I. Investigation Report

The Commonwealth of Massachusetts
Executive Office of Public Safety and Security
Department of Correction
Internal Affairs Unit
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Acting Commissioner

Veronica M. Madden
Deputy Commissioner

Paul L. DiPaolo
Acting
Deputy Commissioner

Karen Hetherson
Assistant Deputy
Commissioner

TO: Captain John Cappello
Internal Affairs Unit

FROM: Sergeant Donald Perry
Internal Affairs Unit

DATE: 25 May 2010

RE: DOC-BSH-09-67 – Death of Inmate Joshua Messier

On May 4, 2009 at approximately 8:43 p.m. Bridgewater State Hospital (BSH) Patient Joshua Messier (M-103880) was returning from a visit with his mother, Lisa Jaskueka-Messier. Upon Messier's return to Housing Unit (B-1), he spontaneously assaulted Correction Officer Christopher Rego by punching him in the back of the head. During the assault, Messier was yelling and making statements he was having a schizophrenic attack while struggling with multiple staff members. After Messier was restrained, he was escorted to the Intensive Treatment Unit (ITU). Upon Messier's arrival, it was reported he began spitting at staff members.

Staff members once again struggled with Messier as they were transitioning him into four-point restraints. Once Messier was placed in four-point restraints, a nurse

entered the room to check his restraints and vital signs. It was determined Messier was unresponsive and having no detectable vital signs. A medical emergency was called (Code 99), and Dr. Joel Olubodun responded. At approximately 9:30 p.m., a call was made for a priority one (1) ambulance. At approximately 10:00 p.m., Messier was transported to Brockton Hospital via the Bridgewater Fire Department. Messier was pronounced dead at approximately 10:26 p.m. by Dr. Richmond (See Emergency Physician Note, Section V).

Personnel who have been identified responding thereafter to BSH included; Superintendent Karin Bergeron, Director of Security Brian Frye, Captain Vincent Martin, Director of Health Services Paula King, Director of Nursing Rhonda Cantelli and Mental Health Clinician Susan Lantagne. Responding from the Office of Investigative Services (OIS) were; Chief Paul Oxford, Captain Tina Goins, Lieutenant Robert McGuiness, Sergeant Amanda McKenzie and Sergeant Donald Perry.

Massachusetts State Police (MSP) also responded to BSH; Captain Joseph Mason, Lieutenant Richard Warmington, Lieutenant Leonard Coppenrath, Trooper David Mackin, Trooper Brian Galvin and Trooper Robert Clemens. MSP took authority over the investigation surrounding Messier's death.

As instructed by Chief Paul Oxford, inquiries by the DOC into Messier's death would not commence until the MSP concluded their investigation.

INVESTIGATIVE ACTION; SUMMARY OF EVIDENCE AND WITNESS STATEMENTS

The MSP were briefed regarding the chronology of events which took place on 4 May 2009. Copies of the B-1 and Intensive Treatment Unit (ITU) video surveillance,

staff reports and Messier's telephone calls were released. MSP searched Messier's cell, measured and sketched germane areas, took photographs and conducted interviews with involved staff.

Information relayed to OIS from BSH Administrators that night included the following; Messier was born on July 16, 1985. He was a white male, approximately 5'10". He weighed 236 pounds. Messier was admitted to BSH on April 1, 2009 under Section 15B (Criminal Responsibility) from Dudley District Court. His parents were currently involved in divorce proceedings. Messier was reported to have been recently upset because he could not complete his college education and his best friend told him he was gay. Messier had a history of violence, assaulting approximately seventy (70) Department of Mental Health staff members in the past. Messier was just involved in a physical altercation with another inmate the day prior to his death (May 3, 2009).

Messier was currently being administered numerous medications including, Klonopin 1 mg (2x daily), Robinul 1 mg (bedtime), Inderal 40 mg (2x daily), Clozaril 100 mg (12pm), Clozaril 450 mg (bedtime), Valproic Acid 500 mg (2x daily) 1,000 mg (bedtime), Milk of Magnesia 30 cc (daily as needed), Mylanta 30 cc (3x daily) and Tylenol 325 mg (2 Tabs/2x daily).

Messier's Medical Summary (See Supportive Documentation and Evidence, Section IV)

Paula King submitted a medical summary indicating the following additional details: Messier was housed in the Intensive Treatment Unit (ITU) upon his admission to BSH until April 7, 2009. He was compliant with his medications during this time. Messier was admitted to Housing Unit B-1 after being discharged from ITU on April 7,

2009. Messier was compliant with his meals and medications during this time. Messier was sent to ITU on April 20, 2009 for an alleged altercation with another patient. Messier was compliant with his medication while in ITU. Messier was discharged from ITU and sent back to B-1 on April 21, 2009. Messier was sent to Housing Unit B-2 on April 27, 2009. Due to another altercation with staff, Messier was transferred on May 3, 2009 to ITU. Due to this altercation, Messier was transferred to B-1. Messier had no medical diagnosis during these times.

Regarding the medical response on May 4, 2009, King reported after the Posey Restraints were applied to Messier, a nurse (Licensed Practicing Nurse Shawn Whinery) was called in to check Messier's restraints and vital signs. The nurse followed protocol and attempted to interview the patient while initiating vital sign checks. The nurse however, did not get a response and continued to assess the oxygen saturation, but was unable to get a reading. A "Code 99" was called at approximately 9:29 p.m.

Dr. Olubodun along with multiple nurses responded and ordered a Priority One ambulance. CPR was initiated. The Automated External Defibrillator (AED) was applied and a shock was given. CPR continued until paramedics arrived. Messier was transported to Brockton Hospital Emergency Room (2159) via Bridgewater Fire Department Ambulance.

BSH Incident Reports (See Reports, Section III)

The following is a list of personnel who submitted incident reports regarding the incident:

1. 623130 – Correction Officer Jessica Gagnon
2. 623123 – Correction Officer Christopher Rego

3. 623111 – Sergeant John Pupek
4. 623129 – Correction Officer Jose Varela
5. 623131 – Sergeant Clifford Foster
6. 623097 – Correction Officer Raymond Thibault
7. 623105 – Correction Officer Robert Desrosiers
8. 623101 – Correction Officer Derek Howard
9. 623119 – Correction Officer John Raposo
10. 623125 – Sergeant George Billadeau
11. 623078 – Correction Officer Peter Chmiel
12. 623110 Correction Officer Timothy Soares
13. 623113 – Correction Officer James Barker
14. 623108 – Sergeant Daniel Kerr
15. 623116 – Lieutenant Darryl Busch
16. 623122 – Correction Officer David Dufresne
17. 623112 – Licensed Practicing Nurse Shawn Whinery
18. 623118 – Registered Nurse Carla Tornifoglio
19. 623117 – Registered Nurse Susan Mchenry
20. 623121 – Registered Nurse Kimberly Evans
21. 623120 – Correction Officer Judekiz Guzman
22. 623109 – Correction Officer Marilyn Legault
23. 623133 – Correction Officer Jessica Gagnon
24. 623128 – Sergeant Donald Campbell

*Dr. Joel Olubodun did not submit a report

Messier's Recorded Telephone Calls (See Miscellaneous, Section V)

Thirteen (13) recorded telephone calls from Messier to his mother were monitored by Sergeant Perry. The dates of the calls ranged from April 8, 2009 through May 4, 2009. The following information was paraphrased; On the night of his death, Messier contacted his mother two (2) times. Messier informed his mother about a fight in the

inmate dining hall. Messier relayed one of the inmates involved in the fight told him, "your next." Messier told his mother he swung at this inmate and this inmate fell to the ground.

MSP Investigative Report (See Supportive Documentation and Evidence, Section IV)

On 23 March 2011, Sergeant Donald Perry received the MSP investigation into the death of Messier. According to the MSP, at approximately 7:55 p.m. on May 4, 2009, Messier entered the visiting room at BSH to visit with his mother. At approximately 9:09 p.m. Messier exited the visiting area and walked into the staff break room (B-1 Unit), which was occupied by Correction Officer Christopher Rego and Sergeant John Pupek. Messier began punching Rego in the head. Rego requested Messier to "Cuff up" without using force. Messier refused to comply with Rego's verbal instructions forcing Rego to physically defend himself. A violent struggle ensued causing Rego and Messier to fall out into the corridor and onto the concrete floor in the area of the Control Room. Additional Correctional Officers responded and assisted placing Messier into leg irons and wrist restraints.

Sergeant Clifford Foster, Correction Officer Derek Howard, Correction Officer John Raposo and Sergeant George Billadeau started escorting Messier from the B-1 Housing Unit and into the Courtyard. While walking, Howard held Messier's left arm, Foster held Messier's right arm, Raposo walked behind in escort and Billadeau monitored the escort. Messier began spitting blood and saliva at the escorting Officers. In response to Messier's spitting, Foster pulled Messier's shirt up and over his head, thus preventing Messier from spitting saliva or blood onto the Officer's.

Upon arriving into the Medical Building, Messier dropped to his knees and refused to walk. Escorting Officer's aided Messier to his feet and continued into the ITU. While entering the ITU, Messier again dropped to his knees, refusing to walk. Escorting Officer's aided Messier to his feet again. The Officer's escorted Messier into ITU Dorm-1 while waiting for the four-point bed restraint in Cell #13 to be prepared. Messier's shirt was then removed from his head. Once the four-point bed was prepared, Messier was escorted into Cell #13. Messier sat on the bed with his feet facing east, towards the foot of the bed. Messier was then physically assisted by Officer's in being rotated so that his feet where in the proper direction (west) so Posey restraints could be applied to his feet. As the Posey restraints were being applied, Messier began struggling by arching his back and head into Howard. Howard attempted to restrain Messier by pushing on Messier's back area. As Messier resisted, Howard lost his balance and attempted to regain control of Messier by lying on top of Messier (chest to back) with his left leg on the bed and his right leg on the floor. Raposo then assisted Howard by pressing against Howard's back. Sergeant Daniel Kerr assisted in placing Messier's right ankle into a Posey restraint while Correction Officer Timothy Soares placed Messier's left ankle into the Posey restraint. After removing Messier's wrist restraints, Raposo was then able to place Messier's right arm into a Posey restraint while Kerr and Correction Officer Eric Baker were able to place Messier's left arm into a Posey restraint. Once Messier was secured in Posey restraints, Howard held a Poly-Captor shield approximately six (6) inches above Messier. Kerr and Raposo cut Messier's clothing from him. A security smock was then paced over Messier.

Licensed Practicing Nurse (LPN) Shawn Whinery entered Cell #13 to conduct an initial restraint check and to check Messier's vital signs. After realizing Messier did not have a pulse, a Code 99 medical response was called and Cardio Pulmonary Resuscitation (CPR) was performed. Bridgewater Fire Department responded and transported Messier to Signature Health Care, Brockton, Massachusetts where he was pronounced dead.

Video Evidence (See Supportive Documentation and Evidence, Section IV)

The following is an abbreviated timeline for the events occurring based upon videotape surveillance.

Building B-1

2109:14 – Messier walking in the B-1 Corridor. Messier walks around the control area and into the staff break room in the unit. (Camera #6)

2109:45 – Several bodies appear from the break room and land onto floor. Lights are out. (Camera #6)

2110:25 – Lights are activated. Several officers are attempting to restrain Messier. (Camera #6)

2112:39 – Messier is aided to his feet with the assistance of several officers. He is escorted by the officers towards a door which leads to the courtyard. (Camera #6)

2112:48 – As Messier is being escorted by Sergeant Clifford Foster, Correction Officer Derek Howard and Correction Officer John Raposo, they pass the Control Room. (Camera #6)

2112:49 – Messier is escorted from B-1 and out into the courtyard. (Camera #3)

*There is no video surveillance available as Messier is escorted thru the courtyard. According to the MSP Investigative Report (See Exhibit 5, Section IV), a measurement of the most direct route from B-1 to the ITU was taken. It was the opinion of MSP that two (2) minutes and four (4) seconds was a reasonable amount of time to cover that distance.

ITU

2114:58 – Messier is continued to be escorted by Foster, Howard and Raposo and enter ITU. Messier falls to his knees. Messier is aided to his feet and is walked down the corridor. (Camera #16)

2115:31 – Messier is escorted into a cell. (Camera #15)

2117:39 – Messier is escorted across the corridor into Cell #13 (Camera #16)

2117:41 through 21:20 – Officer's escort Messier to the bed and place him down in the bed and on his side. Messier's head is repositioned approximately 180 degrees on the bed. Messier is brought into a seated position in the bed and officers start transitioning his restraints to four-point restraints. Officer's are working to restrain Messier with Posey restraints using physical force. Howard puts his weight down on Messier's back. At the same time, Raposa applies downward weight to Howard. (Camera #13)

21:20:08 – Messier is laid down on his back as Officer's continue applying his Posey Restraints.

21:20:12 - A Poly-Captor Shield is placed approximately six (6) inches above Messier.

2121:30 – Messier is secured in Posey Restraints.

2121:31 – 21:23:55 – A Poly-Captor Shield is held over Messier while other Officer's continue to check Messier's restraints and cut of his clothing. A blanket is placed over Messier.

2124:10 – Licensed Practicing Nurse (LPN) Shawn Whinery enters the cell and assesses Messier.

2128 – An Officer calls Code 99 and Messier's restraints are removed

2130:46 – Cardio Pulmonary Resuscitation (CPR) begins

Medical Examiner's Certificate of Death (See Supportive Documentation and Evidence Section IV)

The certificate pronounces Messier's death at 10:26 p.m. on May 4, 2009. The cause was determined to be, "Cardio-Pulmonary arrest during physical restraint, with blunt impact of head and compression of chest, while in agitated state."

Joint Commission's Root Cause Analysis (See Supportive Documentation and Evidence, Section IV)

The Joint Commission review was abbreviated as follows:

1. Going forward, Correction Officer Training will reinforce a patient should be positioned correctly for placement in restraints.
2. Correction Officer's did not get the Code Box in the ITU due to unusual nature of code: Staff were already present in the Room securing the Patient when the Code was called and consequently the Code Box was not brought to the scene in advance of the arrival of the Response Team.
3. Code 99 response occurred per policy. Additional enhancements to this policy have been identified.

Joint Commission Sentinel Event Measure of Success (See Miscellaneous, Section V)

The documentation was submitted to BSH as a follow-up to the Joint Commission's Root Cause Analysis. The responses taken by BSH in regards to the Root Cause Analysis were found acceptable and no further action related to this incident was required.

Director of Quality Improvement for Health Services Kenneth Nelson's Report.

After a review of the video in the ITU, Nelson reported the medical response in the ITU appeared to be appropriate. According to Nelson, Whinery did attempt to medically assess the patient, but it does not appear he conducted the assessment in the correct order. Rather than begin the assessment by checking the patient's airway, breathing and circulation he began the assessment with the blood pressure or circulation. During an approximate three (3) minute time period, Whinery appeared to be trouble-shooting the equipment. A better practice would be for such troubleshooting to begin with an assessment of the patient for airway, breathing and circulation first and then move to the equipment from the patient rather from trouble shooting the equipment to assessing the patient.

103 DOC 505 - Use of Force Policy (See Supportive Documentation and Evidence, Section IV)

The Use of Force Policy in effect was promulgated on July 23, 1999. It was reviewed and signed off on July 18, 2006.

Training Records (See Supportive Documentation and Evidence, Section IV)

Howard and Raposo were documented to be trained in the above mentioned Use of Force Policy.

Disabled Person's Protection Commission (DPPC)

Kaitlyn Rich from the DPPC is currently investigating the incident. No report was available at this time.

Disability Law Center (DLC) (See Miscellaneous, Section V)

On May 6, 2009 the DLC received a complaint regarding the incident and is investigating the incident.

BSH Use of Force Package (See Miscellaneous, Section V)

A Use of Force Reporting Form was completed by BSH. BSH requested the Use of Force be extended due to the incident being under review by the MSP.

Special Operations Division

As of May 11, 2011, Special Operations Division does not have a Use of Force package regarding the incident.

FINDINGS AND CONCLUSIONS

1. Regarding the incident in B-1. Based upon the totality of the circumstances, no misconduct was found against staff or violations to rules regulations and/or policy.

2. Regarding the incident related to security staff's actions in the ITU. Supported by the reported actions of staff, the video evidence and the Use of Force Policy (103 DOC 505) in effect at the time, misconduct was found against Howard and Raposo. Howard and Raposo applied downward pressure to the back of Messier while he was being restrained. Their actions were in violation of 103 DOC 505 regarding the Use of Restraints which states, "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 shall be utilized."
3. Recommendations made by Mr. Nelson should be reviewed by the appropriate authorities.
4. Dr. Olubudum responded to the incident in the ITU, but did not submit an incident report. His failure to report violates, 103 DOC 622 – Death Procedures, specifically: Reporting Requirements which states in part, "All observers of the death/emergency and responders shall complete facility incident reports and submit them to the Superintendent's office or designated area before the end of their shift."
5. BSH can forward the Use of Force package to Special Operations Division for their review.
6. The MSP have concluded their investigation and no charges have been filed as of this date.
7. Messier did spontaneously assault a Correction Officer. He was transported to ITU where he was resistant with the escort. Messier continued resisting officer's

as he was being restrained in four point restraints. Messier expired while being transitioned into four point restraints.

II. Executive Review and Decision(s)

EXECUTIVE REVIEW AND DECISIONS

DOC-BSH-09-67

On May 4, 2009 an investigation was initiated after patient Joshua Messier returned from a visit with his mother Lisa Messier. Upon his return back to his housing unit Messier assaulted Correction Officer Christopher Rego by punching him in the back of the head while yelling he was having a schizophrenic attack. A struggle ensued and Messier fought with staff. Once Messier was restrained he was escorted to the Intensive Treatment Unit. Upon his arrival in the Intensive Treatment Unit he again began to struggle, spitting at staff members. Once the patient was restrained the nursing staff entered the room to check the restraints and vital signs and determined that the patient was unresponsive with no detectable vital signs. A code 99 was called and Dr. Olobodun responded and immediately called for a priority one ambulance. Patient was transported to Brockton Hospital at 22:00 via Bridgewater Fire Department and was pronounced dead at 10:26 pm by Dr. Wende Bursa.

Based on the circumstances surrounding this invesigation, no misconduct was found against staff. However, it is recommended that responding staff, specifically Officers Howard and Raposa attend retraining in the use of restraints.

Send copy of this investigation to Superintendent Murphy for reivew and appropraite action. Specifically, ensure that Officers Howard and Raposa attend refresher training in the use and application of restraints.

Send copy of this investigation to Peter Hefférnan, Acting Director of Clincal Services for review and appropriate as it releates to Dr. Olubudum railing to submit an incident report as well as the recommendations made by Kenneth Nelson.

Karen Hetherson — 6-3-11

Karen Hetherson, Assistant Deputy Commissioner — Date

The Commonwealth of Massachusetts
Disabled Persons Protection Commission

300 Granite Street • Suite 404 • Braintree • Massachusetts • 02184

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October 7, 2011

Michael Cohen, Esq.
Department of Correction
Bridgewater State Hospital
20 Administration Road
Bridgewater, MA 02324

Re: Petition to Review DPPC Case #87368

Attorney Cohen:

Pursuant to the Disabled Persons Protection Commission's (DPPC) Protocol for handling Petitions for Review, I am hereby responding to your Petition objecting to the conclusions in the above referenced case. I have reviewed the issues raised coupled with the evidence submitted in support of your Petition, and have reviewed pertinent components of the case record as well.

For the reasons set forth below, I hereby affirm the conclusions of DPPC Report #87368 as I have determined that there was sufficient evidence to support these conclusions.

Case Background

The alleged victim (ALV) stopped breathing and died on May 4, 2009 soon after being physically restrained. He was a patient at Bridgewater State Hospital (BSH) at the time, and had been collectively restrained by several correctional staff.

Investigative Report

The DPPC Report, which was partially based on a criminal investigation performed by the Massachusetts State Police (MSP), determined that there was sufficient evidence to conclude that ALV's death was caused by the actions of two correctional officers; ALAB 1 and ALAB 2, both of whom played a prominent role in ALV's restraint. In support of this finding, the report relied on the following:

The autopsy report's conclusion that ALV's cause of death was "cardiopulmonary arrest during physical altercation, with blunt impact of head and compression of chest, while in agitated state."

The autopsy report also concluded that ALV's manner of death was "homicide (restrained by correction officers during agitated state) ... and that "compression of the chest" was one of the underlying causes of ALV's death.

The investigators review of the video footage of the incident, taken from a camera situated above the restraint bed wherein ALV was restrained. According to this review "the ALV appears to struggle while in the seated position, at which point ALAB 1 lies on top of ALV with his chest pressed against ALV's back. While ALAB 1 continues to struggle with ALV, ALAB 2 is seen pushing down on ALAB 1's back while ALAB 1 is on top of ALV." The review further noted that the ALAB's pushed down on ALV's back with enough force that the ALV's chest appeared to make contact with the front of ALV's legs ... despite the ALAB's testimony that they placed pressure on ALV's back to maintain him in a seated position.

A review of the Department of Correction's Use of Force Policy Section 505, section III (B) entitled "Management of Disruptive/Combative Inmates," which states "if an inmate continues to struggle once restrintained, staff shall never sit on or put their weight down on an inmate's back."

Petition for Review

In its Petition for Review, DOC contends that the findings of the report are not supported by a preponderance of evidence as required. In support, DOC makes the following arguments:

The lack of wrongdoing on the part of the two officers has been confirmed by the investigation performed by the Massachusetts State Police, and the subsequent failure by a grand jury to indict anyone in the matter.

There is no support for the conclusion that "the manner in which the officers were restraining ALV was consistent with blunt force trauma."

The cause of death contained in the Death Certificate was given as "cardiopulmonary arrest during physical restraint, with blunt impact of head and compression of chest, while in agitated state."

The OCME did not find that ALV had suffered "blunt force trauma to the upper, posterior areas of the shoulders and back ... nor did the the OCME's Death Certificate state that ALV's cardiopulmonary arrest resulted from the compression of the chest.

The video footage reviewed by the investigator confirms the conclusions of the state police and grand jury that no wrongdoing took place. The report incorrectly focused on one short sequence of actions in a much longer sequence of events manifesting the profound concern of staff attempting to restrain a violent, mentally ill patient...

The sole basis for the finding of abuse was the report's suggestion that the DOC's regulations required, at some point, that the officers cease trying to restrain the patient. The actions of the officers were good faith attempts to prevent, not cause, injury to ALV.

The actions of the two ALAB's fall outside of the regulatory definition of abuse pursuant to 118 CMR 2.02 which states in pertinent part that "it shall be an accident and not abuse when a person with a disability incurs an injury, and the injury ... (d) is caused by a caretaker's good faith attempt to prevent injury and/or pain to the person with a disability..."

Final Decision

Upon review of the facts and evidence in this case it is determined that there was a preponderance of evidence supporting the conclusion that the actions of ALAB 1 and ALAB 2 caused ALV's injury.

The fact that the criminal investigation did not result in criminal charges being pursued against either ALAB 1 and/or ALAB 2 does not negate a MGL c 19C finding of abuse as the standard for criminal conduct is significantly higher than that of a c 19C finding. The standard of proof required for a finding of abuse under M.G.L. c.19C is that of a preponderance of the evidence. This means that the evidence is weighed, not with mathematical certainty, but that the greater the weight of the evidence, the greater the probability of the truth. Preponderance of the evidence has been defined in case law as "more probably true than false." Sargent v. Mass. Accident, 307 Mass. 246, 250 (1940).

While Petitioner argues that the actions of ALAB 1 and ALAB 2 were "good faith attempts to prevent injury to ALV" which "fall outside the regulatory definition of abuse," the totality of evidence points to a different conclusion. The autopsy report concluded that ALV's cause of death was "cardiopulmonary arrest during physical altercation, with blunt impact of head and compression of chest, while in agitated state ... noting that compression of the chest" was one of the underlying causes of ALV's death. Furthermore, the internal policy regarding the use of force commands that "if an inmate continues to struggle once restrained, staff shall never sit on or put their weight down on an inmate's back." In the video footage of the incident, ALAB 1 is witnessed lying on ALV's back and ALAB 2 is witnessed pushing ALV's back such that ALV's chest appears to make contact with his legs. Such use of force can not reasonably be deemed accidental, nor was it a demonstration of a good faith attempt to prevent injury.

Conclusion

The conclusions of DPPC Investigation Report #87368 are affirmed. This is the final decision of the DPPC.

Sincerely,

Erik Nordahl
Deputy General Counsel

Reviewed and Approved by,

Nancy A. Alterio
Executive Director

cc. Bernard Murphy, Director of Investigations, DDS
Kathleen Gallagher, Deputy General Counsel, DDS
Lisa Bain, DDS
Kristen Lannigan, DDS
Seana Miller, Investigations Manager, DPPC

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♦ ALSO ADMITTED IN NEW HAMPSHIRE
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September 25, 2012

Plymouth County District Attorney
c/o Tom Flanagan
32 Belmont Street
Brockton, MA 02301-5243

Re: Estate of Joshua Messier

Dear Attorney Flanagan:

This letter is a follow up to our previous conversations and correspondence regarding the Estate of Joshua Messier. As you may recall, we met on several occasions with Joshua's mother to discuss your investigation into Joshua Messier's death at Bridgewater State Hospital (BSH) on May 4, 2009. During our last conversation, you told me that the Plymouth County District Attorney's office would not be prosecuting the correctional officers involved with Joshua's death even though the medical examiner ruled Joshua's death a homicide.

Since our last meeting, my office has obtained a copy of the surveillance videotape from the day in question. Based on our review of the videotape, it appears that the BSH correctional officers acted in a criminal manner directly resulting in Joshua's death. The videotape not only shows the officers applying excessive force (including one officer applying his full weight to Joshua's back while in the seated position), but it also shows the officers intentionally delaying medical attention for upwards of ten minutes after Joshua's body was lifeless.

Based on the contents of the videotape, we respectfully request, on behalf of the Messier family, that you reopen your criminal investigation into the conduct of the BSH correctional officers on May 4, 2009. I look forward to your prompt response.

Very truly yours,

Benjamin R. Novotny

The Commonwealth of Massachusetts
Executive Office of Public Safety and Security

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Paul L. DiPaolo
Acting Deputy Commissioner

TO: Robert Murphy, Superintendent

FROM: Steven P. Ayala , Director, Special Operations Division

DATE: January 11, 2013

INSTITUTION: Bridgewater State Hospital

INMATE'S NAME: Joshua Messier Commitment #: M103880 Case # 2009-0851

DATE OF U.O.F.: Monday May 04, 2009

DATE RECEIVED: Wednesday December 12, 2012 (1318 Days)

Please be advised that this Division has completed its review of the Use of Force package identified above. As a result of this review, we have determined the Use of Force Package (Attached) is not in compliance with the Department's Use of Force Policy, 103 CMR 505, as noted below and is therefore rejected.

- **Form 505-1 was not signed by Sergeant George Billadeau (preparer of the uof package) or signed off by the reviewing authority at the institutional level.**

- **Also, upon review of the surveillence footage, staff members involved in the incident were found to be in violation of 103 DOC 503, in particular:**

503.07 team procedures

5. If an inmate continues to struggle once restrained, staff shall never sit on or put their weight down on an inmate's back. The staff shall control the inmate's upper and lower extremities by means of hands on control.

8. Staff shall always maintain observation of a restrained inmate to recognize breathing difficulties or loss of consciousness. In this regard, staff shall also be alert to issues of obesity, alcohol and drug use and/or psychotic behavior.

If you have any questions please feel free to contact this office.

SPA/rr
cc: File

REJECTED

USE OF FORCE
MASSACHUSETTS DEPARTMENT OF CORRECTION
SPECIAL OPERATIONS DIVISION
FINAL REVIEW

1 P 28

Received by Special Ops
December 12, 2012 = DAYS 1318
Weekends Holidays Factored in

Extension OK [ ] CDR/DVD Video # [X] 043 1

Intake Number 11832 **Do Not remove Cover Sheet**

Date of Incident	Institution	YEAR	Case Number
Monday, May 4, 2009	State Hospital	2009	851

Last MESSIER First JOSHUA Commitment Number M103880

Race: White [X] Black [ ] Hispanic [ ] American Indian [ ] Other [ ] Unknown [ ]

TIME 2110 SHIFT 1500 - 2300

DO NOT REMOVE THIS COVER SHEET

Chemical Agent	
Surv. Video	X
Planned Video	
Restrained	X
Staff Inj	X
Inmate Inj	X
Spontaneous	X
Planned	
Seg Det / SMU	
Gen Pop	X
Outside Trip	
Mental Health	X
Isolation	
HSU	
STG Unit	
Civil Comit	X

Staff Members	Trained
JOHN PUPEK	12/16/08
CHRISTOPHER REGO	12/9/08
CLIFFORD FOSTER	3/17/09
DEREK HOWARD	4/14/08
PETER CHMIEL	6/23/08
RAYMOND THIBAULT	6/16/08
ROBERT DESROSIERS	2/4/08
TIMOTHY SOARES	11/26/08
JAMES BARKER	10/8/08
JOHN RAPOSO	1/13/09
DANIEL KERR	9/23/08

Chemical Application By:
Certified Date

MEDICAL TREATMENT

Inmate HSU X Inmate Refused
Staff HSU X Staff Refused

Assaulted Staff X
Altercation with another Inmate
K9 Authorized [ ] Disruptive
Drug Watch
K9 Utilized
Fifth Point / Chest, Leg Straps

Hours 4 Point Min 4 Point
Hours Normal Restraint Min Normal Restraint

Four Point	X
Assaultive	X
Threatening	
Disoriented	
Refused Order	X
Destroying Property	
Self Destructive	
Eyeball Watch	
Eyeball Sheets	
Cuffs	X
Leg Irons	X
Waist Chains	
Posey Restraints	X
Restraint Chair	
Hand Paddles	
Head Gear	
Chest & Leg Straps	
No Restraints Used	
Specialty Impact Munitions Used	
Tactical Operation	

Stretcher / Stair Chair / Wheel Chair
Boss Chair
Security Smock / Blanket
Deputy Commissioner Notified
Psych Notified / Mental Health
STP Unit

HIPPA Law Invoked by Medical

Video(s) Review Date

CERTIFICATION Expires

VIDEO MALFUNCTION / BATTERY OPERATOR ERROR, TAPE RAN OUT TIME ERROR, TAPE BROKE, NO AUDIO TAPE LOST, PHOTOS

[ ] Rept

Intake Number 11832

DIRECTOR OF SPECIAL OPERATIONS HAS REJECTED THIS USE OF FORCE REPORT

Prior Rejection / Corrections Needed [ ]

Prior Rejection / Corrections Date

Directors Initials [signature] Date 1-3-13

Deputy Commissioner Initials Date Tactical Operation

UNDER BSH-651 POLICY MENTAL HEALTH [X] SRO ATTACHED [X] COMMENTS

Four Point Ordered by

USE OF FORCE
MASSACHUSETTS DEPARTMENT OF CORRECTION
SPECIAL OPERATIONS DIVISION
FINAL REVIEW

224

Received by Special Ops
December 12, 2012 = DAYS 1318
Weekends Holidays Factored in

Extension OK ☐ CDR/DVD Video # [X] 043 1

Intake Number 11832 **Do Not remove Cover Sheet**

Date of Incident	Institution	YEAR	Case Number
Monday, May 4, 2009	State Hospital	2009	851

Last MESSIER First JOSHUA Commitment Number M103880

Race: White [X] Black [ ] Hispanic [ ] American Indian [ ] Other [ ] Unknown [ ]

TIME 2110 SHIFT 1500 - 2300

Chemical Agent

Surv. Video	X
Planned Video	
Restrained	X
Staff Inj	X
Inmate Inj	X
Spontaneous	X
Planned	
Seg Det / SMU	
Gen Pop	X
Outside Trip	
Mental Health	X
Isolation	
HSU	
STG Unit	
Civil Comit	X

Staff Members	Trained
JOSE VARELA	witness
GEORGE BILLADEAU	witness

Chemical Application By:

Certified Date

MEDICAL TREATMENT

Inmate HSU X Inmate Refused

Staff HSU X Staff Refused

Assaulted Staff X

Altercation with another Inmate

Disruptive

K9 Authorized ☐ Drug Watch

K9 Utilized

Fifth Point / Chest, Leg Straps

Hours 4 Point Min 4 Point

Hours Normal Restraint Min Normal Restraint

Four Point	X
Assaultive	X
Threatening	
Disoriented	
Refused Order	X
Destroying Property	
Self Destructive	
Eyeball Watch	
Eyeball Sheets	
Cuffs	X
Leg Irons	X
Waist Chains	
Posey Restraints	X
Restraint Chair	
Hand Paddles	
Head Gear	
Chest & Leg Straps	
No Restraints Used	
Speciality Impact Munitions Used	
Tactical Operation	

DO NOT REMOVE THIS COVER SHEET

Stretcher / Stair Chair / Wheel Chair ☐
Boss Chair ☐
Security Smock / Blanket ☐
Deputy Commissioner Notified ☐
Psych Notified / Mental Health ☐
STP Unit ☐

HIPPA Law Invoked by Medical

Video(s) Review Date

CERTIFICATION Expires

VIDEO MALFUNCTION / BATTERY OPERATOR ERROR, TAPE RAN OUT TIME ERROR, TAPE BROKE, NO AUDIO TAPE LOST, PHOTOS

☐ Rept

Intake Number 11832

DIRECTOR OF SPECIAL OPERATIONS HAS REJECTED THIS USE OF FORCE REPORT

Prior Rejection / Corrections Needed ☐

Prior Rejection / Corrections Date

Directors Initials Date 1-23-13

Deputy Commissioner Initials Date Tactical Operation

UNDER BSR-651 POLICY MENTAL HEALTH X SRO ATTACHED X COMMENTS

Four Point Ordered by

DO NOT REMOVE FROM REPORT

STATE HOSPITAL

PROBLEM AREAS

= DAYS 1318

REPORT HAS BEEN: REJECTED

Extension OK

LAST NAME	FIRST NAME	COMMITMENT NUMBER	CASE NUMBER	VIDEO NUMBER	Tapes Submitted
Messier	Joshua	M103880	2009 851	043	1

INCIDENT DATE: Monday, May 4, 2009 DATE RECEIVED BY SPECIAL OPS: Wednesday, December 12, 2012

Intake Number 11832

UNDER BSH651 POLICY MENTAL HEALTH [X]

FORM 505-1 WAS NOT SIGNED BY SERGEANT GEORGE BILLADEAU (PREPARER OF THE UOF PACKAGE).OR SIGNED OFF BY THE REVIEWING AUTHORITY AT THE INSTITUTIONAL LEVEL.

ALSO, UPON REVIEW OF THE SURVEILLENCE FOOTAGE, STAFF MEMBERS INVOLVED IN THE INCIDENT WERE FOUND TO BE IN VIOLATION OF 103 DOC 503, IN PARTICULAR:

503.07 TEAM PROCEDURES

5. IF AN INMATE CONTINUES TO STRUGGLE ONCE RESTRAINED, STAFF SHALL NEVER SIT ON OR PUT THEIR WEIGHT DOWN ON AN INMATE'S BACK. THE STAFF SHALL CONTROL THE INMATE'S UPPER AND LOWER EXTREMITIES BY MEANS OF HANDS ON CONTROL.

8. STAFF SHALL ALWAYS MAINTAIN OBSERVATION OF A RESTRAINED INMATE TO RECOGNIZE BREATHING DIFFICULTIES OR LOSS OF CONSCIOUSNESS. IN THIS REGARD, STAFF SHALL ALSO BE ALERT TO ISSUES OF OBESITY, ALCOHOL AND DRUG USE AND/OR PSYCHOTIC BEHAVIOR.