last passes through at 9:11:33 PM. The B1 Rm Cor S video captures a struggle to restrain Messier that lasts approximately two minutes and thirty-three seconds. Though seven correctional officers responded to the scene, the 6 B1 T area video shows at least two or three correctional officers actively engaged in the restraint of Messier. Those officers are Rego, Pupek and Sergeant Clifford Foster. Officer Robert Desrosiers stated in his report that he assisted in placing leg irons on Messier. Officer Howard states in his report that he held Messier's upper torso as he was being placed in waist restraints.

Once Messier is handcuffed behind his back, Officer Robert Desrosier places leg irons on him. Sergeant George Billadeau, who was the Acting Sector One Lieutenant, assisted Officer Thibault Raymond in controlling Messier legs as the leg irons were applied. Messier was then brought to his feet. According to Foster, after Messier was brought to his feet, he then began spitting blood and saliva. The back of Messier's shirt was pulled over his head by Foster to prevent Messier from further spitting and he was removed from the area.

The 3 B1 Foyer video shows Messier being escorted out through the open foyer trap door doorway at 9:12.48 PM. One correctional officer is on each side of Messier, and it appears that each officer has his arm hooked under Messier's armpit area, with their arms extended, as they escort Messier who appears to be dragging his feet in a manner not consistent with cooperation in his forced movement. These officers are identified as Sergeant Foster, on the right, and Howard, on the left. Sergeant Billadeau and Officer John Raposo follow behind. Once Messier passes through the entrance doorway to the foyer, two correctional officers can be observed entering the foyer area through the entrance the Messier had just passed through. Foster, Howard, Billadeau, and Raposo escorted Messier across the courtyard to the ITU building. Following the restraints being applied, Rego went to the infirmary for medical attention and Pupek relinquished control to the responding officers.

Video footage from the 16 ITU Cor. camera, which begins at 9:14:53 PM, shows Messier being brought into the ITU area through a doorway at 9:15:00 PM.[3] He appears to be on his knees and is being moved forward by Foster and Howard.[4] He is then, while in the corridor, brought to his feet at 9:15:26 PM. According to the internal investigation testimony of Viola Patterson a mental health worker on the ITU, Messier appeared to be "breathing pretty heavily," or out of breath as he was brought into the ITU; Kerr corroborated this characterization. Additionally, Patterson testified that while Messier was in the dorm room, she heard him twice say, "I can't breathe." The video shows Messier being brought into a room, and the 15 ITU 4 Point M video picks up video footage of Messier and the correctional officer escort as they enter the room, which is referred to as a dorm room because it is bigger that a cell room, containing a bed with attached restraints. Messier is brought into the room at 9:15:33 PM, taken to the bed, but not placed on the restraint bed. Rather, he is moved away from the bed and is positioned face first up against a wall. Messier does not appear resistant to the movement or

---

3 The video evidence shows Messier exiting the B 1 Unit at 9:12:48 and entering the ITU at 9:15:00, two minutes and twelve second after his exit from the B 1 Unit. No video is available during this time period. Captain Richard Warmington of the Massachusetts State Police, assigned on the May 4, 2009, to investigate the death of Messier, testified that, measured from the B1 Unit exit to when video shows Messier entering the ITU, Messier would have travelled 606 feet and that the time to travel this distance would be approximately two minutes.

4 There is evidence that Messier had dropped to his knees while being escorted to the ITU, but the action was not captured on any surveillance video.

placement. The sweatshirt covering Messier's face was removed, and it is reported that Messier stated, "Thank, you."

The 15 ITU 4 Point M video also shows that, prior to Messier's entrance into the ITU, a correctional officer entered the dorm room at 9:12:05 and retrieved some item from the shelving in the room. The officer exists the room and, from what the camera captures of his leg movements, appears to have proceeded down the corridor, not across from the dorm room to Cell 13, the room across from the dorm room and the room where Messier was eventually restrained. Two correctional officers entered the dorm room at 9:13:15. One officer began checking the restraints attached to the dorm room bed. Another officer came to the doorway at 9:13:20, and the officer who was checking the restraints stopped his examination at 9:13:28, and the two officers exited the room at 9:13:32. The officers do not appear to have walked directly across the hallway. However, video footage from the 16 ITU Cor. camera begins at 9:14:53 PM and their movement is not captured. The 13 ITU Cell 13 video begins at 9:14:46 PM and, therefore, does not capture whether these officers did go directly to Cell 13.

While Messier was in the dorm room, the 13 ITU Cell 13 video does show Sergeant Daniel Kerr, the officer-in-charge of the ITU, and Officer James Barker attaching leg and arm restraints to the bed in a cell across from the dorm room. The 15 ITU 4 Point M video shows Messier being removed from the dorm room at 9:17:40 PM. The 16 ITU Room Cor video shows Messier being brought out of the dorm room and taken across the hall to the cell room where he was placed in four point restraints.

The 13 ITU Cell 13 video shows Messier entering the room at 9:17:42 PM accompanied by six correctional officers.[5] According to Billedeau, Messier began to become resistant to his movement as entry was made into Cell 13.

The video 13 ITU Cell 13 shows Messier being placed upon the restraint bed at 9:17:48 PM. There are now seven correctional officers in the cell; Acting Lieutenant Billadeau, Officer Howard, Officer Raposo, Sergeant Foster, Sergeant Kerr, Officer

---

[5] In his civil deposition testimony, Billadeau testified that the dorm room, although having a restraint bed, is a room that is used only if a cell room is unavailable. He stated that the dorm room does not have a door and persons have "broken out of four-point restraints before," and, therefore, the use of the room could pose a danger of assault to others in the ITU, should a person escape from the restraints. He further testified, however, that the cell doors are not allowed to be closed if a person is placed in four-point restraints.

Barker, and Officer Soares. By 9:17:55, Messier is completely rotated 180 degrees on the bed to face in the opposite direction. His initial position placed his upper body in the location where his legs would be secured by leg restraints that had been attached to the corners of the bed. Messier is placed in an approximately 90 degree seated position with his legs extended on the bed and hands handcuffed behind his back. The process of applying the ankle restraints begins. Foster, Kerr, and Soares are involved in the application of the leg restraints. Howard has his hands and forearms against Messier's back. Billadeau, Raposo, Kerr, and Barker are observing.

The video appears to show, beginning at approximately 9:17:55 PM, Messier's resistance to Howard's efforts, through the use of his hands and forearms against Messier's back, to maintain Messier's seated position. At this point Howard is standing next to the right side of the bed as oriented to Messier's position on the bed. This seated position-ninety degrees-is sought to be maintained to avoid an inmate from injuring his wrists if he were to fall backward, and it also serves the purpose of avoiding a struggle to remove handcuffs from an inmate who is in a prone position while handcuffed behind his back. The movement as observed in the video also shows that Messier was actively resisting the application of the ankle restraints and that those involved in the application of the restraints were having difficulty in removing the leg irons, the application of the restraints, and control of Messier's legs.

Although Messier's hands were handcuffed behind his back, there remained a potential for injury to him or those involved in his restraint. Billadeau testified in his civil deposition that as the leg irons were removed, it was a potential possibility that the removal of the leg irons from one leg could allow that end of the leg iron, attached to a chain, to be used as a weapon by the movement of the other leg. Messier's body movements in his resisting also posed a danger of Messier using his head to strike the involved officers. Soares stated in his civil deposition that Messier could have head butted others. In his civil deposition, Barker stated that Messier could have bitten the staff as has happened in the past.

Although these described potential acts are foreseeable, the video evidence and statement of those involved do not suggest that Messier actuated any such behavior. Nevertheless, they remained active potentials. Messier's resistance posed a danger to him and others.

In any event, the struggle continues, while Howard stands next to the bed, until 9:18:41 PM. At this point, the video shows Howard repositioned so that his left leg is on the bed in a stretched out position and his right leg is on the ground. At 9:18:42,

Messier's upper body appears to be bent forward by pressure being applied by Howard to Messier's back. At 9:18:48 Howard places the full weight of his upper body on top of Messier's back, i.e., chest to back, and, by this move, essentially folds Messier into a closed clamshell position-chest to knees and upper thighs.[6] Raposo, at the same time, places his left hand upon Howard's right shoulder and appears to be pushing down on Howard's back. At approximately 9:18:55, Raposo places both of his hands on the back of Howard to apparently aid in maintaining the clamshell position of Messier, and in this act, Raposo appears to have repositioned himself so that he is on the bed frame enabling him to exert force against Howard's back with his arms and upper body weight.[7] Raposo maintains this position until approximately 9:19:29. The video evidence suggests that because of the manner in which Howard was positioned, Raposo would have known that Messier, at the least, had been bent significantly forward by Howard, although Raposo may not himself been aware that Messier was in a clamshelled position. The clamshelled position is maintained until approximately 9:19:36, at which time it appears the pressure placed on Messier's back was partially released. It then appears that the handcuffs were removed and the correctional officers guided Messier's upper torso back so that, at 9:20:08, Messier is positioned prone on the bed. Kerr places a plexiglass shield above Messier's body and face. Billadeau moves to the head of the bed and takes control of the shield. Wrist restraints are applied by Kerr and Barker on the left and Foster, Soares, Howard, and Raposo on the right. Messier is fully restrained by 9:21:30 PM. The purpose of the shield was to prevent Messier from spitting on the officers involved in his restraint. Billadeau supervises the entire restraint process.

Although the video is framed, with some exceptions, by one second intervals, Messier does not appear, after the release of the pressure on his back, to resist the process

---

6 Howard in his deposition testimony maintained that the position of his legs on the bed was in effort to maintain balance. In a statement to State Police, he described the position as one of leverage. At his deposition, he stated that though he may have used the word "leverage," he used it with the meaning of balance. In his deposition, he admitted that Messier's back was not in a ninety-degree position, but he maintained that while Messier was "slightly bent forward," he was not "folded over." Although the quality of the video evidence is not cinematic, Messier was clearly, to use Howard's phrase, folded over.

7 In his civil deposition, Raposa stated that he was 5' 5" inches tall and weighed, at the time, approximately 165 pounds. Howard, in his civil deposition stated that he was 5' 11" - 6' tall and weighed 225 pounds, but that weight was his weight as of August 1, 2013, when he was deposed.

of his wrists being restrained. Nor does it suggest any movement by Messier following the release of the pressure on his back or subsequent to restraints being placed on his wrists.

Statements made by Billadeau and Kerr indicate that Messier's breathing during the restraint process is characterized as breathing loudly or breathing heavily. Billadeau stated that following the application of the wrist restraints, Messier was conscious, breathing, and had his eyes open. Kerr stated that he observed that Messier's stomach was moving, he was breathing, and his eyes were open.

Following the application of all restraints, Kerr and Raposo began cutting off Messier's clothing. Howard took over the control of the polycaptor shield. A suicide prevention blanket was brought into the room and at 9:22:23[8] Messier's lower body was covered. Messier's sweatshirt was then removed. By 9:23:43 Messier was fully naked. Howard then removes the shield and backs away. All but two correctional officers leave the room. The video displays no conscious movement by Messier, rather the evidence is that he simply was staring toward the ceiling.

Shawn Whinery, LPN, enters the room with a blood pressure machine at 9:24:10.[9] Whinery observes that Messier's eyes were open and he appeared to be staring into the corner of the ceiling. He asks Messier a few general questions, but did not receive a response. According to Whinery, the lack of a response would not be unusual because a restrained person may be angry or not want to make incriminatory statements. The cuff to the machine was placed on Messier's arm at 9:24:46. An attempt was made to read Messier's blood pressure through the use of the machine. According to statements made by Whinery, the machine showed an error message. Whinery observed that the cuff had over-expanded and the velcro to the cuff had separated. The cuff was removed at 9:25:46 and a larger cuff was placed back on at 9:26:09. Whinery observed that the machine did not show a pulse. Whinery checked Messier's neck for a pulse at 9:27:24. At 9:28:00, Kerr appears to be using his radio. A second check of the neck area occurred at 9:28:05.

---

8 According to Whinery, the blanket is considered a suicide prevention blanket because the manufacturer claims that it cannot be torn.

9 No nurse had been in the room as the restraints were being applied as the number of correctional officers involved in the struggle in the confines of the small room precluded him from entering.

The cuff to the machine was removed from Messier's arm at 9:28:18. Messier's wrist restraints were removed and Messier, with his hands resting on his abdomen area, was handcuffed by 9:28:52. A third and fourth neck check was recorded at 9:29:07 and 9:29:20. At 9:29:32, Carla Tornofiglio, a registered nurse, enters the cell. She proceeds over to Messier and appears to check for a pulse on Messier's right wrist. She rapidly exits at 9:29:43. A Code 99, an emergency medical situation, was declared.[10] Whinery places a stethoscope on Messier's chest and checks for an apical pulse. Doctor Joel Olubodun, the Code Team doctor, enters at 9:29:57 and is, thereafter, shown using a stethoscope to check Messier's heart. Susan McHenry, RN, a member of the Code Team, begins chest compressions at 9:30:42. Shocking pads, referred to as automatic external defibrillator pads (AED), are placed on Messier's chest by Whinery. The video shows persons clearing away from Messier's body at 9:32:51. A shock appears to have been delivered at this time.[11] This sequence occurs two more times, at 9:35:20 and 9:37:50. Outside personnel arrive at the cell at 9:44:30. Messier was placed on a backboard, placed on a stretcher, and removed from the cell by 9:50:03. Messier was transported to the Signature Healthcare Hospital in Brockton where he arrived at approximately 10:16 PM, and he was there pronounced dead by Doctor Wendy Buras at 10:26 PM.

III. Restraint Authorization

Billadeau instructed the officers to place Messier into restraints and supervised the process. In his civil deposition, Billadeau acknowledges never having been directly told by the ITU medical staff to place Messier into restraints. He does, however, recount his belief that restraints were authorized by Carla Tornfoglio, R.N. According to Billadeau, the ITU would have been aware of the assault on correctional staff prior to Messier's arrival at the ITU. Kerr, the officer-in-charge of the ITU, would have notified Tornfoglio, and she also would have been made aware of the assault situation by

---

[10] Officer Jessica Gagnon, who was working the Control Center on May 4, 2009, at the time the code was called, documented it as being called at 21:29 (9:29) PM. She also documented a 911 call to Bridgewater Fire at 21:31 (9:31) PM. Gagnon documents that Bridgewater Fire Department is on sight as of 21:38 (9:38) PM, an ambulance arrived at 21:40 (9:40) PM, EMT's entered the ITU at 21:44 (9:44) PM, and they exited with Messier at 21:52 (9:52) PM.

[11] According to notes to the Root Cause Analysis the pads to the AED were initially placed incorrectly on Messier's body.

telephone or the public address system.[12] Billadeau drew the inference that, because Kerr was preparing Cell 13 and would have alerted Tornfoglio to the situation, Tornfoglio had authorized the restraint. He also drew the inference that, because medical "staff didn't indicate otherwise," there was authorization. Billadeau stated in his deposition that Tornfoglio was in a position to observe the activity in the dorm room and would have been able to see that Messier was going to be placed in four-point restraints.

In answers to interrogatories in connection with the civil action, Billadeau states that he "sent a radio transmission requesting the medical unit to prepare a four-point restraint." In his deposition, he states that the transmission was directed to Kerr and made during the escort of Messier across the courtyard. According to Billadeau, it was made for the purpose of "preparing for contingency."

Messier was not assessed by medical staff prior to his placement in restraints. On May 12, 2009, the Director of Security, Brian Frye, sent an email to command staff. In the email, Frye wrote the following. "Escorting officers will not begin the process of placing a patient into four-point restraints until directed to by the Sector Lieutenant or ITU OIC, following medical assessment. Placing a patient into four-point restraints prior to medical assessment and subsequent verbal restraint order is no longer a viable option." Soares stated in his civil deposition that, in his experience, if there was an assault upon staff or other violent assault, medical staff would not assess a person before authorizing a 4-point restraint. He stated that, because of the nature of the assault, he acted under the assumption that Messier was going to be placed in restraints.

Tornifoglio filled out an INITIAL SECLUSION OR RESTRAINT FOR CRISIS TREATMENT PLAN on May 4, 2009. She documents the time as 21:23 (9:23) PM. On the first page of the two page form, Tornifoglio in the section titled **Behavioral target symptoms that require intervention**, the following: Placed in 4 pnts by DOC S/P[13] use of force. Pt. was being checked upon placement in 4 pnts. No BP [zero] pulse - code 99 called. (Pt. Was an assault on staff - u-of @ 21:10). On page two of the form, in the section titled **Crisis treatment plan disposition and intervention,** Tornifoglio checked the boxes marked Occurrence or Serious Harm to Others and Restraint. She additionally noted that Dr. Olubodun was notified at 9:23 PM. Kimberly Evans, RN, a Code Teram

---

12 Whinery stated in his civil deposition that he was made aware of Messier's assault on staff on the B1 Unit by the public address system.

13 According to Dr. Robert Diener, the medical director for BSH, S/P stands for "status post."

responder on May 4, 2009, in her Internal Investigation testimony stated that the form Tornifoglio filled out could be written after the 4 point restraints were applied. This is consistent with evidence presented by McHenry to the Internal Investigation team.

IV. Restraints

(A) Statutory Authority; G.L. c. 123, § 21

The use of restraints is provisionally authorized by statute. In relevant part, G.L. c. 123, § 21 provides as follows:

> Restraint of a mentally ill patient may only be used in cases of emergency such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide; provided, however, that written authorization for such restraint is given by the superintendent or director of the facility or by a physician designated by him for this purpose who is present at the time of the emergency or if the superintendent or director or designated physician is not present at the time of the emergency, non-chemical means of restraint may be used for a period of one hour provided that within one hour the person in restraint shall be examined by the superintendent, director or designated physician.

(B) Regulations, Bridgewater Policy on Use of Seclusion and Restraints, and General Post Orders

Three exhibits were introduced that address the use of restraints. See 103 CMR 505 Department of Correction; Use of Restraints; 103 BSH 651 Use of Seclusion and Restraints; and 103 DOC 503 Department of Correction; Forced Movement of Inmates.

The following sections of each exhibit are relevant to this court's inquiry into the death of Messier.

Pursuant to statutory authorization, the Department of Correction has promulgated regulations concerning the use of force at 103 CMR 505. The applicability of the regulations apply to all employees of the Department except "that 103 CMR 505.10 [Requirements Governing the Use of Instruments of Restraint] shall not apply when instruments of restraint are applied to inmates that have been admitted or committed to the Bridgewater State Hospital under the provisions of M.G.L. c. 123." 103 CMR 505.04.

Messier was a patient of BSH admitted under the provisions of G.L. c. 123. § 6(a), pending a hearing on a petition filed under G.L. c. 123, §§ 7 & 8.

Notwithstanding the inapplicability of 103 CMR 505.10, in these circumstances, the Department of Correction promulgated, as an attachment to 103 CMR 505, Standard Operating Procedures to 103 CMR 505. It, too, is applicable to all employees of the Department, except that "Sections VI Special Restraints and III A Management of Disruptive/Combative Inmates shall not apply to those inmates who have been admitted or committed to the Bridgewater State Hospital under the provisions of M.G.L. CH. 123." Relevant, and not excepted, is the following provision of Section III B Management of Disruptive/Combative Inmates:

B. To prevent the potential for positional asphyxiation the following guidelines have been established to prevent in-custody deaths due to restraining an inmate:

1. If as a result of a use of force it becomes necessary to restrain an inmate to the ground, bed, floor etc., the inmate, once handcuffed, shall, as soon as possible, be placed on his/her side or be placed in a sitting position. The inmate shall never be kept face down on his/her stomach.

2 If an inmate continues to struggle once restrained staff shall never sit on or put their weight down on an inmate's back. The use of leg irons and/or the holding down of the legs will be utilized.

...

5. Staff shall always maintain observation of a restrained inmate to recognize breathing difficulties or loss of consciousness. Staff shall be alert to issues such as obesity, alcohol and drug use, or psychotic behavior.

The Department of Correction itself has also issued a policy that contains relevant information. Entitled <u>Forced Movements of Inmates</u>, see 103 DOC 503, its declared purpose is "[t]o establish department standards for the forced movement or extraction of an inmate." Section 503.02 of the policy, entitled <u>Requirements Governing the Use of Instruments of Restraint</u>, provides in part that "2. Instruments of restraint shall not be used as punishment.... 7. Instruments of restraint shall only be used by employees trained in their proper use. Such training shall be documented.... 12. The application of instruments of restraint shall be such that they provide the least amount of physical

restraint necessary for the situation. This may include the use of handcuffs, waist chain or leg restraints, separately or in combination.... 14. If four point restraint is authorized by the superintendent, or his/her designee, or the shift commander as allowed by [103 CMR] 505.10(5), the assistant deputy commissioner shall be notified immediately. In those instances where the use of four-point restraints have been ordered as medically necessary by a member of the medical or mental health staff, the director of health services or designee shall be notified during business hours...."

In addition, the Department of Correction has also promulgated a policy specifically for the Bridgewater State Hospital on the Use of Seclusion and Restraint. See 103 BSH 651. Relevant are the following sections.

II. <u>DEFINITIONS</u>

...

I. <u>Emergency</u> - Imminent risk of harm to self or others such as the occurrence or serious threat of extreme violence, personal injury or attempted suicide. Examples include assault on others, fight, and threats to hurt oneself or others.

...

III. <u>POLICY</u>

It is the policy of Bridgewater State Hospital to prevent, reduce, and strive to eliminate the use of seclusion and restraint in a way that is consistent with the mission of {BSH] and its commitment to provide a safe environment for its patients, staff, and visitors. Toward this end BSH is committed to the prevention of emergencies that otherwise might have the potential to lead to the use of seclusion and restraint. It is the policy of BSH that the use of non-physical interventions is preferred to the use of these special treatment procedures. BSH is also committed to using seclusion and restraint only when there is an imminent risk of a patient physically harming himself or others...."

...

B. Seclusion and restraint must be authorized by the Medical Director or a physician who is present at the time of the emergency. If the physician or medical Director are not available in the event of an emergency, a non-chemical means of restraint may be used for a period of one (1) hour provided that within the one (1) hour period the patient is examined by the physician or the Medical Director. An initial order for seclusion or restraint must be completed by a licenced (or licence eligible) mental health professional or a registered nurse. If this does not occur within the one-hour period, the patient may be secluded or restrained for an additional one (1) hour period until he is examined by the physician or the Medical Director.

...

V. PROCEDURE

...

B. Transfer to ITU

...

2. If the Sector Lieutenant is unable to de-escalate the patient or if s/he believes an emergency exists, the Sector Lieutenant shall order that the patient be placed in wrist restraints and escorted to the ITU and placed in Cell 15. Upon placement of the patient in Cell 15, the Sector Lieutenant shall immediately notify the physician, registered nurse, psychologist, social worker, or certified physician's assistant assigned to the ITU so that one of those staff members can immediately assess the patient.

3. In any instance where a significant incident precedes the placement of a patient in seclusion or restraint, the Sector Lieutenant shall inform the physician responsible for ITU coverage of the circumstances that led to the use of seclusion or restraint. This communication from the Sector Lieutenant shall occur by the fastest means possible and no later than one hour after the incident has occurred.... For the purpose of this section, a significant incident shall include but not be limited to: ... and assault on staff ... a use of force....

...

C. Initiation of Seclusion & Restraint

1. If, upon assessment, the licensed (or license eligible) healthcare professional, mental health professional or registered nurse believes that an emergency exists, s/he shall order that the patient be placed in seclusion or restraint for up to one hour and shall write the Initial Seclusion or Restraint Order Form, which includes the Conditions of Seclusion and Restraint on the reverse side, and accompanying Incident Report (via IMS).

...

H. Unit Operations

1. A patient placed in seclusion and restraint in the Intensive Treatment Unit shall have his clothing removed from him at the time of his admission to the unit and the patient shall be strip searched....

...

b. For patients who refuse a strip search, an order for restraints may be written by the Medical Doctor. Once placed in restraints, the patient's clothes shall be cut off and a security smock issued.

...

VI. STAFF TRAINING

...

C. Correction Officers and other staff authorized to apply restraint or seclusion are trained and demonstrate competence in the topics cited in [VI.](B.) above. The staff members also receive ongoing training in and demonstrate competence in the safe use of restraint and other use of force situations as well as the application and removal of all mechanical restraints.

Finally, several Post Orders for Bridgewater State Hospital were introduced as exhibits. Relevant are Bridgewater State Hospital General Post Orders Responsibilities of Correction Officers and the Intensive Treatment Unit Post 178 Charge Officer.

General Post Orders Responsibilities of Correction Officers. In this order the USE OF FORCE section, in part, states as follows:

> Staff members are authorized to apply physical restraints necessary to gain control of a patient/inmate who appears to be dangerous because: the patient/inmate assaults any person, the patient inmate attempts suicide, the patient inmate inflicts wounds upon self, or the patient inmate becomes violent or displays imminent violence. This rule of restraints does not apply to routine movements requiring precautionary movement or transfer of patient/inmate. In an immediate use of force situation, staff may respond with or without the presence or direction of a supervisor. In all other situations, a Lieutenant shall be physically present. It must be remembered that force is not authorized and shall not be used as a disciplinary measure or punishment....

Intensive Treatment Unit Post 178 Charge Officer. The DUTIES AND RESPONSIBILITIES section, , in part, states as follows:

> All patients escorted to ITU for Assessment/Seclusion shall be placed in a holding cell with handcuffs and legions and held in the holding cell until ITU Clinical Staff confirm or rule out the need for four(4) or five (5)point restraints and or Emergency Medication. Only after ITU Clinical Staff have advised ITU Security Staff regarding the need for restraint of IM's shall the patient be moved to an ITU or ITU Overflow cell.

V. Training Material

The court has reviewed the training material submitted. The material submitted includes the following titles: Use of Force 2.5 hrs; Use of Force/ Phase II (Hands-on) 1

hr.; Use of Force 1 hr.; Defense Tactics Phase I (Psychological); Defense Tactics Phase II (Hands On); Restraint Equipment 2.5 hrs.; Use of Force/Restraints; Forced Movement of Inmates; Transportation of Inmates 3.0 hrs.; Extraction Team 2.5 hrs; Restraint Equipment/Application 2 hrs.

As to Howard, he attended the Use of Force seminar on 10/9/06. But he also attended a seminar entitled Use of Force-Defensive Tactics on 4/7/09 that credited him with 3 hours of training and again on 4/14/08 in which he received 2 hours of credit.

As to Raposo, he attended the Defense Tactics Phase I (Psychological) course on 9/26/06. But he also attended the following courses for which the training material has not been submitted: Use of Force Regulations and Tactics, 9/26/06 3 hours of credit, Defense Tactics Phase 2 (Hands-on) on 10/6/06, 3 hours of credit and 9/28/06 2 hours of credit; Use of Force – Defensive tactics on 1/13/09 3 hours of credit, 12/17/07 2 hours of credit; Forced Movement of Inmates/Extraction Practical on 11/9/06 2.5 hours of credit and on 11/3/06 2.5 hours of credit; Forced Movement of Inmates/Extraction (Basic) on 10/27/06 3 hours of credit; Restraint Equipment and Application Techniques on 10/26/06 2 hours of credit, 9/21/06 2 hours, and 9/20/06 2 hours of credit.

As to Billideau, his training record reflects that he attended a Defense Tactics course on 9/19/01 and received 2 hours of credit and is also is credited as having attended the following courses for which the training material has not been submitted: Positional asphyxiation .25 hours of credit; Use of Force/Defense Tactics on 4/21/08 2 hours of credit; Use of Force on 4/30/07 2.25 hours of credit, 9/19/01 2 hours of credit, and 11/2/99 2 hours of credit; Use of Force/Restraints on 5/9/05 2.5 hours of credit; Defense Tactics 8 hours of credit; Use of Force/move Team 3 hours of credit; Use of Restraints on 9/19/01 1 hour of credit, Seclusion and Restraints 5/13/05 .05 hours of credit and on 10/16/97 for 1 hour of credit; and on 11/4/98, he attended a video presentation of Seclusion and Restraint.

Finally, Kerr's record indicates that he attended the Extraction Team course on 6/19/98 course and received 2.5 hours of credit; the Use of Force course on 6/19/98 for which he received 2.5 hours of credit; and Forced Movement of Inmates of 1/12/06 for 2 hours of credit. But he also attended a Defensive Tactics course on 5/17/02 2 hours of credit and on 1/10/06 2.25 hours of credit; a Use of Force course on 5/17/02 2 hours of credit, 1/18/07 2.25 hours of credit, and 9/23/08 8 hours of credit; Restraint Equipment/Transportation on 6/12/98 5 hours of credit; Transportation of Inmates 2 hours of credit, Rules and Regulations (self-study) 3/30/04 1 hour of credit; Use of Force/Restraints 2/14/05 2.5 hours of credit; Restraint Practicles [sic] 2/15/05 2 hours of credit; Use of Force Regulations and tactics 1/10/06 2.25 hours of credit; Restraint

Equipment and Application 1/1-/06 2.25 hours of credit; and Use of Force/Defensive tactics 9/24/07 2 hours of credit.

The court finds that, as to Howard, in the Use of Force seminar he attended on 10/9/06, he would have received the following relevant instructions:

VI. REQUIRMENTS GOVERNING THE USE OF INSTRUMENTS OF RESTRAINT

...

B. Instruments of restraint shall not be used as punishment.

...

E. Except as described in 103 CMR 505.10(3) and (4), instruments of restraint will only be used when all other reasonable methods of control have been considered and deemed inappropriate, and then only on the documented approval of the Superintendent, or, in his absence, his designee. The shift commander may authorize the use of instruments of restraint for up to two hours....

F. Instruments of restraint shall only be used by employees trained for their purpose. Such training shall be documented.

G. Instruments of restraint used for purposes other than as described in 103 CMR 505.10(3) and (4), shall only be used until the restrained inmate has exhibited through his actions or statements that he will not resume the conduct which resulted in the decision to use instruments of restraint...

As to Raposo, at the Defense Tactics Phase I (Psychological) course on 9/26/06, he would have received relevant education on the following:

PROCEDURAL GUIDELINES FOR THE CARE OF SUBDUED/RESTRAINED SUBJECTS

....

IMPORTANT

1. Positional Asphyxia can occur even in subjects involved in mild physical activity, particularly when other factors create physical or emotional stress.
2. The risk of positional asphyxia increases when individuals with predisposing factors become involved in a violent struggle, are restrained behind-the-back, and are placed in a stomach-down position.

3. Minor impairment of the respiratory function occurring within 10-20 minutes can be fatal, particularly if they are intoxicated.

4. ....

5. Immediate efforts to revive subjects of Positional Asphyxia are 100% unsuccessful.

Finally, Kerr would have learned the following relevant material:

Use of Force course; See Howard above.

Forced Movement of Inmates course:

What special Precautions should be taken to avoid positional asphyxia
If an inmate continues to struggle once restrained, staff shall never sit or put weight down on the inmates back
Once restrained inmate shall be rolled onto his/her side or placed in a sitting position
Inmate shall never be transported face down on their stomachs while using a stretcher, gurney or backboard
Inmate shall always be carried by his/her extremities, and never by the restraint equipment.

While the precise training materials available to each of the correctional officers may not be clear, the testimony of the witnesses were demonstrably clear that each of the correctional officers was trained and understood that he was not to put pressure on an inmate or patient's back once he is placed in restraints.

V. Medical Testimony

Medical testimony on the cause of death was presented through Dr. Mindy Hull, a medical examiner for the Massachusetts Office of Chief Medical Examiner and who performed an autopsy on Messier on May 5, 2009, and through Dr. Edward McDonough, an assistant medical examiner for the state of Delaware and a former employee of the Office for the Chief Medical Examiner for the State of Connecticut who testified as an expert to assist the court.

Dr. Hull presented the medical opinion that Messier's death was caused by cardiopulmonary arrest, i.e., the heart and lungs stooped functioning, during physical restraint with blunt impact to the head and compression of chest while in an agitated state. Dr. Hull further testified that she could not state that the chest compression

observed during the period of time Howard and Raposo applied weigh against Messier's back as he was being restrained in Cell 13 was the "straw" that metaphorically "broke the camel's back" and caused Messier's death. It was, however, in her opinion, a significant cause along with other factors in the cause of Messier's death. Dr. Hull testified that there was no evidence to support a finding that Messier died from positional asphyxiation.

Messier, absent any agitated state, had high blood pressure, was obese, was taking Clozapine, a medication that, itself, can cause sudden death, and was schizophrenic, a condition, according to Dr. Hull, which can "mysteriously" result in sudden death. These conditions were circumstances that Messier, as characterized by Dr. Hull, "br[ought] to the table." According to Dr. Hull, these factors along with Messier's agitated state, in which the heart pumps faster and blood pressure rises, and the chest compression "culminat[ed] into a downward spiral" leading to cardiac dysrythmia, a condition in which the heart does not have normal rhythm and presents a condition of rhythm "not sufficient to allow the heart to actually pump blood through the body." In this condition "the vital organs, the brain, the heart itself, [and] the lungs ... are not getting the oxygen that they need in order to sustain life."

Dr. McDonough agreed with the conclusion of Dr. Hull except that he placed more significance to the length of time Messier's chest was compressed during the Cell 13 restraint process. Dr. McDonough found significant the temporal relationship between Messier being bent over and his apparent lack of response after the weight of Howard and Raposo is removed from Messier's back and is ultimately laid down on the restraint bed. Dr. MsDonough agreed with Dr. Hull that the death was a cardiac event that, because of the chest compression, decreased Messier's ability to respire and was part of the pathway leading to the cardiac event.

VI. Legal Conclusions

It is first incumbent upon the court to note that in no way did Joshua Messier cause his own death. As Dr. Hull stated, Messier's death was a homicide at the hands of another. The court must determine if there is probable cause to believe that a crime occurred, which resulted in Messier's death.

Central to the court's inquiry into Messier's death is whether the use of force in the application of restraints was the proximate cause of Messier's death. The court concludes that, (1) in general, correctional officers may be entitled to use reasonable force to bring an assaultive patient under control, including the use of restraints according

to promulgated regulations and standards; (2) the use of reasonable force[14] to effectuate restraint in such circumstances could excuse a resulting death, but that, in the circumstances of Messier's death, certain correctional officers used excessive force[15] in the restraint process; (3) the excessive force was a proximate cause of Messier's death; and (4) its use constituted wanton and reckless conduct.

There is no merit to the argument that in a correctional facility housing mentally ill persons correctional officers are not entitled to use force, including restraint, to restrain an assaultive patient/inmate. Statutorily the use of mechanical restraints is conditionally authorized. See G.L. c. 123, § 21. Death resulting in the proper exercise of restraint, if the proper degree of force applied in the restraint process was the proximate cause, may be excusable, i.e., an accidental death occurring during the proper use of force would not constitute an unlawful killing. This would not be the case if there was the use of excessive force in the process and that force was a proximate cause of death. Death resulting from the use of excessive fore may be classified as an unlawful killing.

In the circumstances of Messier's death, the court finds from the video evidence, the documentary evidence, and the testimony that both a reasonable use of force and an excessive use of force were used in the restraint process. The force used to place Messier onto the restraint bed and in the actual act of placing restraints onto his legs and wrists was reasonable. Excessive force was, however, used in controlling Messier during the application of restraints. While restrained by mechanical restraints, Messier was placed in a position that compromised his ability to respire. Over two hundred pounds were placed upon Messier's back causing him to be pushed forward into a clamshell position. Howard kept him in this position for fifty-four seconds and Reposa aided Howard in maintaining Messier in this position.

It is clear from the medical evidence that Messier's death was not due solely to the position in which Messier was placed. The positioning was not a "but for" cause of death. The medical testimony is that the totality of the circumstances caused the death of Messier. The totality, from the viewpoint of the medical examiner, includes Messier's

---

[14] 103 CMR 505.06 defines reasonable force as follows: "The force that an objective, trained and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to subdue an attacker, overcome resistance, effect custody, or gain compliance with a lawful order."

[15] 103 CMR 505.06 defines excessive force as follows: "Force which exceeds reasonable force, or force which was reasonable at the time its use began but was used beyond the need for its application."

weight, the medication he was taking, the assault and struggle in the B1 building, his transport to the ITU unit, and the process of completing the 4-point restraint. The video clearly shows Messier alive at the time the restraints were being applied. It also shows Messier's resistance to the process. Yet when the force used by Howard and Raposo is released, and Messier is placed on his back, the video does not show any sign of continuing struggle. Indeed it shows no conscious movement at all by Messier. Dr. McDonough credibly testified that there exists a temporal connection between the excessive use of force and the lack of movement following the release of the improper force, and Dr. McDonough and Dr. Hull both agreed that the positioning of Messier during the application of restraints to his legs and arms was a significant contributing factor in Messier's death. The recorded evidence suggests that death occurred during the use of excessive force placing him in the clamshell position, while at the same time permissible force was being used to apply the restraints.

Although the medical evidence cannot separate the use of reasonable force from excessive force and demonstrate which force caused Messier's death, the legal issue does not present such uncertainty. As stated in *Commonwealth v. Baker*, 67 Mass.App.Ct. 760 (2006),

> Proximate cause "is a cause, which, in the natural and continuous sequence, produces the death, and without which the death would not have occurred." *Commonwealth v. Rhoades,* 379 Mass. 810, 825 (1980), quoting from California Jury Instructions, Criminal § 8.55 (4th rev. ed.1979). A proximate cause "need not be the sole or exclusive cause of death." *Commonwealth v. Santiago,* 425 Mass. 491, 504 (1997). See *Commonwealth v. Maynard,* 436 Mass. 558, 563 (2002) ("there may be more than one proximate cause of a victim's death"). "Where a defendant causes an injury which, along with other contributing factors or medical sequella of the injury, leads to death, jurors may determine that the defendant's acts were the proximate cause of the injury." *Commonwealth v. Perry,* 432 Mass. 214, 225, 733 N.E.2d 83 (2000). Those contributing factors may include preexisting conditions of the victim: a defendant "takes the victim as he ... finds [her]." *Commonwealth v. Starling,* 382 Mass. 423, 429 (1981). To be proximate, however, a cause cannot be too "remote in the chain of events leading to [the victim's] death." Commonwealth v. Rhoades, 379 Mass. at 824.

Commonwealth v. Baker, 67 Mass.App.Ct. at 763-764.

As further explained by *Baker*, in response to Baker's argument that, "because the medical examiner testified that multiple blunt force trauma was only one of a combination of factors that caused the victim's death and would not alone have caused the death, it can only be viewed as a contributing cause of death and that, under *Commonwealth v. Rhoades, supra,* a contributing factor is insufficient to constitute proximate cause," the court pointed out "that the *Rhoades* court was not troubled with the notion that a contributing factor of death may also be a proximate cause of death. Rather, the difficulty the court had was with the additional language the trial judge used in connection with the term 'contribute.' In *Rhoades,* the judge's instruction improperly suggested to the jury that an act which 'in any way contributed to hasten' or 'in any way constituted a link, no matter how remote' in the chain of events leading to death, permitted a finding of guilt." *Commonwealth v. Baker*, 67 Mass.App.Ct. at 766-767. As observed in *Baker*, "[c]ases decided after *Rhoades* have also concluded that a contributing cause can be a proximate cause of death and have recognized that there may be a combination of causes that result in death. See, e.g., *Commonwealth v. Davis,* 403 Mass. 575, 582 (1988) (blow to the head was the proximate cause of death even though extreme cold contributed to the death as well). See also *Commonwealth v. Maynard,* 436 Mass. at 564, quoting from *Commonwealth v. McLeod,* 394 Mass. at 745 n. 21 ('When the conduct of two or more persons contributes concurrently as proximate causes of a death, the conduct of each is a proximate cause of the death regardless of the extent to which each contributes to the death. A cause is concurrent if it was operative at the moment of death and acted with another cause to produce the death')." *Commonwealth v. Baker,* 67 Mass.App.Ct. at 767.

What is critical to the understanding of proximate cause is that the cause cannot be remote. *Commonwealth v. McLeod,* 394 Mass. 727, 735 (1985). " 'Proximate cause' defines a point beyond which the law will not recognize a contributing factor as a cause giving rise to liability. "The term "proximate" is used in contrast to the term "remote" ' [Citation omitted.]" *Id.* Further, criminal liability need not be dependent upon isolating the action of any one individual and determining whether the isolated action alone would have caused death. An individual could properly be convicted of murder or of manslaughter if his acts contributed to the victim's death "even if his actions alone would not have been sufficient to cause the death." *Id.* at 747. Massachusetts is not a "but for jurisdiction." We look to whether an act was a substantial or contributing factor. *Burrage v. United States,* 187 L.Ed. 2d 715, 726 (2014) citing *Commonwealth v. Osachuk,* 43 Mass.App.Ct. 71, 27-73 (1997).

Messier's death, expressed as the result of the totality of the circumstances, addresses a cumulative result and includes the use of force. Excessive force was plainly a

substantial contributing cause to the cardiac dysrythmia, or, otherwise stated, a proximate cause of the resulting death. It is true that the medical examiner cannot state with certainty which type of force caused Messier's death, i.e., reasonable or excessive force. And this court cannot find that the use of excessive force was the sole cause of Messier's death. But the facts fully warrant the finding, consistent with the medical examiner's testimony and video evidence, that the use of excessive force substantially contributed to Messier's death in conjunction with the other factors identified by the medical examiner.

As to the issue of criminal intent, "[a] fine line distinguishes murder in the second degree based on third prong malice from the lesser included offense of involuntary manslaughter. See *Commonwealth v. Skinner*, 408 Mass. 88, 93 (1990), and cases cited. 'Without malice, an unlawful killing can be no more than manslaughter.' *Commonwealth v. Judge*, 420 Mass. 433, 437 (1995), and cases cited. 'The difference between the elements of the third prong of malice and ... involuntary manslaughter lies in the degree of risk of physical harm that a reasonable person would recognize was created by particular conduct, based on what the defendant knew. The risk for the purposes of third prong malice is that there was a plain and strong likelihood of death.... The risk that will satisfy the standard for ... involuntary manslaughter "involves a high degree of likelihood that substantial harm will result to another." ' *Commonwealth v. Sires*, 413 Mass. 292, 303-304 n. 14,(1992), quoting *Commonwealth v. Welansky*, 316 Mass. 383, 399 (1944)." *Commonwealth v. Lyons*, 444 Mass. 289, 293 (2005).

The circumstance of Messier's death demonstrates that the use of excessive force was not a fleeting use of force.[16] Howard applied the excessive force for at least fifty-four seconds and the Raposo's use of supporting force lasted approximately thirty-four seconds. The force used placed Messier in a position whereby oxygen was deprived to his body thereby significantly contributing to the death. Understanding the fine line between murder and manslaughter, the court cannot state without significant reservation that a reasonable person would recognize that, from the position into which Messier was placed and the length of time that the position was maintained, there was a plain and strong likelihood of death. But an objectively reasonable person would recognize without any reservation that the circumstances under which Messier was placed, while restraints were

---

16 The court is aware that correctional officers may in some circumstances be required to make split-second decisions on the use of force to meet certain challenges. The sustained use of force in this case clearly demonstrates the use of force beyond what was needed and permissible. The sustained force used was objectively unreasonable and excessive.

being applied to his legs and arms, involved a high degree of likelihood that substantial harm would result to Messier.

Howard and Raposo's application of body weight to the back of Messier while he was being restrained and causing him to be folded forward into a clamshell position for 54 seconds was contrary to the regulatory guidelines and standard operating procedure of Bridgewater State Hospital. It was also objectively unreasonable. The intentional conduct of each was wanton and reckless. It constituted an excessive and unreasonable use of force, which was a substantial contributing factor in the death of Messier. The evidence supports the finding that Howard and Raposo are criminally liable under the theory of involuntary manslaughter based upon wanton and reckless conduct. See *Commonwealth v. Osachuk*, 43 Mass.App.Ct. 71, 73 (19770)("When the conduct of two or more persons contributes concurrently to the death, the conduct of each is the proximate cause, regardless of the extent to which each contributes").[17]

The court also finds that Billadeau shared in the intent required for the crime of involuntary manslaughter. His conduct was wanton and reckless. On the B 1 Unit, Messier was having a schizophrenia attack. In the ITU, Messier is gasping for air, is heard twice saying, "I can't breathe," and is bruised with blood on his face and a deep gash on his head.

Despite all this, Billadeau, as the supervisor in charge, failed to request any type of medical assessment prior to placing Messier in four point restraints.[18] A medical assessment might have detected that Messier was experiencing a respiratory problem.

---

[17] The court has not found a case where excessive use of force in the context of a legal right to restrain would constitute a legal battery and that legal battery, if the proximate cause of death, would give rise to a theory of involuntary manslaughter based upon a battery. As the court has found, in these circumstances, the excessive force does give rise to involuntary manslaughter based upon the theory of wanton and reckless conduct. The court cannot conclude that the intent in the application of the force applied was to inflict death giving rise to a first prong murder charge or that it created a plain and strong likelihood of death giving rise to a charge of second degree murder.

[18] Seen in its worst light, the shift commander candidly testified that if a patient or inmate strikes a correctional officer or other staff, the correctional officers would automatically place him in restraints.

As the supervising officer Billadeau stood by passively and allowed over 200 pounds of pressure to be applied to Messier's back causing him to fold forward to a near 45 degree angle for a period of 54 seconds. He made no attempt to intervene.

Billadeau signed the post orders indicating his knowledge of and compliance with all regulations, guidelines and operating procedures governing the use of restraints. He was trained and understood the restrictions on placing pressure on a patient's back while in restraints and the need for a medical assessment prior to placing a patient in four point restraints.

Even if the Use of Force Standard Operating procedure did not apply in this situation, it acts as a clear acknowledgement within the Department of Corrections that putting pressure on the back of a restrained patient could cause positional asphyxiation or otherwise result in death. Common sense required that Billadeau, as the person in charge with command authority, intervene, and the failure of any such intervention demonstrates both wanton and reckless conduct and a knowing and meaningful participation in the wanton and reckless acts of Howard and Raposo, which significantly contributed to Messier's death.

The evidence also supports a finding that Howard, Raposo, and Billedeau, in addition to involuntary manslaughter, violated Messier's constitutional rights, itself a crime. G.L. 265, § 37.[19] Every individual has a constitutional right to personal security and to be free from unreasonable seizures. Article 14 of the Massachusetts Declaration of Rights[20] and the Fourth Amendment to the United States Constitution.[21] This right to personal security does not disappear in a correctional setting. *See, e.g., Commonwealth v. Harvey*, 397 Mass. 351 (1986)(upholding conviction of police officer who, instead of transporting person in protective custody to station instead drove him to a dark area, took

---

19 G.L. c. 265, § 37, provides, in part, as follows: "No person, whether or not acting under color of law, shall by force or threat of force, willfully injure, intimidate or interfere with, or attempt to injure, intimidate or interfere with, or oppress or threaten any other person in the free exercise or enjoyment of any right or privilege secured to him by the constitution or laws of the commonwealth or by the constitution or laws of the United States."

20 Art. 14 provides, in relevant part, as follows: "Every subject has a right to be secure from all unreasonable ... seizures, of his person...."

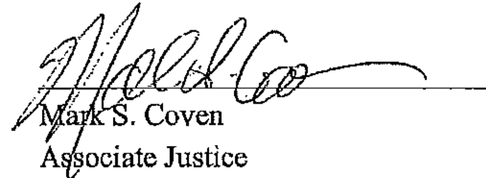
21 The Fourth Amendment guarantees the right of "the people to be secure ... against unreasonable ... seizures."

money from him, and abandoned him). The right not to be "deprived of ... life ... but by the judgment of his peers, or the law of the land," is also a constitutional guarantee. Article 12 of the Massachusetts Declaration of Rights.[22] Further, the Fourteenth Amendment's due process clause protects the liberty interests of persons. *O'Sullivan v. Secretary of Human Services*, 402 Mass. 109, 197 n.10 (1988)("Seclusion practices in violation of G.L. c. 123, § 21, constitute a violation of a protected liberty interest under the Fourteenth Amendment's due process clause").

The court cannot conclude that Kerr's actions or supervisory authority at the relevant point in time[23] make him criminally responsible for the death of Messier or otherwise criminally responsible.

The above constitutes the Court's Report. The Report and a copy will be forwarded to the Clerk-magistrate of the Brockton District Court who is to transmit the official Report, the official transcript, and exhibits introduced to the Clerk-magistrate of the Plymouth Superior Court for filing upon the receipt of the official transcript. A copy of the Report and transcript shall be maintained at the Brockton District Court.

Dated: This 31st day of March, 2015



Mark S. Coven
Associate Justice

---

[22] Art. 12 provides, in relevant part, as follows: "And no subject shall be arrested, imprisoned, despoiled, or deprived of his property, immunities, or privileges, put out of the protection of the law, exiled, or deprived of his life, liberty, or estate, but by the judgment of his peers, or the law of the land."

[23] Although Kerr was the sergeant in charge of the ITU, once Billadeau entered the ITU with Messier, he, as acting lieutenant, assumed command.