

**SETTLEMENT AGREEMENT AND RELEASE**

WHEREAS, Disability Rights Vermont ("DRV") has brought an action pursuant to 42 U.S.C. § 1983 and other federal and state laws on behalf of John Doe [REDACTED] to redress alleged deprivations of his rights, captioned *John Doe v. State of Vermont, et al.*, Civil Action No. 2:09-CV-274 (the "lawsuit" or the "litigation"); and

WHEREAS, defendants (collectively the "State Defendants") dispute the standing of plaintiff to bring this action, deny the allegations that the State Defendants have violated plaintiff's rights; and

WHEREAS, nothing in this Agreement is intended to, nor shall be construed as, an admission of liability; and

WHEREAS, plaintiff and defendants are involved in the pleading phase of the litigation as of the date of this Agreement; and

WHEREAS, it is mutually advantageous for both parties to settle this dispute without further litigation;

NOW THEREFORE, in consideration for the payment described below, the mutual covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

**I. PROCEDURE**

- A. Execution of Release: Simultaneous with the execution of the Settlement Agreement, [REDACTED] shall execute a Release in favor of the State in the form attached as Exhibit A to this Agreement.
- B. Dismissal of Action with Prejudice: In accordance with Federal Rule of Civil Procedure 41(a), upon the execution of this Agreement and Release, the Parties shall execute a Stipulation of Dismissal of the litigation with prejudice and without costs, in the form attached as Exhibit B, which defendants will file with the Court.
- C. Effective Date of the Agreement: This Agreement shall become effective upon the final execution of this Agreement and Release and the filing and entry of the Stipulation of Dismissal of the litigation by the Court, in accordance with Federal Rule of Civil Procedure 41(a) (the "Settlement Date").

## **II. LETTER OF APOLOGY**

The Executive Director of the Vermont State Hospital will execute a letter of apology, dated on the same date as the execution of this Agreement and Release, in the form attached as Exhibit C.

## **III. MODIFICATION OF NURSING ADMISSION ASSESSMENT**

The State will modify the nursing admission assessment to include a question about the patient's preferences regarding the type of EIP (safety planning tool). Since physicians are required to review the nursing assessment and sign it, they will be aware of the patient's initial EIP preferences and will consider, but not be bound by, that initial preference when they make an assessment of the need for involuntary medication in combination with seclusion or restraints. Because this change will have an impact on patient care 24/7 with the entire nursing staff, it will take approximately 6 months to fully implement this change, i.e. change the assessment, modify relevant policies, conduct trainings with nurses and physicians, so that the change is implemented in a way that is operationally feasible. The State agrees to begin to implement the changes immediately upon execution of this Agreement and Release and complete the process within 6 months of the Settlement Date.

## **IV. AMENDMENT TO CON FORMS FOR INVOLUNTARY MEDICATION**

- A.** The State will modify the Certificate of Need ("CON") Forms ("VSH Forms # PN-04-05-A and B") used when Emergency Involuntary Medication is ordered for a patient in Seclusion/Restraints, in the form attached as Exhibit D. Specifically, the content of Exhibit D will replace the section of the current CON Forms entitled "Physician Assessment Of Need For Emergency Involuntary Medication."
- B.** The State Defendants do not have any current plan to further amend the new page 4 of the CON's (Exhibit D) in the foreseeable future, but the State Defendants and their successors are free to amend the new page 4 of each amended CON Form to comply with current law and regulatory input from DOJ and CMS and will provide notice of such change to DRV within a reasonable time. Any other changes to page 4 of the amended CON Forms should be accomplished only after prior notice to DRV or its successor. In the event that DRV expresses an objection to the changes to the CON Forms proposed by the State Defendants, the parties will resolve the dispute through binding arbitration and not through court action. The parties will agree on an arbitrator and also agree to each pay half of the cost of the

arbitration. If the parties cannot agree on an arbitrator, then they will submit the dispute to arbitration through the American Arbitration Association.

## V. PAYMENT

Without any admission, implication or suggestion by Defendants that plaintiff is a prevailing party, within five (5) days of the Settlement Date of this Agreement, the State will pay plaintiff the sum of [REDACTED]. This payment will be by check made payable to Disability Rights Vermont.

## VI. REMEDIES AND EXPIRATION OF AGREEMENT

This Settlement Agreement shall remain in effect for a period of five years from the effective date of the Settlement Agreement. During that time, either party may commence an action to enforce the terms of this Settlement Agreement, provided however:

- A. The party has made good faith efforts to resolve the dispute without litigation;
- B. Any action for breach of this agreement shall be filed in Washington Superior Court in the State of Vermont; and
- C. The remedy available in any such action shall be specific performance. In addition, an award of attorneys' fees and costs associated with such an action may be awarded to the prevailing party if the court finds that the party against whom judgment is entered acted frivolously or in bad faith.

## VII. MISCELLANEOUS

- A. Negotiation and Drafting of Document: This Agreement is a document which both Parties have negotiated and drafted; therefore, the general rule of construction interpreting a document against the drafter shall not be applied in any future interpretation of this Agreement.
- B. Entire Agreement: This Agreement represents the entire and only Agreement between the parties. All prior agreements, representations, statements, negotiations and understandings shall have no effect.
- C. Amendments: No changes, modifications or amendments to the terms and conditions of this Agreement shall be effective unless reduced to a writing signed by both Parties.

D. Governing Law: The law of the State of Vermont shall govern any dispute regarding this Agreement.

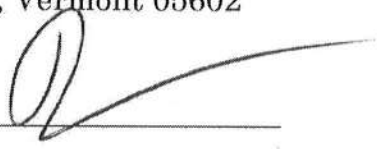
**VIII. AUTHORITY**

The undersigned representatives of the Parties certify that each is fully authorized by the Party he or she represents to enter into the terms and conditions of this Settlement Agreement and to execute and bind that Party to it.

By the signatures below, and for the consideration contained herein, the Parties agree to be bound by the terms and conditions of this Agreement.

**DISABILITY RIGHTS VERMONT**

141 Main Street  
Suite 7  
Montpelier, Vermont 05602

By: 

For the Plaintiff

STATE OF VERMONT

SS.:

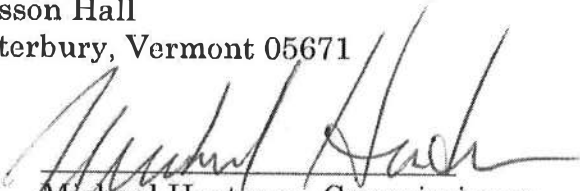
COUNTY OF Washington

At Montpelier, in said county, this 27 day of May, 2010, personally appeared A. J. Rubin on behalf of Disability Rights Vermont and acknowledged that the foregoing instrument has been subscribed by him for Disability Rights Vermont as his free act and deed and in accordance with authority granted to him by Disability Rights Vermont.

Before me, Margaret J. Bancroft  
Notary Public

My commission expires: Feb 2011

**STATE OF VERMONT**  
**DEPARTMENT OF MENTAL HEALTH**  
103 South Main Street  
Wasson Hall  
Waterbury, Vermont 05671

By:   
Michael Hartman, Commissioner  
For the State Defendants

STATE OF VERMONT  
SS.:  
COUNTY OF \_\_\_\_\_

At Waterbury, in said county, this 1 day of June, 2010,  
personally appeared Michael Hartman on behalf of the Vermont Department of  
Mental Health and acknowledged that the foregoing instrument has been  
subscribed by him for the Vermont Department of Mental Health as his free act and  
deed and in accordance with authority granted to him by Vermont Department of  
Mental Health.

Before me,   
Notary Public

My commission expires: 2/10/11

**EXHIBIT D**

**PART 1**

**CERTIFICATE OF NEED (CON) FOR SECLUSION**  
**and when EMERGENCY INVOLUNTARY MEDICATION is**  
**ordered for a patient in seclusion**

ADDRESSOGRAPH ↑

**SECLUSION ALONE:** RN completes pages 1 and 2. MD completes page 3.

**WHEN EMERGENCY INVOLUNTARY MEDICATION IS GIVEN TO A PATIENT IN SECLUSION:** In addition, MD and RN complete page 4.

<b>PHYSICIAN ASSESSMENT OF NEED FOR EMERGENCY INVOLUNTARY MEDICATION</b>			
1. Physician considerations for initiating Emergency Involuntary Medication while patient is in Seclusion (check all that apply) <input type="checkbox"/> Continued seclusion has not prevented the patient from causing serious harm to self or others <input type="checkbox"/> Continued seclusion in and of itself has created an immediate risk of serious harm to the patient or others <input type="checkbox"/> self-injurious behavior <input type="checkbox"/> cardiac concerns <input type="checkbox"/> other medical conditions <input type="checkbox"/> serious injury due to trauma <input type="checkbox"/> other _____			
2. MD assessment of risk of initiating Emergency Involuntary Medication while patient is in Seclusion (check all that apply) <input type="checkbox"/> health complication <input type="checkbox"/> re-traumatization <input type="checkbox"/> compromised patient autonomy <input type="checkbox"/> compromised therapeutic relationship <input type="checkbox"/> other _____			
3. The use of Emergency Involuntary Medication is necessary because the patient's behavior presents an immediate risk of harm to self or others. Please explain:  <div style="border: 1px solid black; height: 100px; width: 100%;"></div>			
MD signature	MD printed name	Date	Military Time

<b>RN ADMINISTRATION AND ASSESSMENT OF EFFECTIVENESS OF EMERGENCY INVOLUNTARY MEDICATION</b>			
If Emergency Involuntary Medication is given, list the medication(s) (must also document on MAR):	Time Administered		
Was a brief hands-on used to administer emergency involuntary medication? <input type="checkbox"/> Yes <input type="checkbox"/> No - This does not require a separate CON.			
Was the person identified at time of admission (Admission Assessment, p. 11) contacted regarding this use of emergency involuntary medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If no person was identified at the time of admission, does the patient want someone to be called? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of person to be notified: _____ Phone: _____ If patient said yes, did you call? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? _____			
Does the patient have a guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If the patient has a guardian, you must notify him/her, even when the patient does not want the guardian called. Document the guardian's name and number as "person to be notified" above.</i>			
<b>RN ASSESSMENT OF THE EFFECTIVENESS OF THE EMERGENCY INVOLUNTARY MEDICATION</b> (one hour following administration):  <div style="border: 1px solid black; height: 100px; width: 100%;"></div>			
RN Signature	RN Printed Name	Date	Military Time

**EXHIBIT D**

**PART 2**



**CERTIFICATE OF NEED (CON) FOR RESTRAINT  
and when EMERGENCY INVOLUNTARY MEDICATION is  
ordered for a patient in restraints**

ADDRESSOGRAPH ↑

DATE: \_\_\_\_\_ B1 B2 BR

**RESTRAINT ALONE:** RN completes pages 1 and 2. MD completes page 3.

**WHEN EMERGENCY INVOLUNTARY MEDICATION IS GIVEN TO A PATIENT IN RESTRAINTS:** In addition, MD and RN complete page 4.

PHYSICIAN ASSESSMENT OF NEED FOR EMERGENCY INVOLUNTARY MEDICATION			
1. Physician considerations for initiating Emergency Involuntary Medication while patient is in Restraint (check all that apply)			
<input type="checkbox"/> Continued restraint has not prevented the patient from causing serious harm to self or others			
<input type="checkbox"/> Continued restraint in and of itself has created an immediate risk of serious harm to the patient or others			
<input type="checkbox"/> self-injurious behavior <input type="checkbox"/> cardiac concerns <input type="checkbox"/> other medical conditions <input type="checkbox"/> serious injury due to trauma <input type="checkbox"/> other _____			
2. MD assessment of risk of initiating Emergency Involuntary Medication while patient is in Restraint (check all that apply)			
<input type="checkbox"/> health complication <input type="checkbox"/> re-traumatization <input type="checkbox"/> compromised patient autonomy <input type="checkbox"/> compromised therapeutic relationship			
<input type="checkbox"/> other _____			
3. The use of Emergency Involuntary Medication is necessary because the patient's behavior presents an immediate risk of harm to self or others. Please explain:			

MD signature \_\_\_\_\_ MD printed name \_\_\_\_\_ Date \_\_\_\_\_ Military Time \_\_\_\_\_

RN ADMINISTRATION AND ASSESSMENT OF EFFECTIVENESS OF EMERGENCY INVOLUNTARY MEDICATION	
If Emergency Involuntary Medication is given, list the medication(s) (must also document on MAR):	Time Administered
Was a brief hands-on used to administer emergency involuntary medication? <input type="checkbox"/> Yes <input type="checkbox"/> No - This does not require a separate CON.	
Was the person identified at time of admission (Admission Assessment, p. 11) contacted regarding this use of emergency involuntary medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no person was identified at the time of admission, does the patient want someone to be called? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of person to be notified: _____ Phone: _____	
If patient said yes, did you call? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not?	
Does the patient have a guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If the patient has a guardian, you must notify him/her, even when the patient does not want the guardian called. Document the guardian's name and number as "person to be notified" above.</i>	
<b>RN ASSESSMENT OF THE EFFECTIVENESS OF THE EMERGENCY INVOLUNTARY MEDICATION</b> (one hour following administration):	

RN Signature \_\_\_\_\_ RN Printed Name \_\_\_\_\_ Date \_\_\_\_\_ Military Time \_\_\_\_\_