UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

WILLIAM ROE, et al., on behalf of Themselves and all others similarly situated,	:	
Plaintiffs,	:	
v.	:	Case No.: 2:89-cv-00570 (KAD)
MICHAEL HOGAN, et al.,	:	
Defendants.	:	
	:	June 3, 2021

PLAINTIFFS' MEMORANDUM IN SUPPORT OF THEIR MOTION FOR COMPLIANCE

I. INTRODUCTION

Pursuant to paragraph 29 of the Court's January 1991 Order in this case, Members of the Plaintiff Class file this Motion for Compliance with the consent decree in this case, and accompanying Motion for a Temporary Restraining Order (TRO) to prevent the indefinite temporary closure of Whiting Forensic Hospital (WFH) Unit 6 and the transfer of current patients to other units in WFH, and for an order for adequate staffing for all units at WFH including no mandated overtime.

The parties to this action settled the case in 1990 and the Court entered a consent decree (Doc. No. 38). See *Roe v. Hogan*, Agreement and Settlement (January 1991)(Order or Consent Decree) attached as Appendix 1 to Plaintiffs' Motion for a Temporary Restraining Order. Plaintiffs, as class members, have a right to have this matter heard and the consent decree enforced. Order at ¶ 29. In accordance with the requirements of the Order, Plaintiffs have, in good faith, attempted to resolve the noncompliance with Defendants but have been unsuccessful

and therefore file this Motion seeking an Order by this Court finding the Defendants in noncompliance with the Order. *See* Declaration of Deborah A. Dorfman in Support of Plaintiffs' Motion for Compliance and Temporary Restraining Order (Dorfman Decl.), Exhs. 1-8. The Court has an affirmative duty to protect the integrity of the decree. *Berger v. Heckler*, 771 F.2d 1556, 1569 (2d Cir. 1985).

This Motion and Memorandum is supported by the Declarations of Hal Bassow (Bassow Decl.); Susan Werboff (Werboff Decl.); Stephen Morgan (Morgan Decl.); Christopher Craigwell (Craigwell Decl.); Thomas Connors (Connors Decl.); David McKeever (McKeever Decl.); and the Dorfman Decl. all filed in support of Plaintiffs' Motion for Compliance and Temporary Restraining Order. This Motion and Memorandum is also supported by the Declarations of Gail Litsky (Litsky Decl.); Ricardo Pagan (Pagan Decl.); and Arthur Elliot (Elliot Decl.) all filed in support of Plaintiffs' Motion for Compliance.

II. Parties

David McKeever is an acquittee committed to the jurisdiction of the Psychiatric Security Review Board (PSRB). McKeever Decl., ¶¶ 2-3. Mr. McKeever has Usher Syndrome, a genetic condition resulting in substantial impairment of his vision and hearing. Id., ¶4. He is a patient of WFH and currently resides on WFH Unit 6. Id., ¶ 2. As an acquittee, Mr. McKeever is a member of the *Roe v. Hogan* plaintiff class as a "Plaintiff," "Patient," and "PSRB Acquittee." Order, ¶¶ 1, 4, and 5.

Anthony Henry is an acquittee committed to the jurisdiction of the PSRB. Mr. Henry has intellectual and developmental disability, including autism, and a mental health condition. Werboff Decl., ¶ 5. He is a patient of WFH and currently resides on WFH Unit 3, having been the first person transferred in this action on Wednesday, May 26, 2021. *Id*., ¶ As an acquittee,

Mr. Henry is a member of the *Roe v. Hogan* plaintiff class as a "Plaintiff," "Patient," and "PSRB Acquittee." Order, ¶¶ 4, and 5.

Stephen Morgan is an acquittee committed to the jurisdiction of the PSRB. Mr. Morgan has a mental health condition. Morgan Decl., ¶ 7. He is a patient of WFH and currently resides on WFH Unit 4. Mr. Morgan was moved over his objection with a show of force from five DMHAS police officers on June 1, 2021. As an acquittee, Mr. Morgan is a member of the *Roe v. Hogan* plaintiff class as a "Plaintiff," "Patient," and "PSRB Acquittee." Order, ¶¶ 1, 4, and 5.

Gail Litsky is an acquittee committed to the jurisdiction of the PSRB. She is a patient of WFH and currently resides on Dutcher North 2. *Id*., ¶ 2. As an acquittee, Ms. Litsky is a member of the *Roe v. Hogan* plaintiff class as a "Plaintiff," "Patient," and "PSRB Acquittee." Order, ¶¶ 1, 4, and 5.

Ricardo Pagan is an acquittee committed to the jurisdiction of the PSRB. Pagan Decl., ¶ 2. He is a patient of WFH and currently resides on Dutcher South 1. *Id*., ¶ 2. As an acquittee, Mr. Pagan is a member of the *Roe v. Hogan* plaintiff class as a "Plaintiff," "Patient," and "PSRB Acquittee." Order, ¶¶ 1, 4, and 5.

The *Roe v. Hogan* consent decree defines the "Defendants," as "the named defendants, their successors in office, their agents, employees and assigns." Order, ¶ 2. For the purposes of this motion, the defendants are Jose Crego, Acting Chief Executive Officer of Whiting Forensic Hospital and Commissioner Merriam Delphin-Rittmon, Commissioner of the Connecticut Department of Mental Health and Addiction Services.

III. Whiting Forensic Hospital – Historical Background

Whiting Forensic Hospital (WFH) was founded in 1970. Public Act 73-245 formally renamed the facility the Whiting Forensic Institute (WFI) in 1973. From 1970 through 1985,

four of the six units were occupied, psychiatrists were contracted from a group in Springfield, Massachusetts and only visited WFI weekly.

After the acquittal of John Hinckley in 1982 for shooting President Ronald Reagan, the Connecticut legislature created the Psychiatric Security Review Board in 1985 to centralize ongoing review and to monitor acquittees who required hospitalization and treatment after an acquittal by reason of mental health condition. (General Statutes §§ 17a-580 – 17a-603.)

In 1986, the Commissioner of the Department of Mental Health appointed the first Director of Forensic Services in the Office of the Commissioner. The appointment, supported by the Governor and the Commissioner, was intended to consolidate agency policy of WFI as an accredited hospital focused on treatment of patients rather than custodial security as a corrections facility.

On July 28, 1989, a forensic patient in CVH on an eight-hour pass killed a nine-year old girl on Main Street in downtown Middletown during a street fair. All forensic patients and acquittees were pulled back to the hospital regardless of risk, stability and recovery. (*See*, *Barna v. Hogan*, 964 F. Supp. 52 (D. Conn. 1997))

In 1989 a class action lawsuit was filed by William Roe and others on behalf of the class of acquittees subject to the jurisdiction of the Psychiatric Security Review Board. The State settled that case and agreed to a settlement agreement on December 5, 1990 in *Roe v. Hogan*, the consent decree at issue in this motion.

In 1995, along with the closure of Fairfield Hills Hospital and Norwich State Hospital, Whiting Forensic Institute merged with and became a division of Connecticut Valley Hospital (CVH) as the Whiting Forensic Division (WFD) of CVH. The overall focus of WFH had varied from security to treatment depending on the director at the time. The consolidation with CVH

was an attempt to emphasize that WFD was a hospital whose focus was to provide treatment, recovery and wellness, not imprisonment and punishment.

In March of 2017, a whistleblower WFD staff informed administration of WFD of CVH that a patient on WFD Unit 6 had been severely abused by staff for many years and that the abuse was ongoing. Thirty days of video was reviewed and the abuse was confirmed. Over forty staffers were disciplined, terminated, or allowed to retire. Ten WFD staff were criminally prosecuted. Nine pled guilty and one was convicted by a jury for crimes related to the abuse.

On May 1, 2018, as a result of Center for Medicaid and Medicaid Service (CMS) reviews, the Governor issued an executive order separating the Whiting Forensic Division from CVH and created a stand-alone hospital, Whiting Forensic Hospital.

Whiting Forensic Hospital is composed of twelve units across two buildings. Whiting Forensic Hospital Maximum Security Service, commonly known as Whiting, is a facility with six units, five of which are currently staffed. Units 1, 2 and 3 are competency restoration units. Patients on competency restoration units are patients facing criminal charges who have been evaluated and found not competent to stand trial and ordered committed by the Superior Court for treatment and restoration services pursuant to General Statutes § 54-56d. These units may also treat civil patients, Department of Corrections (DOC) transfers or acquittees. Civil patients are patients with a legal status of committed by probate court pursuant to General Statutes § 17a-498 or voluntary legal status pursuant to General Statutes § 17a-506. Acquittees are patients committed by the Superior Court after an acquittal on criminal charges by reason of mental health condition and committed to the jurisdiction of the Psychiatric Security Review Board. Department of Corrections transfers are committed pursuant to General Statutes §§ 17a-512 to 17a-520. Whiting Units 4 and 6 generally treat patients who are acquittees, but may also have

civil patients and DOC transfers. The current census of Unit 4, to the best of counsel's knowledge, is eleven patients. Unit 4's maximum capacity is usually not more than nineteen patients. Unit 4 staff also cover a single patient in a suite of rooms on unit 5 which is designated as Unit 4 Extension. Unit 6's current census is twelve, to the best of counsel's knowledge. Unit 6's maximum census is usually eighteen. The maximum census capacity of Whiting Maximum Security Service is 91 patients.

Whiting Forensic Hospital patients are also treated in Dutcher Hall Enhanced Security Service. Dutcher Hall has six treatment units with a capacity of between 21 to 24 persons per unit. Dutcher South 2 is a competency restoration unit for patients who generally have lower level charges and lower bonds. All the other Dutcher Hall units are units with patients with a legal status of acquittee, civil, and Department of Corrections transfers or end of sentence. The maximum capacity of Dutcher Hall is 138.

IV. RELEVANT FACTS

A. Ongoing and Significant Staffing Shortages at WFH

1. Required Staffing Levels at WFH

Whiting Maximum Security Service and Dutcher Enhanced Security Service each have their own staffing office. Deposition of Dr. Tobias Wasser, M.D., Wilkes v. Lamont, Case No. 3:20cv594 (D. Conn. 2020); Tr. Pgs. 40:53 attached as Exh. 8 to Dorfman Declaration. Each hospital has a position designated as "Schedulers" who are responsible, with supervision from the nurse supervisors, Directors of Nursing and the Chief of Nursing Services to ensure that there are adequate numbers of staff working each shift. *Id*., Tr. 43-44. There are three shifts for each unit. The first shift is from 6:45 a.m. to 2:45 p.m. The second shift is from 2:45 p.m. to 10:45 p.m. The third shift is from 10:45 p.m. to 6:45 a.m. *Id*., Tr. 44.

Whiting Maximum Security Service staffing, for units of up to eighteen patients, on the first and second shift, there is a minimum required staff of at least five nursing staff. *Id*., Tr. 44. This is in addition to the professional staff who generally work the first shift Monday through Friday. Professional staff includes psychiatrist, psychologist, social worker, rehabilitation therapist, unit director, and unit clerk. The minimum nursing staff for each unit for the first and second shift is at least five. The minimum of five can be a combination of at least one registered nurse and forensic treatment specialists (FTS's) at Whiting. *Id*., Tr. 44. Staffing requirements decrease when the census decreases. On third shift in Whiting, the total number of nursing staff required is four. *Id*., Tr. 44. The number of nursing staff required for any unit on any shift can increase if a patient is under a psychiatrist's order for increased observation of 1:1 or 2:1. *Id*., Tr. 45.

The units in Dutcher carry a higher number of patients on each unit, up to 24. *Id*., Tr. 44-45. If the census of the unit is 21, the nursing staff on first and second shift is six. If the census on a Dutcher unit is 24, the unit must be staffed with seven. *Id*., Tr. 44-45. The Third shift for Dutcher units, like Whiting reduces by one from the day shifts.

2. Current Staffing Shortages

WFH is understaffed. *See* Decls. of Morgan, ¶ 5; Craigwell, ¶ 6; Bassow, ¶ 6; Connors Decl., ¶ 4; McKeever Decl., ¶6. Although understaffing has been a relatively long-standing issue at WFH, the problem in recent months has intensified. As a result of this understaffing, Defendants have imposed an administrative plan to close Unit 6 at WFH and merge the patients from Unit 6 with the patients on Unit 4 and move some others from Units 4 and 6 to other units, including competency restoration treatment units. Additionally, the hospital has mandated overtime for direct care staff. At the same the hospital remains understaffed. As a consequence

of Defendants' actions, patients have been placed at risk of physical and psychological harm, have been denied individualized assessments and treatment as well as opportunities to participate in recreational and leisure activities and the opportunity to participate in treatment planning.

3. Indefinite Temporary Closure of Unit 6 at WFH

To try to address its chronic understaffing problems, Defendants have decided, in part, to indefinitely temporarily close one of its units-Unit 6 at the maximum-security building at WFH (Unit 6) -and transfer most of the patients from Unit 6 to Unit 4, and transfer some patients to other units, including competency units, at WFH. *See* Connors Decl., ¶ 4; Bassow Decl., ¶ 6; Craigwell Decl., ¶ 6; Morgan Decl., ¶ 5; McKeever Decl., ¶ 6; *see also* Werboff Decl., ¶ 4. They have also decided to transfer at least one patient from Unit 4 to a competency unit. *See generally* Connors Decl. Specifically, the patients on Units 4 and 6 were notified of this impending move on May 17, 2021, by staff, and subsequently at a "community meeting" on May 19, 2021, during which the Acting Chief Operating Officer, Joseph Crego, informed the patients of the move and that the reason for this move was due to staff shortages and a reduced census at WFH. Connors Decl., ¶ 4; Bassow Decl., ¶ 6; Craigwell Decl., ¶ 6; Morgan Decl., ¶ 5; Werboff Decl., ¶ 4; McKeever Decl., ¶ 6. The decision was not based upon the Plaintiffs' individual clinical needs, but rather administrative needs of the hospital; the patients and/or their legal representatives were not permitted any input into this decision. Craigwell Decl., ¶¶ 6, 9, 10, 11, 13; Morgan Decl., ¶¶ 5, 7, 8; Werboff Decl., ¶¶ 4, 7, 10, 11, 15; Bassow Decl., ¶¶ 6, 9, 10, 12, 16; Connors Decl. ¶¶ 4, 7, 8, 9, 13; McKeever Decl., ¶¶ 7, 9-11, 14. The Plaintiffs had no opportunity to discuss the proposed move with their treatment teams. Although they informed the Plaintiffs that the transfer would go into effect on June 1, 2021, Defendants have already started this process. *See* Decl. of Connors, ¶ 11 and Werboff, ¶ 10. They have already moved at least four of the patients:

Anthony Henry, Thomas Connors, Stephen Morgan, and one other patient from Unit 6 to Unit 4, although Plaintiffs' Counsel requested on several occasions that Defendants refrain from doing so while the parties attempted to resolve the dispute as required by paragraph 29 of the Order. *See id.* As discussed below, the merger of the patients from Unit 6 with those on Unit 4 and the movement of other patients to other units to administratively address the ongoing understaffing at WFH places the Plaintiff Class at risk of irreparable harm including risk of physical assaults, decreased physical space, and lost opportunities for active treatment as well as participation in activities such as recreational and leisure activities.

a. Immediate Risk of Patient-to-Patient Assault

Defendants have not sufficiently evaluated and considered the individual treatment implications of merging the Unit 6 patients with Unit 4 patients on to one unit or transferring other patients to competency units before taking these actions. First, there was no sufficient evaluation of each patient's risk factors and treatment needs as they relate to being moved from Unit 6 to Unit 4 or to other units or from Unit 4 to other units, prior to their move to the new units and Defendants' implementation of their plan. *See e.g.*, Werboff Decl., ¶¶ 7, 10, 11, 15; *see also* Morgan Decl., ¶¶ 5, 7-10, 12; Bassow Decl., ¶¶ 6, 9, 12, 15, 16. Such assessments to determine whether the Plaintiffs have any risk factors that would place them at risk of physical assault if moved are necessary. Evaluation of each patient's current risk is essential prior to any move so as to avoid placing patients who are particularly vulnerable with patients who have problems with aggression. Consequently, as a result of the unit merger, some patients with histories of physical altercations with each other will be housed together on the merged unit. Morgan Decl., ¶ 12; Bassow Decl., ¶¶ 9, 14, 15; McKeever Decl., ¶ 13.

Further compounding the problem and enhancing the serious risk of patient-to-patient assaults is the reduction in physical space that will be afforded the patients if the two units are merged. As a result of the merger, there will be twice as many patients on one unit but only half the living space that they previously had when on separate units. *See* Bassow Decl., ¶ 15; Morgan Decl., ¶ 12. Some of the patients will also be required to share dorm rooms with two or three other patients when previously, the Unit 6 patients each had their own rooms. *See* Bassow Decl., ¶ 9, Craigwell Decl., ¶ 12. This sharing of bedroom space will also increase the likelihood of patient-to-patient assaults—particularly without a prior specific assessment of risk. The likelihood of assaults will also increase if patients like Mr. Bassow and Mr. Morgan are required to share rooms with other patients with whom they have a history of conflict. *See* Bassow Decl., ¶ 9.

For example, Plaintiff Class Member Anthony Henry is diagnosed with an intellectual disability, autism, anxiety, and depression and is committed to the custody of the PSRB. Werboff Decl., ¶¶ 2-3, 5. Mr. Henry had been on WFH U6 for at least two years prior to his recent transfer to Unit 3, a competency restoration unit at WFH Unit on May 26, 2021, due to staffing problems and census changes at the hospital. Werboff Decl., ¶¶ 3-4, 7. Defendants unilaterally moved Mr. Henry without prior notification to Mr. Henry's conservator, Susan Werboff, and without providing her the opportunity to have input regarding the move and discussion with Mr. Henry's treatment team. Id., ¶ 10. Any transition, including changes in units, schedules and staff, are difficult for Mr. Henry. Because of Mr. Henry's intellectual disability and autism, Mr. Henry is particularly vulnerable to abuse and conflicts with other patients *See* Werboff Decl., ¶ 13. Mr. Henry has resided on Unit 3 in the past and had conflict with other patients residing on that unit. *Id*. It was these very conflicts which led, in part, to Mr.

Henry's transfer to Unit 6 approximately two years ago. *Id*. Now, he has been returned to Unit 3, without Defendants first having conducted a risk assessment or the necessary treatment planning in advance of his move, Ms. Werboff does not believe Mr. Henry will be safe on Unit 3. *See id*., ¶ 14. Mr. Henry's Master Treatment Plan stated that treatment would occur on WFH U6 through the time that he was moved. Mr. Henry's conservator states that the move is likely to cause irreparable harm to him. *See id*., ¶¶ 7, 14.

David McKeever is another patient on WFH Unit 6. His safety will also be at immediate risk of irreparable harm if he is forced to move to Unit 4. Mr. McKeever has resided in Dutcher North 1, WFH Unit 4 and currently WFH Unit 6. McKeever Decl., ¶ 3. Mr. McKeever has Usher's Syndrome, a genetic condition that causes substantial visual impairment and hearing impairment. *Id*., ¶ 4. Mr. McKeever uses a cane for ambulation. Mr. McKeever has not been given an opportunity to object, consent or express concerns about moving from Unit 6. *Id*. Mr. McKeever is at increased risk of victimization due to his visual and hearing impairments. *Id.* Additionally, Mr. McKeever has had conflicts with some of the patients on Unit 4 which is why, in part, he was placed on Unit 6. *Id*., ¶ 13. Defendants' plan to transfer him back to Unit 4 to satisfy their staffing problems places Mr. McKeever at risk of irreparable harm because he will be placed with some of the patients for whom his clinicians previously decided Mr. McKeever should be separated. Mr. McKeever wants to remain on Unit 6. *Id*., ¶ 12. Mr. McKeever's master treatment plan states that his treatment shall occur on WFH Unit 6. *Id*., ¶ 8.

In another representative example, Class Member Hal Bassow has been diagnosed with PTSD, is committed to the PSRB and has been a patient at WFH for over thirteen years and on Unit 6 for over two years. Bassow Decl., ¶¶ 2-4, 7. Mr. Bassow has also been a patient on WFH Unit 4 for many years in the past. *Id*., ¶ 5. Mr. Bassow learned about administration's plan to

close WFH U6 from staff on Monday, May 17, 2021. *Id*., ¶ 6. He was given no notice, no chance for input and no treatment team meeting or chance for input or individualized assessment of whether the transfer was in his best interest. *Id*., ¶ 6. Mr. Bassow's master treatment plan states that his treatment shall occur on WFH U6. Mr. Bassow wants to stay on WFH U6. *Id*., ¶ 8. Mr. Bassow was initially placed on Unit 6, in part, because of the past conflicts he had with some of patients on WFH U4. *Id*., ¶ 13. As a result of these conflicts, he was traumatized. *Id*., ¶ 14. Because of the impending merger, Mr. Bassow is now slated to move back to Unit 4 and will be reunited with the very patients with whom he has ongoing conflicts and from whom it was clinically determined that he should be separated. *Id*., ¶¶ 14-15. Mr. Bassow fears for his safety and wishes to stay on Unit 6. *Id*., ¶¶ 13-15. Not only will returning Mr. Bassow to Unit 4 place him at imminent risk of assault, but it also places him at risk of worsening his mental health symptoms due to his fears and anxieties about being in close proximity to the very patients with whom he has had conflicts and had from whom he had to be separated in the first instance. *See id*. Mr. Bassow has not been given any opportunity for input, concerns or discussion about an individualized assessment of his treatment needs on another unit. *Id*.

Stephen Morgan, a man diagnosed with schizophrenia, is committed to the PSRB and a patient who was on WFH Unit 6. *See* Morgan Decl., ¶ 2. Mr. Morgan spent the last eleven years between WFH Unit 4 and Unit 6. *Id*., ¶¶ 3-4 Mr. Morgan has a history of conflicts with other patients on Unit 4. *Id*., ¶ 12. Only a few months ago, Mr. Morgan was moved to Unit 6 from Unit 4 because one of the patients with whom he had a conflict threatened him. *Id*. Now, because of the staffing shortages at WFH and decisions made by Defendants based upon administrative needs, rather than Mr. Morgan's clinical needs, he was transferred back to Unit 4 on June 1, 2021 where he is again housed with the patients with whom he has past conflicts, including the

person who has threatened his safety. *Id*. Mr. Morgan fears for his safety and understandably does not want to return to Unit 4. *Id*., ¶¶11-12. Mr. Morgan was not given notice of the administration's intent to close Unit 6 and transfer all of the patients to other units. *Id*., ¶ 5. Mr. Morgan was not given an opportunity to give input, express his concerns, or participate in an individualized assessment of whether a treatment is in his treatment interests instead of administrative convenience and fiat. *Id*., ¶¶ 5, 7-9. Mr. Morgan wants to return on Unit 6. *Id*., ¶ 11.

b. Loss of Opportunities for Active Treatment, Recreational and Leisure Activities and Risk of Regression

Defendants' decision to transfer most of the patients from Unit 6 to Unit 4 and some to other units at WFH, including competency restoration units, even though the affected patients from Unit 6 and Unit 4 are almost all long-term patients who are committed to the custody of the PSRB, places them at immediate risk of harm by impairing their ability to receive the active treatment that they have been assessed to need.

For example, Class Member Thomas Connors has been a patient in WFH for two and half years. Connors Decl., ¶ 2. He has resided on Unit 4, Unit 6, Unit 2, Unit 4A and currently is on WFH Unit 2, a competency restoration unit even though he is not committed for competency restoration treatment. *Id*., ¶ 3. Mr. Connors is an acquittee. *See id*. Mr. Connors found out about the plan to close WFH Unit 6 and transfer patients to WFH Unit 4 and other units on Monday, May 17 from staff. *Id*., ¶ 4. Later that week WFH Unit 4 staff held a community meeting of the patients and formally informed them of the closure of Unit 6 and transfer of most Unit 6 patients to WFH Unit 4. Mr. Connors states that the Acting Chief Executive Officer told patients on Unit 4 that the closure of Unit 6 was due to staffing shortages and reduced census. *Id*., ¶ 4. Mr. Connors was not given an opportunity to discuss the closure of Unit 6, give input or voice his

objection and concerns. *Id*., ¶¶ 4,7-9. Mr. Connors will not be given appropriate treatment on Unit 2, a competency restoration unit, because the treatment that he needs is not available on that unit. *Id*., ¶ 7. Mr. Connors has been assaulted by three patients on Unit 6, which is the reason he was transferred to Unit 4, temporarily transferred to Unit 4A and then to Unit 2. *Id*., ¶ 11. Moving Mr. Connors was not based on his individualized needs for treatment, but for administrative convenience and fiat.

In another example, Mr. Henry was moved from Unit 6 to Unit 3, a competency restoration unit at WFH, because of staffing problems and census changes at the hospital. *Id*., ¶¶ 4, 7. Because of Mr. Henry's intellectual disability and autism, he has specialized treatment needs that are different from other patients. *See* Werboff Decl., ¶¶ 5, 7, 8. Additionally, as a result of his disabilities, Mr. Henry experiences significant difficulty with transitions and any change requires careful advance planning. *See id*., ¶7. This requisite treatment planning did not occur before Mr. Henry was moved to Unit 3 from Unit 6. Instead, Defendants unilaterally moved Mr. Henry and only notified his conservator after the fact. *Id*., ¶¶ 4, 10. Mr. Henry and Ms. Werboff want for Mr. Henry to return to Unit 6. *Id*., ¶ 12.

The risk of harm to Mr. Henry as a result of his sudden administrative transfer from Unit 6 to Unit 3 is heightened by the fact that unlike of the staff on Unit 6 who were familiar with, and had some training, to work with people with autism like Mr. Henry, the staff on Unit 3 do not have this same background and training, nor are they familiar with Mr. Henry's unique treatment needs. Werboff Decl., ¶ 8.

4. Pervasive Staffing Shortages and Mandatory Overtime Interfere Throughout WFH Impair Plaintiffs' Opportunities for Active Treatment, Recreation, and Leisure Activities.

The Plaintiff Class Members residing at Dutcher Hall have also been adversely affected by the staffing shortages at WFH. Arthur Elliott and Ricardo Pagan are patients on Dutcher South 1 who have had their rights violated under the Order as a result of Defendants' ongoing staff shortages. Mr. Elliott and Mr. Pagan are both acquittees. Elliot Decl., ¶ 2; Pagan Decl., ¶ 2. Dutcher South 1 has regularly been short staffed, especially on weekends and holidays Elliot Decl., ¶¶ 6-7; Pagan Decl., ¶¶ 6-7. Staffing shortages have resulted in loss of some fresh air breaks at 4 p.m. or time off the unit in the Dutcher courtyard at 7 p.m. Elliot Decl., ¶ 9; Pagan Decl., ¶ 8.

Plaintiff Gail Litsky is a patient on Dutcher North 2. She is the only female patient on that unit. Litsky Decl., ¶ 2. Ms. Litsky is an acquittee. Dutcher North 2 has regularly been short of nursing staff, especially on weekends and holidays. *Id*., ¶ 6. Staffing shortages have caused Ms. Litsky to be denied treatment required by her master treatment plan including fitness groups, recovery/relapse prevention group, fresh air and use of the bathroom. *Id*., ¶¶ 8, 9, 10. The lack of sufficient staff also makes Ms. Litsky anxious and feel unsafe. *Id*., ¶¶ 11, 12.

V. ARGUMENT:

A. Legal Standard for Interpreting Consent Decrees

Courts construe a consent decree as they would a contract. *U.S. ex rel. Anti-Discrimination Center of Metro N.Y., Inc. v. Westchester Co., N.Y*, 712 F.3d. 761, 767 (2d Cir. 2013) *quoting Doe v. Pataki*, 481 F.3d 69, 75 (2d Cir. 2007)("Consent decrees 'reflect a contract between the parties (as well as a judicial pronouncement), and ordinary rules of contract interpretation are generally applicable."). Specifically, Courts first look to the terms of a consent decree in order to determine the obligations and rights of the parties. *Id*. at 768. However, in

interpreting consent decrees, courts do not look at any one provision in isolation but rather "in light of the obligation as a whole and the intention of the parties as manifested thereby." *Id*. at 767 *quoting JA Apparel Corp. v Abboud*, 568 F.3d 390, 397 (2d Cir. 2009)(citations and internal quotation marks omitted).

Here, when construing the provisions of the *Roe* Order, it is clear that Defendants, as a result of implementing their merger plan to address their understaffing problems as well as their ongoing chronic staffing shortages are in noncompliance with several provisions of the Decree. These specific violations are discussed immediately below.

B. Defendants' Violations of *Roe v. Hogan* Settlement Agreement

1. Defendants Have Failed to Provide Plaintiffs with the Requisite Evaluations and Assessments Prior to Deciding to Move Them to Other Hospital Units as Required By Paragraph 13 of the Order.

Section II of the *Roe v. Hogan* Order provides for the general principles governing the settlement. Defendants' merger plan violates Paragraphs 11 and 13 of the Order. Paragraph 11 requires state hospitals to provide humane, dignified and clinically appropriate psychiatric patients regardless of their legal status. Among the many requirements of the Order, Paragraph 11 requires that ["a]ll decisions concerning the care and treatment of PSRB patients shall be made on the basis of individual evaluations and assessments." Order, Section II, ¶11. Likewise, Defendants are also in noncompliance with Paragraphs 13 and 15.b of the Order. Paragraph 13 requires that:

> The DMH hospitals are also responsible for insuring [sic] that decisions concerning the care and treatment of PSRB patients are made *after* explicit, individualized consideration of their history, the course of their disability, their current mental status, and a determination of whether participation in any particular program or activity will pose a danger to the patient or others. PSRB patients shall be provided with appropriate care and treatment which has its goal the restoration of the patient to, or maintenance of the patient at his/her highest level of functioning, . . . In this regard all treatment decisions

> concerning PSRB patients shall be made only *after* an individualized evaluation and assessment of each patient which explicitly considers and documents the patient's mental status and degree of danger, if any.

Order, ¶ 13 (*emphasis added*).

The plain language of the Order mandates that such assessments "shall" be completed and that any treatment decisions with respect to a patient's treatment must be made "after" the evaluations are completed. Here, Defendants abruptly announced their unit merger plans to Plaintiffs on May 17, 2021. This decision was made without the requisite specific individual evaluations or assessments to determine the appropriateness of the transfer of the individual patients or how their individual treatment needs would be affected. As a result of Defendants' failure to afford the Plaintiffs with individualized assessments and related treatment planning with respect to the transfers, some are being, or will be, forced to reside on treatment units with patients with whom they have had prior conflicts and for whom past clinical determinations have been made to separate them. *See e.g*, Morgan Decl., ¶ 12; Bassow Decl., ¶¶ 13-14; McKeever Decl., ¶ 13. Ironically, prior to deciding to implement their unit merger plan, some of the affected Plaintiff Class Members' treating professionals assessed them to need protection and separation from others with whom they had prior conflict. Now, due to administratively driven needs, Defendants are proceeding to undo those critically important clinical decisions. Going forward without adequately addressing those clinical determinations as required by the Order will necessarily pose an increased risk of danger and harm to these patients. Conversely, had Defendants done the necessary assessments and treatment planning and obtained the requisite input from the affected patients, they would not have reasonably proceeded with the Unit Merger Plan that poses such potential for immediate and irreparable harm.

As a result of the Defendants' administrative decision to transfer them without individual assessments and treatment planning to other units that do not have available the treatment that they need, the patients are not getting treatment as required by their master treatment plans. *See e.g*, Connors Decl., ¶¶ 7-12; Werboff Decl., ¶¶ 7-14. Some members of the Plaintiff Class are also at imminent risk of not receiving the necessary care and treatment that they need in order to have their mental health restored, or maintained, at the highest level of functioning.

All decisions concerning the care and treatment of PSRB patients shall be made on the basis of individual evaluations and assessments, the results of which shall be properly documented in the patient's record. Order at ¶ 11.

2. Defendants Failed to Base Their Decision to Close Unit 6 and Transfer Patients on Clinical Reasons.

Under Paragraph 13 of the Order, Defendants are required to provide PSRB patients with appropriate care and treatment that has as its goal the restoration or maintenance of the patient at his or her highest level of functioning. Order at ¶ 13. Humane, dignified and clinically appropriate treatment means including the patient in decisions about their treatment, including which unit they reside on. Treatment should be individualized and clinically appropriate.

The decision to close Unit 6 was not based on the needs of the patients but on administrative convenience and fiat. Further, the patients were transferred by administrative fiat, by non-treating administrators, not the patients' treatment team. The transfers were/are being done for collective administrative convenience, not for a clinical reason, not based on an individualized assessment of any patient's clinical need and not in order to maintain any patient at their highest level of functioning. The transfers will inevitably disrupt each patient's life, routines, comfort, safety, treatment and privileges and overall ability to have their mental health restored and/or maintained.

3. Defendants' Actions Adversely Affect Plaintiffs' Rights Under Paragraph 12 of the Order.

Section II, paragraph 12 of the Order requires Defendants to provide treatment with increasing levels of freedom and responsibility consistent with their individual clinical status. Order, ¶ 12. Transfers of the Plaintiffs to new units commonly result in reduction in privileges, increased levels of observation and close monitoring until the patient gets accustomed to the new unit and staff are sure that the patient is stable and safe. Unnecessarily transferring a patient may, in some cases, cause weeks of increased observation and decrease in privileges for each patient transferred. The problem is likely to be exacerbated when the patients are placed back on units with individuals with whom they have or have had conflicts and in a more crowded space.

4. Defendants are also in noncompliance with the *Roe* Order as a result of their failure to permit the Plaintiffs with the opportunity to fully participate in their treatment planning when they unilaterally decided to move them to Unit 4 or other Units as required by paragraph 15.b.ii of the Order**.**

Defendants actions also violated the provisions of Paragraph 15(b)(ii) of the Order that provides that "[e]ach patient shall be allowed and encouraged to fully participate in person in the development of his/her treatment plan . . . opportunity to fully participate in the treatment planning process, and the right to express written approval or disapproval of the treatment plan . . ." *Id*., II.15(b)(ii). When Defendants decided to close Unit 6 and merge most of the patients together on Unit 4 to attempt to address staffing shortages, this decision was made without providing any of the affected patients with the opportunity to participate in this aspect of their treatment planning or to disapprove of the treatment plan as is their explicit right under Paragraph 15(b)(ii) of the Order. *See* Decls. of Connors, ¶ 4, 7, 8,13; Werboff, ¶¶ 4, 7, 10, 15; Bassow, ¶ 6, 9, 10, 12, 16; Morgan, ¶ 5, 7-10, 13; Craigwell, ¶ 6, 10, 11, 12; McKeever Decl., ¶ 7. Had Defendants sought such input from the affect Plaintiff Class Members, as required by

the *Roe* Order, they would have heard from the Plaintiffs and/or their legal representatives, that the proposed move imposed real and immediate risk of harm or injury – that's precisely why the *Roe* Order obligates Defendants to follow that process. These are not merely technical requirements that Defendants failed to follow, but instead requirements tied to clinical needs of the Plaintiff Class that Defendants are obligated to address.

5. Defendants failed to provide the Plaintiff Class Members with the right to have an advocate prior to their unilateral decision to move the Plaintiffs as required by paragraph 15.b.ii of the Order.

Section III of the *Roe v. Hogan* settlement agreement provides for the practices and policies for treatment of PSRB patients. All of the movants and declarants are PSRB patients as defined in the agreement. Section III paragraph 15.b.ii states that each patient has a right to an advocate. Order, ¶ 15.b.ii. Despite this requirement, none of the patients were provided the opportunity to meet with their advocate until after being told the move was going to occur or to object.

6. Defendants' actions also violate Paragraphs 15.b.iv, 15.c, and of the Order

Section III paragraph 15.b.iv. provides that each patient's master treatment plan shall include a description of the particular services and programs which are adequate and appropriate, and the location and frequency thereof, consistent with the patient's needs and least restrictive of their freedom. Administration told all of the patients on WFH U6 that the unit was closing down and they would be transferred. All of the patients' master treatment plans were written by WFH Unit 6 staff and for treatment and programs for Unit 6. The location and frequency was for WFH U6. None of the movants' master treatment plans, other than possibly Mr. Henry, since he has already been moved, provides for any services or location of treatment other than on WFH U6.

Section III paragraph 15.c. requires that all individualized psychiatric, therapeutic, rehabilitative, vocational, recreational and leisure programming shall be provided to each patient in accordance with their master treatment plan. Order, ¶ 15.c. Movants and declarants have each stated that they were given no notice of the closure of WFH U6, any pretext that the closure and transfer was based on an individualized assessment of their clinical medical needs, or that their master treatment plans had been changed and they would be moved in accordance to their needs as written in their master treatment plans. Declarants have all stated that the closure of WFH U6 was done for administrative convenience and not based on the necessary individualized assessments of their clinical presentation or their treatment needs or with treatment planning in which the individual patient was permitted to participate. Understaffing Dutcher South 1 and Dutcher North 2 violates this section of *Roe v. Hogan* because the understaffing of units results in failure to provide fresh air, recreational activities, and safe access to restrooms on those units.

Section III paragraph 17 prohibits Defendants from unilaterally changing any patient's master treatment plan. Order, ¶ 17. Patients and their advocates have the right to participate in any change in the master treatment plan. Declarants have been told they are all to be transferred to different units. None of the patients have had input into the changes in their treatment plan since being told of WFH U6 closure and transfer of all patients.

VI. Conclusion

Defendants have violated the terms of *Roe v. Hogan* consent decree by unilaterally closing WFH U6 and transferring all of the patients based on administrative convenience, not individualized assessments of each patients needs and treatment as documented in their master treatment plans. Moreover, chronically understaffing units in Dutcher deprives patients of

treatment as provided in their treatment plans and threatens the safety of the units. For the foregoing reasons, the Plaintiffs' Motion for Noncompliance should be granted.

DATED this third day of June, 2021.

Respectfully submitted,

THE PLAINTIFFS,

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Certificate of Mailing

I hereby certify that the above Memorandum in Support of Plaintiffs' Motion for Compliance was filed on the Court's CM-ECF filing system and emailed to all counsel on the 3rd day of June 2021 to:

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