SCOPE

Following the death of Bridgewater State Hospital (BSH) patient Joshua Messier on May 4, 2009, the Department of Correction ("DOC") took certain steps to determine whether the officers involved in the events immediately preceding his death acted appropriately. My review considers whether those steps were taken properly.

The basis for this report is a series of interviews and a review of documents related to the incident. Interviews were conducted with the following current and former DOC managers:

1. Commissioner Luis Spencer
2. Former DOC Commissioner Harold Clarke
3. Deputy Commissioner Peter Pepe
4. Assistant Deputy Commissioner Karen Hetherson
5. DOC General Counsel Nancy White
6. BSH Supervising Counsel Michael Cohen
7. BSH Superintendent Robert Murphy
8. Director of Special Operations Steven Ayala
9. BSH Deputy Superintendent Pat DiPalo

This report consists of a timeline of pertinent events, an analysis of key issues, and relevant conclusions and findings.

EXECUTIVE SUMMARY

Joshua Messier died at BSH on May 4, 2009. Immediately thereafter, the State Police and the Plymouth County District Attorney's Office began an investigation into the circumstances surrounding his death. DOC delayed its Internal Affairs Unit ("IAU") investigation into the death while the criminal investigation was pending. The criminal investigation was ongoing in February 2010, when the Office of the Chief Medical Examiner concluded that the manner of Messier's death was a "homicide" and that its cause was "[c]ardiopulmonary arrest during physical restraint, with blunt impact of the head and compression of chest, while in agitated state."

Given that DOC had postponed its internal investigation pending the outcome of the criminal investigation, senior DOC leadership should not have commented on the acts of the correction officers while the criminal investigation was pending (except as asked to participate in that investigation). At least one document indicates that then-Commissioner Harold Clarke did not maintain silence on this issue. Minutes of a February 9, 2010 DOC Executive Staff meeting indicate that Commissioner Clarke took "exception" to the OCME's determination that Messier's death was a homicide because "everything was appropriately and professionally done." When interviewed, Commissioner Clarke indicated that he felt it was important to express support for those involved based on his belief that they did not act with any type of criminal intent. I do not question the sincerity of that belief. But given that DOC had not yet evaluated the actions of the correction officers on the night in question, comments from senior leadership regarding the appropriateness of those actions risked influencing the subordinates ultimately charged with that evaluation.

By early 2011, the DOC became aware that the criminal investigation into this matter was closed. At that time, the DOC's IAU began an investigation into Messier's death. The investigation focused on two distinct uses of force by correction officers against Messier. The first took place in BSH Housing Unit B-1. That evening, after returning from a visit with his mother, Messier spontaneously assaulted Correction Officer Christopher Rego in BSH Housing Unit B-1. Thereafter, multiple officers

were needed to restrain him. The IAU investigation found no fault with that restraint.

Then, Messier was escorted to BSH's Intensive Treatment Unit. There, the correction officers attempted to place Messier in four-point restraints. Per the IAU investigation, during the restraint process, two correction officers — specifically Correction Officer Derek Howard and Correction Officer John Raposo — "applied downward pressure to the back of Messier while he was being restrained." Those actions violated DOC Use of Force policy 103 CMR 650[1]. Additionally, the IAU investigation should have specifically addressed the actions (or inactions) of Acting Lieutenant George Billadeau.[2] Acting Lieutenant Billadeau was in the room while Messier was restrained, and supervised what the IAU found to be a violation of DOC policy, but he did not intervene.

A report of the IAU investigation was issued on May 25, 2011. Approximately one week later, the report was reviewed by Assistant Deputy Commissioner Karen Hetherson. As documented, Hetherson's review was insubstantial. She concluded that "[b]ased on the circumstances surrounding this investigation, no misconduct was found against staff." When asked to elaborate as to the basis of her decision, she indicated that, in her view, the correction officers involved did not "mean to cause [Messier] any harm." The proper inquiry was whether any DOC policies were violated during the use of force and if so, by whom. The IAU investigation answered those questions as to Correction Officers Howard and Raposo. Hetherson was unable to articulate a basis for departure from that conclusion. Hetherson also had the power to return the IA investigation to the Unit for further findings. She should have done so, particularly regarding the actions (or inactions) of Sergeant Billadeau.

While the criminal investigation was pending, the BSH Superintendent (and, on one occasion Acting Superintendent) requested

---

[1] This Use of Force policy is cite specific to Bridgewater State Hospital. The language prohibiting the placement of weight on an inmate's back during restrain is identical to the language of 103 CMR 505, which is DOC's general Use of Force policy and applies to all institutions.

[2] It appears that, on the night in question, Billadeau — who, at the time, held the rank of Sergeant — had been assigned as Acting BSH Sector One Lieutenant. Accordingly, he will be referenced in this report as an Acting Lieutenant.

extensions of time to submit the Use of Force Package[3] to the Special Operations Division ("SOD") of DOC, which was charged with reviewing it. Together with other documents, those reports constituted a Use of Force package. Following the delay in submitting the Use of Force package until the criminal investigation was concluded, the package languished, unsubmitted, until December 7, 2012 when it was sent to SOD. On January 11, 2013, SOD Director Steven Ayala rejected the Use of Force package for procedural and substantive reasons. Among other things, he concluded that "staff members involved in the incident" did not comport with DOC policy, including the prohibition on applying force to a patient's back while that patient is restrained and the requirement that the staff shall always maintain observation of a restrained patient to recognize breathing difficulties or a loss of consciousness. His rejection also noted that the report should have been signed by Acting Lieutenant Billadeau but was not.

No material actions were taken following SOD Director Ayala's rejection of the Use of Force package. DOC improperly failed to reconcile the basis for rejection with the executive review of the IAU report (which had found no misconduct). There was not then nor is there now DOC policy that addresses how such discrepancies should be reconciled. Upon receipt of this report, Commissioner Spencer should immediately develop such a policy.

At present, Assistant Deputy Commissioner Hetherson's executive review of the IAU report must be disregarded. It is unsupported and, when offered a chance to explain her decision it became clear that her decision was badly flawed. Accordingly, the IAU investigation finding that Correction Officers Howard and Raposo improperly applied force to Messier's back stands; that finding is further supported by the rejection of the Use of Force package. This violation of DOC policy is sufficient to warrant the imposition of discipline to be determined consistent with the DOC hearing process.[4] Until that process is complete, Correction Officers Howard and Raposo should be placed on leave.

---

[3] A Use of Force Package is comprised of official forms, incident reports, records, and other documents relative to the use of force incident.

[4] Pursuant to state law, i.e., G.L. c. 31, § 41, and DOC policies based upon it, no disciplinary action exceeding a five-day suspension may be taken without a hearing and the opportunity for the correction officers to present conflicting or mitigating evidence.

During this review, I have concluded that the IAU report is insufficient in as much as it failed to meaningfully address the role of Acting Lieutenant Billadeau in the events of May 4, 2009. The report should be returned to the IAU to determine whether — on the basis of this report, the relevant documents, the video tape of the events in question, and any other materials the IAU deems relevant — it is appropriate for Commissioner Spencer to begin the disciplinary process against Acting Lieutenant Billadeau on the current record or, alternatively, whether further investigation is needed. Until a final decision is made concerning any discipline to be imposed on Acting Lieutenant Billadeau, he should be placed on leave.

This reporting process has given rise to certain additional concerns regarding whether DOC complied with its own reporting and investigatory requirements following Messier's death, i.e., those reporting and investigatory requirements distinct from the disciplinary process. Spencer will return to me a full accounting as to whether those requirements were met in the aftermath of Messier's death and, if any were not, a full explanation for the omission together with concrete steps to prevent any such omissions in the future.

SEQUENCE OF EVENTS

2009

May 4, 2009 **Joshua Messier dies following a use of force during the application of Posey restraints.**

May 4-5, 2009 **Reports from BSH restraint team, medical staff and other relevant records are submitted to BSH Superintendent Karen Bergeron**

May 5, 2009 **Autopsy performed by the Office of the Chief Medical Examiner**

May 5, 2009 **Crime Prevention and Control Unit (CPAC) of the Plymouth County District Attorney's Office commences its investigation**

May 20, 2009 **BSH Superintendent Karen Bergeron makes a written request to extend the time for submission of the Use of Force package to the Special Operations Division (SOD)**

Reason: "This Use of Force incident is currently under review by the State Police and Plymouth County D.A.'s Office due to the death of the patient following a Code 99 at the conclusion of the UOF. The timetable for this investigation and any other subsequent investigation by the Office of Investigative Services is not known at this time."

Response: Authorized for 6 months by Deputy Commissioner for Administrative Services Ron Duval.

July 6, 2009 **Assistant Deputy Commissioner Terre Marshall grants a request by Director of Quality Improvement Kenneth Nelson to accept a BSH Root Cause**

Analysis "as the equivalency of the mortality review" that is mandated by DOC regulations.

July 9, 2009 **BSH submits its Root Cause Analysis (RCA) to The Joint Commission**
Explanation: This 24-question analysis is required by The Joint Commission, which accredits the DOC.[5] Its purpose is to drill down into the root causes of a "Sentinel Event" e.g., Messier's death. The root cause analysis focuses on systems and processes, rather than individual performance. The goal is to identify those causes, identify strategies for risk reduction and create an action plan, successful implementation of which is then monitored by The Joint Commission.

Nov. 18, 2009 **Second request for extension of time for submission of Use of Force package made by Acting BSH Superintendent Lisa Mitchell**
Reason: "This Use of Force incident is currently under review by the State Police and Plymouth County D.A.'s Office due to the death of the patient following a Code 99 at the conclusion of the UOF. The timetable for this investigation and any other subsequent investigation by the Office of Investigative Services is not known at this time." Previous request acknowledged.
Response: Authorized for 90 days by Deputy Commissioner for Administrative Services Ron Duval.

---

[5] The Joint Commission (TJC) describes itself as "an independent, not-for-profit organization [that] accredits and certifies more than 20,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards." The Joint Commission was founded in 1951 and is the nation's oldest and largest standards-setting and accrediting body in healthcare.

The Joint Commission is governed by a 32-member Board of Commissioners that includes physicians, administrators, nurses, employers, a labor representative, quality experts, a consumer advocate and educators. It provides accreditation services for the a number of different types health care organizations, including general, psychiatric, children's and rehabilitation hospitals.

Dec. 22, 2009 **The Joint Commission accepts the DOC's RCA and action plan.**
BSH is notified that follow-up monitoring will commence in accordance with Sentinel Event Policy. Follow-up monitoring will determine whether the improvements planned as a result of the root cause analysis have been successful and sustained.

2010

Feb. 3, 2010 **Autopsy report completed**
Cause of Death: Cardiopulmonary arrest during physical restraint, with blunt impact of the head and compression of chest, while in agitated state.
Manner of Death: Homicide (restrained by correction officers during agitated state).

Feb. 9, 2010 **Commissioner Clarke comments on the OCME's autopsy report during an Executive Staff Meeting, and indicates his view that "everything was appropriately and professionally done"**

Feb. 23, 2010 **Third request to extend submission time for the UOF package is made by BSH Superintendent Karen Bergeron**
Reason: "This Use of Force incident is currently under review by the State Police and Plymouth County D.A.'s Office due to the death of the patient following a Code 99 at the conclusion of the UOF. The timetable for this investigation and any other subsequent investigation by the Office of Investigative Services is not known at this time." Previous request acknowledged.
Response: Authorized for 90 days by Deputy Commissioner for Administrative Services Ron Duval.

May 4, 2010 **Per a Statement of the Plymouth County District Attorney's Office, a prosecutor and CPAC Officers meet with Medical Examiner Mindy Hull re: the Messier autopsy**

May 24, 2010 **Fourth request to extend submission time for the UOF package is made by BSH Superintendent Robert Murphy.**
Reason: "This Use of Force incident is currently under review by the State Police and Plymouth County D.A.'s Office due to the death of the patient following a Code 99 at the conclusion of the UOF. The timetable for this investigation and any other subsequent investigation by the Office of Investigative Services is not known at this time." Previous request acknowledged.
Response: Authorized for 90 days by Deputy Commissioner for Administrative Services Ron Duval.

May 28, 2010 **Deputy Commissioner of Administrative Services Ron Duval retires.**

May 29, 2010 **Acting Deputy Commissioner Karen Hetherson is made Acting Deputy Commissioner for Administrative Services.**

June 10, 2010 **Acting Deputy Commissioner Karen Hetherson assumes responsibility for reviewing all IA reports.**

June 30, 2010 **DOC notified by The Joint Commission that the agency is 100% compliant with all recommendations of The Joint Commission.**

Aug. 3, 2010 **Anne Scott Blouin, RN, Ph.D. sends BSH Superintendent Robert Murphy the results of The Joint Commission's Sentinel Event Measure(s) of Success. (SE-MOS)** DOC meets or exceeds all action plan recommendations and The Joint Commission determines no further action is required.

Aug. 30, 2010 **Fifth and final request to extend submission time for the UOF package is made by Acting Superintendent Pat DiPalo, who signs on behalf of Superintendent Robert Murphy.**

Reason: "This Use of Force incident is currently under review by the State Police and Plymouth County D.A.'s Office due to the death of the patient following a Code 99 at the conclusion of the UOF. The timetable for this investigation and any other subsequent investigation by the Office of Investigative Services is not known at this time."
NOTE: In acknowledging that there has been a previous request for extension, this language appears: "This Use of Force has been referred to the DOS Legal Office for a determination if the Use of Force Package needs to be completed or not. As of this date, no determination has been made." DOS refers to the Director of Security at BSH, which does not have a legal office, and the DOC legal office indicates that it never received the package. When interviewed, Acting Superintendent Pat DiPalo indicated that the phrase was a transcription error, and that he intended to reference the Special Operations Division ("SOD") office.
Response: Request for indefinite extension granted by Prison Division Deputy Commissioner James Bender.

Sept. 1, 2010 **Date of last report in the CPAC Unit investigation.**

Nov. 13, 2010 **Commissioner Clarke resigns**

Nov. 14, 2010 **Ron Duval returns to DOC as Acting Commissioner**

2011

Jan. 14, 2011 **Luis Spencer is appointed Acting Commissioner**

March 21, 2011 **IAU Sergeant Donald Perry's log entry states that he receives the CPAC investigation into Messier's death. It appears that at some point prior to this date, the Plymouth County District Attorney's Office determined that it would not present the case to a grand jury**

March 23, 2011 **The IAU investigation references this date as the date when IAU Sergeant Donald Perry receives the CPAC reports composed during its investigation into Messier's death**

April 11, 2011 **Luis Spencer is appointed Commissioner**

May 25, 2011 **DOC Internal Affairs Unit completes its investigation**
Finding: No violation of DOC policy in the B Building use of force. Violation of Use of Force policy 103 CMR 505 in the ITU use of force by Officers Howard and Raposo because they applied weight to Messier's back while attempting to restrain him.
The IA investigation does not explore and makes no finding as to whether Acting Lieutenant George Billadeau, who supervised the restraint team, violated the DOC Use of Force Policy by failing to intervene.

June 1, 2011 **BSH Superintendent Karen Bergeron retires**

June 3, 2011 **Executive Review and Decision of the IAU investigation.**
Finding: Assistant Deputy Commissioner Karen Hetherson determines: "Based on the circumstances surrounding this investigation, no misconduct was found against staff. However, it is recommended that responding staff, specifically Officers Howard and Rapos[o], attend re-training in the use of restraints."

July 14, 2011 **MA Disabled Persons Protection Commission report**
Concludes conduct of COs Raposo and Howard constituted abuse.

July 26, 2011 **Officer Derek Howard receives training in Four Point Restraints.**

Nov. 20, 2011 **Commissioner Spencer reverses the decision to have the Deputy Commissioner for Administrative Services review all IAU reports.**

2012

April 30, 2012 **Officer John Raposo receives training in Use of Force/Restraints.**

May 7, 2012 **Officer Derek Howard receives training in Use of Force/Restraints.**

May-June 2012 **Litigation filed in state and federal courts.**

Late Nov. 2012 **In conversation, Deputy Commissioner Peter Pepe asks SOD Director Steve Ayala what happened with his review of the Use of Force Package. Ayala tells him that it was not submitted to SOD.**
Ayala orders BSH Superintendent Robert Murphy to submit it immediately and Pepe instructs Ayala to prioritize SOD's review.

Dec. 7, 2012 **Use of Force package submitted by BSH Superintendent Robert Murphy to SOD**

2013

Jan. 11, 2013 **Use of Force Package is rejected by Special Operations Division**
Reason: SOD Director Steven Ayala cites violation of Use of Force Policy (103 CMR 505) and failure of (then) Acting Lieutenant George Billadeau and BSH Superintendent Robert Murphy to properly sign off on the package.

ANALYSIS

I. BACKGROUND

Bridgewater State Hospital (BSH) is an accredited medium security structure that sits on a campus in the Southern Sector of the Department of Correction's facilities. Though classified as a medium security facility, the DOC considers it a maximum security facility due to the volatility of its population and the diverse reasons that serve as a basis for commitment.[6] BSH provides court ordered evaluations and treatment services for civilly committed adult men who, due to mental illness, need hospitalization in a strict security setting.

The chain of command at BSH does not differ from that of other DOC facilities. DOC executive leadership is primarily comprised of the Commissioner, General Counsel, three Deputy Commissioners and a number of Assistant Deputy Commissioners for two operational sectors and many administrative divisions. At the top of the daily operations chain for each facility is an Assistant Deputy Commissioner, who is responsible for all facilities in his/her sector, and a Superintendent, who has responsibility for a single facility within that sector. The ranks descend from there to captains, lieutenants, sergeants and officers, all of whom are members of the Massachusetts Correction Officers Federation Union (MCOFU) collective bargaining unit.

Pursuant to a decision made by a former BSH Superintendent in 2003, all decisions regarding clinical care, medication and the use of restraints and seclusion are made by or must be authorized by medical staff. The Medical Director at BSH is appointed by the Commissioner and is a DOC employee. The current medical vendor, MHM has been providing mental health services to BSH since 2007. The vendor and all medical staff report to the Medical Director.

[6] Persons are committed to BSH for competency and criminal responsibility evaluations, evaluations related ascertain their ability to serve a sentence in a penal environment, for additional treatment or following a finding of not guilty by reason of insanity. They may be charged with crimes ranging from minor misdemeanors to major felonies

II. ANALYSIS OF KEY EVENTS

A. DOC Response to OCME findings

Dr. Mindy Hull of the Office of the Medical Examiner performed Joshua Messier's autopsy and released preliminary findings on May 5, 2009. The autopsy report was completed on February 2, 2010. Specifically, she found the cause of death to be "homicide" and the manner of death to be "Cardiopulmonary arrest during physical restraint, with blunt impact of the head and compression of chest, while in agitated state."

One week after the autopsy report was completed, DOC held a regularly-scheduled Executive Staff meeting. The minutes of that meeting, dated February 9, 2010, and compiled by then-Commissioner Clarke's executive assistant, reflect the following notes concerning statements made by then-Commissioner Clarke:

> Back in May, a patient came to Bridgewater State Hospital for an evaluation from the courts and he had passed away – we received information from the Medical Examiner that this patient's death has been determined to be a homicide. We take exception to this – everything was appropriately and professionally done. The Medical Examiner chose the word homicide – the term homicide - means death at the hands of another. General Counsel White and Commissioner Clarke will be reaching out to BSH staff and all involved – this will hit the media at some point, not sure when. Deputy Commissioner Duval will also reach out to the unions as General Counsel White is meeting with staff today at 3:00 pm. Deputy Commissioner Madden asked if anyone from MHM was going to be present – she will find out.

General Counsel Nancy White confirmed that she and Deputy Commissioner Ron Duval did address staff and union members pursuant to Clarke's directive.

When asked to explain his comments in a telephone interview, former Commissioner Clarke recalled that he was surprised at the OCME's finding that Messier's death was a homicide. He felt strongly that the finding implied criminal culpability where there was none and wanted to reassure staff that the Department was aware of the findings and would publicly express support for the officers involved.

Commissioner Clarke resigned from the DOC on November 13, 2010.

B. The Internal Affairs Unit ("IAU") Investigation & Subsequent Executive Review

1. The Structure of the Internal Affairs Unit

(i) Prior to June 2010

Prior to September 2011, the Internal Affairs Unit was part of a larger investigative unit within the DOC called the Office of Investigative Services. Under the prior practice, the Chief of Internal Affairs reported directly and submitted completed investigations to the Deputy Commissioner of the Prison Division.

It was the responsibility of the Deputy Commissioner of the Prison Division to review completed investigations and, if necessary, make an independent determination as to whether any DOC policies were violated and to refer the matter to the BSH Superintendent for appropriate discipline if any policy violations were found.

At that time, the Assistant Deputy Commissioner in charge of Administrative Services had the authority to review completed IA investigations, but that was not a formal responsibility of the role. Karen Hetherson assumed the role of Assistant Deputy Commissioner in charge of Administrative Services on February 15, 2009.[7] .

(ii) Post-June 2010

[7] Hetherson had been DOC's Human Resources Director since November 2, 2002, and that remains part of her responsibility today.

Deputy Commissioner Ron Duval who, at the time, was in charge of Administrative Services, retired on May 28, 2010. Karen Hetherson was promoted to Acting Deputy Commissioner in Charge of Administrative Services.

On June 10, 2010, as Acting Deputy Commissioner of Administrative Services, Hetherson undertook the responsibility of reviewing all IA reports, a responsibility that had previously been that of the Deputy Commissioner in Charge of the Prison Division.

Karen Hetherson remained Acting Deputy Commissioner for Administrative Services until she was replaced by Don Gianciappo on December 5, 2010.[8] But, when she was no longer Acting Deputy Commissioner and returned to her sole capacity as Assistant Deputy Commissioner, Hetherson remained responsible for reviewing IAU investigations. She was relieved of that responsibility on November 20, 2011, when Commissioner Spencer began to implement a series of changes to IAU supervision, policy and practice.

2. The IAU Investigation

The IAU investigation did not commence until early 2011, after the Plymouth County District Attorney's Office declined to present the matter to a grand jury. It was concluded on May 25, 2011. The investigation consisted of a review of staff reports and records, CPAC interviews with the officers and medical staff and a review of the video surveillance of the interaction between Messier and DOC officers in the ITU. The report, which catalogues the information on which it relies, does not list any IAU-conducted interviews with the DOC officers involved. Accordingly, it does not appear that any such interviews occurred.

The IAU report reflects that the Messier incident began with Messier's unprovoked assault on Officer Rego in an area of BSH known as the B Building. The IAU investigation found that the use of force against Messier in response to that assault was proper.

The IAU investigation also addressed the use of force against Messier in the BSH Intensive Treatment Unit ("ITU"). It found that Officers

[8] Gianciappo resigned on January 15, 2011.

Howard and Raposo violated the DOC's Use of Force policy in the ITU when they placed weight on Joshua Messier's back as he resisted their attempts to restrain him.

The IAU investigation makes no finding as to whether Acting Lieutenant George Billadeau, who supervised the restraint team, violated the DOC Use of Force Policy by failing to intervene.

3. Executive Review of the IAU Investigation

On June 3, 2011, Hetherson submitted her findings following her supervisory review of the IA investigation. Her finding reads as follows:

> Based upon the circumstances surrounding this investigation, no misconduct was found against staff. However, it is recommended that responding staff, specifically Officers Howard and Rapos[o] attend retraining in the use of restraints.
>
> Send copy of this investigation to Superintendent Murphy for review and appropriate action. Specifically, ensure that Officers Howard and Rapos[o] attend refresher training in the use and application of restraints.
>
> Send copy of this investigation to Peter Heffernan, Acting Director of Clinical Services for review and appropriate as it rel[ates] to Dr. O[lobodum][9] [f]ailing to submit an incident report as well as the recommendations made by Kenneth Nelson.[10]

Hetherson's finding does not distinguish the use of force in the B Building from the use of force in the ITU.

Between June 10, 2010 and November 20, 2011, Hetherson reviewed 209 IAU investigations. When asked how many times she had found cause to disagree with the results of an investigation, Hetherson said she did not think there was such an instance. In addition, the Messier

[9] The IAU report reflects that Dr. Olobodum (whose name is spelled inconsistently throughout the report) responded to the ITU following Messier's restraint.

[10] Kenneth Nelson was the Director of Quality Improvement at BSH.

investigation represents the only instance in which she prefaces her findings with the words, "Based on the circumstances surrounding this investigation." She did not elaborate as to the meaning of that phrase.

Assistant Deputy Commissioner Hetherson was questioned extensively concerning the basis of her findings. She stated that she reviewed the completed investigation documents and watched the ITU surveillance video. She focused on whether there was evidence that the officers' conduct was intentional. She believed that the officers had not received training[11] on the use of restraints and that was the basis of her finding.

When asked specifically how she viewed the conduct of Correction Officers Howard and Raposo in light of the language of the Use of Force policy prohibiting the placing of weight on the back someone being restrained, Assistant Deputy Commissioner Hetherson responded that the incident happened very quickly and reiterated her belief that officers did not mean to cause harm.

When asked specifically if she had watched the video with anyone from SOD or the DOC's Training Division; or if she had consulted with anyone from those Divisions before she made her finding, she responded that she had not.

When asked if she had considered whether any unintentional or negligent conduct constituted a violation of the Use of Force policy, she responded that she could not recall specifically, but did not believe she had. Hetherson was asked specifically whether in her review of the IAU report she noted the absence of discussion or findings relative to Acting Lieutenant Billadeau's supervision and considered sending the investigation back for a determination. She responded that she did not.

To better understand the basis for her decision-making, Assistant Deputy Commissioner Hetherson was asked:

1. Whether anyone ordered her to find as she did;

[11] It is not clear why Hetherson believed this, as she neither spoke to the officers involved nor reviewed DOC records regarding their training.

2. Whether anyone suggested that she make certain conclusions or findings; and
3. Whether she spoke with anyone before making her decision.

She responded "No" to each question and said, unequivocally, that she would not have let anyone influence her decision. With regard to question 3, she added that she "did not recall talking to anyone except her Executive Assistant, when [they] were going over the reports."

Assistant Deputy Commissioner Hetherson sent her decision to BSH Superintendent Murphy for follow-up. The decision included an order for retraining. When questioned, she indicated that she considered that order to be a remedial rather than disciplinary measure.

Upon learning that Hetherson had overruled the findings in the IAU report, BSH Superintendent Robert Murphy was surprised. When interviewed, he relayed that he sought Hetherson out and asked her if she was "sure" about her decision regarding the IAU investigation.[12] When asked whether anyone had ever spoken with her about her decision to express disagreement with it, Hetherson said she "did not recall" having a conversation of that nature.

C. Submission of the Use of Force Package

1. DOC Policy Regarding the Use of Force

Pursuant to DOC policy, whenever a planned or spontaneous use of force occurs, a package of forms, officer reports, video and medical records (if any) is submitted up through the chain of command to the Special Operations Division (SOD). SOD reviews the package and determines whether the use of force was consonant with DOC Use of Force Policy. A Use of Force Package can be accepted, rejected or sent back for correction.

[12] Murphy recalls that Peter Pepe — who, at the time, was Acting Assistant Commissioner for the Southern Sector — was present for that conversation. Pepe recalls that Murphy spoke to Hetherson alone, but he subsequently was made aware of topic of their conversation.

DOC policy required that reports to be included in the Use of Force package must be written by the end the officer's shift.

2. Delay in Submission of the Use of Force Packet

In this case, all of the officers involved in the B Building use of force and the ITU use of force were working the 3pm to 11pm shift. They submitted reports concerning the use of force against Messier in the late evening of May 4, 2009 or in the early morning hours of May 5, 2009.[13]

Although the key portions of the Use of Force package, i.e., the officer reports, were drafted immediately following the incident, the package was not submitted to SOD until December 12, 2012 (approximately 3 years and 6 months after the incident).

As described below, this delay was authorized by DOC upon in response to multiple requests by BSH leadership, though the basis for those requests was moot by early 2011, when the criminal investigation had concluded.

On May 20, 2009, former BSH Superintendent Karen Bergeron requested, in writing, an indefinite extension on submitting the package to SOD, citing the following reasons: "This Use of Force incident is currently under review by the State Police and the Plymouth County DA's Office due to the death of a patient following a Code 99 at the conclusion of the UOF. The timetable for this investigation and any subsequent investigation by the Office of Investigative Services is not known at this time." Superintendent Bergeron's request for an indefinite extension was denied by Deputy Commissioner Ron Duval. He did authorize a 6-month extension on May 26, 2004.

Thereafter, written requests for indefinite extensions – all citing the same reasons as the first - were made on November 18, 2009, February 23, 2009, May 24, 2010 and August 30, 2010. Three of these requests were made by then-BSH Superintendent Karen Bergeron. One request

[13] These reports of several correction officers involved were edited at some time following that point but prior to their submission to the SOD.

was made by Acting BSH Superintendent Lisa Mitchell.[14] The first request was granted, but the extension was limited to 6 months. The second, third and fourth requests were granted, but the extension was limited to 90 days. The first four requests were approved by Deputy Commissioner Ron Duval.

The last request for an indefinite extension was submitted by BSH Deputy Superintendent Pat DiPalo. When interviewed, DiPalo indicated that he had signed Superintendent Murphy's name on the form and indicated he had signed on Murphy's behalf by including an "@" sign after Murphy's name. DiPalo signed in his capacity as Acting Superintendent, a position he assumed whenever Murphy was out of the office for any period of time. That DiPalo signed the request is supported by the cover memo accompanying it, reflecting that it was sent by "Patrick DiPalo, Acting Superintendent," to "James Bender, Deputy Commissioner." The request was authorized without time restriction by Deputy Commissioner James Bender.[15]

On February 3, 2010, The Office of the Medical Examiner (OCME) determined that the cause of death was "homicide."[16] Per a statement given by the Plymouth County District Attorney's Office, on May 4, 2010, Assistant District Attorney Thomas Flanagan and investigators from the State Police met with Medical Examiner Mindy Hull. Per that statement, during the meeting, Dr. Hull "advised [Assistant District Attorney] Flanagan that she did not find evidence of positional asphyxia during the autopsy."

At some point following that discussion, the Plymouth County District Attorney's Office (per its statement) "determined that there was insufficient evidence to proceed on criminal charges against the correction[] officers

---

[14] Lisa Mitchell was a Deputy Superintendent at BSH. She was only named Acting Superintendent when the Superintendent was out of the office, e.g., on vacation or out sick.

[15] The request includes language that it was sent to "the DOS Legal Office for a determination" of whether the "Use of Force Package needs to be completed or not." When asked about this language, DiPalo indicated the phrase "DOS Legal Office" — which does not exist — was a transcription error, and that he intended to reference the SOD office.

[16] The OCME distinguishes homicide (death at the hands of another) from suicide (death by one's own hand) and accidental death (misadventure). The finding does not imply culpability, as that determination is left to the District Attorney.

involved in the restraint of Joshua Messier." It is not clear when that determination was made, nor is it clear when that determination was relayed to DOC. Nonetheless, it is a reasonable supposition that the determination was made at some point prior to March 23, 2011, when State Police investigators shared their investigatory reports with the IAU.

By that time, at the latest, the basis for the requested extensions for the submission of the Use of Force package had been eliminated. Nevertheless, according to Deputy Commissioner Peter Pepe, the failure to submit the Use of Force package following the conclusion of all investigations of Joshua Messier's death by outside law enforcement agencies went unnoticed until late November of 2012. At that time Deputy Commissioner Peter Pepe asked SOD Special Operations Division ("SOD") Director Steve Ayala for the results of his analysis of the use of force. Ayala told him that SOD had not received the package. Ayala then contacted BSH Superintendent Robert Murphy and instructed him to submit it immediately. Deputy Commissioner Pepe instructed Ayala to prioritize the analysis.

3. Rejection of the Use of Force Package

Pursuant to Use of Force regulation 103 CMR 505 13(5), "[the] Director of the Special Operations Division shall review the reports and may request additional information or may submit an intake to the Office of Investigative Services for official investigation."

The package was received by SOD on December 12, 2012 and rejected by Director Steven Ayala on January 11, 2013 for not being in compliance with the Department's Use of Force Policy, 103 CMR 505. Specifically, Ayala found:

- The package was not signed by then Acting Lieutenant and now current Lieutenant George Billadeau, who prepared the it and who supervised the application of restraints the night Messier died;
- The package was not signed off by the institutional reviewing authority, namely BSH Superintendent Robert Murphy; and
- Based on his Division's review of the video surveillance footage of the incident in the ICU, "staff members violated the Department's Use of Force policy" by:

- placing weight on Messier's back as he resisted being restrained; and
- failing to maintain proper observation of Messier's ability to breathe once he was restrained.

DOC regulations, specifically 103 CMR 505 13(5), are silent as to what, if any, further steps should be taken by the SOD if a Use of Force package is rejected for substantive reasons and an IAU investigation on the same issue has already been completed and reviewed. However, upon receipt of a rejected Use of Force package and pursuant to 103 DOC 230.05, the BSH Superintendent can take any appropriate action, including a request for investigation, imposition of discipline up to a five-day suspension or a request for discipline exceeding a five-day suspension.[17]

In this case, by the time Superintendent Murphy received the rejected package from Director Ayala, Assistant Deputy Commissioner Karen Hetherson's executive review of the IAU investigation had concluded and her findings had been made. Officers Raposo and Howard had already received the re-training that was ordered. As indicated above, Superintendent Murphy has stated that he challenged Hetherson's decision directly at or near the time it was made and had expressed his concerns to Peter Pepe, who, at that time, was next in the chain of command.

[17] As noted above, any disciplinary sanction exceeding five days requires notice and a hearing, e.g., G.L. c. 31, § 41.

III. FINDINGS & CONCLUSIONS

A. DOC Response to OCME findings

1. DOC has offered an explanation for its delay of an IAU investigation following Messier's death, i.e., the pendency of a criminal investigation.

2. Given that explanation, DOC leadership should not have commented on the criminal investigation (except as asked to participate in that investigation), and it particularly should not have expressed a view as to the appropriateness of the conduct of the correction officers involved.

3. Accordingly, the comments of Commissioner Clarke on February 9, 2010 — regardless of the sincerity of the belief that motivated them, which I have no reason to discount — were not appropriate.

B. IAU Investigation

1. The IAU investigation, concluded on May 25, 2011, determined that Officers Howard and Raposo failed to comply with DOC policy when they applied pressure to Messier's back while he was handcuffed and in the process of being put in four-point restraints.

2. The Executive Review of that investigation — conducted by Assistant Deputy Commissioner Karen Hetherson — was conclusory. Without written explanation, Hetherson concluded that "[b]ased on the circumstances surrounding this investigation, no misconduct was found against staff." When interviewed and asked to elaborate on the basis of her finding, Hetherson relayed that, in her view, none of the officers intended to harm Messier. Negligent conduct can also result in a policy violation. As Hetherson knew or should have known, her review should have first determined whether the officers involved complied with DOC policy, without regard to whether they did so intentionally or unintentionally. Upon finding that the conduct was not intentional, her analysis should have turned to whether it

was unintentional. The IAU investigation made a conclusion on that issue as to Officers Howard and Raposo, and at no time has Hetherson offered a basis to depart from it.

3. BSH Superintendent Murphy brought his concerns regarding Assistant Deputy Commissioner Karen Hetherson's Executive Review to Hetherson's attention. Hetherson did not take any material steps in response.

4. The IAU investigation was incomplete in at least one material respect, i.e., its failure to address the actions (or inactions) of Acting Lieutenant Billadeau who supervised the restraint of Messier and did not intervene. Hetherson should have addressed that deficiency, which she could have accomplished in a number of ways (e.g., by determining herself whether Acting Lieutenant Billadeau violated DOC policy or by returning the investigation to the IAU with an instruction that the IAU should determine whether Acting Lieutenant Billadeau's supervision complied with DOC policy).

C. Use of Force Package

1. BSH leadership requested that it be permitted to delay the submission of a Use of Force package on five occasions. On each occasion, it cited the pendency of a criminal investigation. Even were I to accept that justification as sufficient to delay the submission of the Use of Force package, the justification ceased to exist in early 2011.

2. Nevertheless, the Use of Force package was languishing, unsubmitted, until late November 2012 when Deputy Commissioner Pepe discovered that it had not been submitted. He promptly instructed BSH Superintendent Murphy to submit the package immediately and instructed SOD Director Ayala to prioritize its review. The Use of Force package was submitted on December 7, 2012.

3. Once submitted, the Use of Force package was promptly rejected by the SOD. Like the IAU investigation, the SOD's review of the Use of Force packet noted, among other

things, the violation of DOC policy prohibiting the application of force to the back of a restrained patient.

4. Commissioner Spencer was made aware of the rejection of the Use of Force packet. He did not take any steps to reconcile that rejection with the Executive Review of the IAU report, which had concluded that no misconduct had occurred.

5. The above findings warranted the following steps:

    a. Commissioner Spencer has received a formal reprimand for allowing the Use of Force package to languish, unsubmitted until December 7, 2012; and for failing to take any material action upon receiving notice that the Use of Force package had been rejected by the SOD.

    b. Bridgewater Superintendent Robert Murphy has received a formal reprimand for allowing the Use of Force package to languish, unsubmitted, until December 7, 2012.

D. Other Issues

1. My review has given rise to concerns regarding whether DOC complied with its own reporting and investigatory requirements following Messier's death, i.e., those reporting and investigatory requirements unrelated to employee discipline. By way of example, DOC typically will conduct a mortality review following an unexpected death at BSH. It appears that no such review has been performed.

E. Next Steps

1. <u>Remaining Disciplinary Process</u>.

    a. The two DOC inquiries that properly focused on whether Correction Officers Howard and Raposo complied with the DOC prohibition on applying pressure to the back of a restrained inmate concluded that they did not. The sole conclusion otherwise, i.e.,

the Executive Review, was conclusory and, based on later-proffered explanation, incorrect.

b. The Commissioner should determine the appropriate punishment for Correction Officers Howard and Raposo and comply with statutory and regulatory processes associated with that punishment. Each officer should be placed on leave until the disciplinary process has concluded.

c. Neither the IAU report nor the Executive Review thereof nor the SOD's Use of Force addressed the actions (or inactions) of Acting Lieutenant Billadeau on the night of May 4, 2009.

d. Commissioner Spencer should examine those actions or inactions, determine an appropriate punishment (or, alternatively, whether he requires further information from the IA), and begin the disciplinary process. Acting Lieutenant Billadeau should be placed on leave until that process is complete.

2. <u>Prompt Reporting</u>

a. Commissioner Spencer will undertake a full accounting as to whether DOC complied with its own reporting and investigatory requirements following Messier's death. If any such requirements were not followed, an explanation should be provided, together with concrete steps to ensure that no such omissions are repeated (if appropriate).

APPENDIX A

The following documents were reviewed:

- Department of Correction policies 650, 651 and 505 regarding the use of force and use of restraints;
- Bridgewater State Hospital Use of Force Package, dated December 12, 2012;
- DOC Internal Affairs investigation numbered DOC-BSH-09-67 and dated May 25, 2011;
- Report of the Office of the Chief Medical Examiner, dated February 3, 2010;
- The Executive Review and Summary of Internal Affairs Investigation numbered DOC-BSH-09-67 and dated June 6,2011;
- DOC organizational charts for 2009 and 2011;
- Plymouth County CPAC investigation, dated September 1, 2010;
- Minutes of a DOC Labor/Management meeting dated February 11, 2010;
- Minutes of DOC Executive Staff Meeting, dated February 9, 2010;
- Autopsy and findings of the Office of the Chief Medical Examiner re: the death of Joshua Messier dated February 3, 2010.
- Undated press statement of District Attorney Timothy Cruz re: OCME findings;
- Executive reviews and findings of IAU investigations from November 2010 to November 2011.