

AFFIDAVIT OF NANCY THOMAS

I, Nancy Thomas, being duly sworn, depose and say:

1. My name is Nancy Thomas. I have a BA and an M.Ed from Duke University and a JD from the University of Maine School of Law. I am licensed to practice law in the State of Maine and in the Federal District Court of Maine. I make this affidavit on my personal knowledge, information and belief, and to the extent that statements are based on information and belief, I believe them to be true.

2. From 1981 to 1985, I engaged in the private practice of law. From June 1985 until May 1986, I was Executive Secretary for the Consumer Advisory Board (CAB).

3. From May 1986 until November 2005, I worked for the Office of Advocacy, which is part of what is now the Department of Health and Human Services (Department). I provided advocacy services for people residing at Pineland Center (1986-1996), and then for people in the community receiving developmental services from DHHS and for patients at the former Augusta Mental Health Institute. For most of those years, I was also a member of the CAB.

4. During the summers of 2006 and 2007, I was the Interim Executive Director for the Consumer Advisory Board. Starting in October 2007, I became the Executive Director, a position I still hold.

5. I was first introduced to the Pineland Consent Decree when I started working for the CAB in 1985. Then as an advocate, I used it and its successor, the Community Consent Decree, as a tool for interpreting rights of class members.

6. My duties as an advocate at Pineland included providing rights training for all Pineland staff; attending regular and special planning meetings, then called Interdisciplinary Team meetings; responding to complaints from consumers and their guardians; investigating adult protective and rights violations reports; and participating in placement planning during Pineland's final years.

7. During my 10 years at Pineland, I knew many of the residents there and became familiar with their way of life and the activities available to them. I was familiar with all residential buildings and day programs. As part of responding to complaints, I became very familiar with problems and abuses that occurred there. Examples of substantiated allegations of abuse that I investigated as part of a team included:

- A staff member systematically struck the wrists, elbows, knees and ankles of nonverbal residents under his care with a large steel clip on his key ring; gave cold showers, sometimes with clothing on, and hit people if they made noise; bent back the fingers of a female resident until she showed pain, sometimes to the point of tears; gave people food but no utensils and made them dump their food when they did not eat it with their hands; and struck at least two residents on their faces. Witnesses indicated these abuses had been occurring for at least a year. A warrant was issued for the staff person's arrest, but law enforcement authorities were unable to locate him.

-A staff person stood residents in a corner or forced them to sit on a coffee table to keep them from falling asleep.

-Two staff members forced a man with a fear of heights to stand on a milk crate for misbehaving. Both staff members were found guilty of endangering the welfare of an incompetent person as a result. The investigation found that one of these staff members also stood on another man's throat while balancing between hallway walls with his hands and threw a third man's shoes down a hill and forced him to walk barefoot across rough terrain for approximately twenty feet in order to retrieve them.

-A staff person sat on a female's chest and forcibly brushed her teeth, which could have resulted in choking, and called her degrading names.

-Numerous other cases of physical assault and verbal abuse by staff members.

All of these events took place after 1983 when the District Court released the Defendants from active supervision and investigations continued until several months before Pineland closed.

8. Residents of Pineland often were a long distance from their families and the communities where they were born and unable to have regular contact with them. I remember hearing during my early years at Pineland that in the past, families were sometimes told not to maintain contact after their family member was admitted to Pineland. Between 1999 and 2001, several years after his discharge from Pineland, I had the experience of going with a Class Member I will refer to as "NT", his volunteer correspondent, and his community providers to the Pleasant Point Reservation, where he was reunited with his family for what I understand was the first time since he was admitted to Pineland when he was around six years old. Several siblings literally lined up to greet him and welcome him back to the family. NT is nonverbal, and I had observed while he was at Pineland that he would become excited and spit when he was in crowds of people. This behavior continued for some time after he left Pineland and I understand

it still occasionally occurs. In contrast, at the pow wow we attended with him, he remained totally calm with his family, many other people, and much activity surrounding him. While he now has annual trips to visit his family, he has not had the full family life he would have enjoyed if contact with his family and its traditions could have occurred throughout his life. For over forty years, I understand he had no contact at all.

9. Many people housed at Pineland had behavior issues which often were addressed by severely intrusive behavior plans or emergency interventions which included restraint. A number of residential buildings had restraint chairs with chest, leg, waist and arm straps to immobilize an agitated person until calm. These chairs were in use when I began working at Pineland in 1986 and were used regularly until several years before Pineland closed. When the restraint chair was removed, staff had to find other, more humane ways to interact with people when they were very agitated.

10. Both as an advocate and as a member of the CAB, which was overseeing compliance, I became aware of many areas where the Department failed to comply with the Pineland Decree after the District Court terminated active supervision in 1983. These conditions occurred in the late 1980's and early 1990's and led to the Complaint filed in 1991. Placement requirements of the Pineland Consent Decree were not being met and some people who were admitted to Pineland would not have needed to be admitted if there had been adequate crisis support in the community. As part of my work with the CAB, I gathered information from Bureau of Mental Retardation Regional Administrators to find out what community barriers were leading to Pineland admissions. Letters I received from Regional Administrators indicated that there was a lack of short term and long term home placements and a lack of community mental health services. Sometimes respite beds were filled and not available during a crisis.

11. After the 1991 Complaint was filed by Plaintiffs, I became part of the Consent Decree negotiation group. The new Decree contained provisions to address areas of noncompliance that had been identified by the CAB. It also contained a provision for mechanisms of future compliance, which I understood would include arrangements for the Class to enforce their rights to the benefits of the Decree for the remainder of their lives.

12. Both as a member and as Executive Director of the CAB, I have participated in Consent Decree monitoring activities since the Decree was entered in 1994. As an obligation and at the CAB's request, the Department has provided information about crisis services, unmet needs, Individual Support Coordinator ratios, ISC contacts, grievances and appeals, community integration, and other areas. Many of

these reports have contained information about individual class members. The CAB also has routinely reviewed individual adult protective and rights violation reports, and has been able to oversee severely intrusive behavior plans and safety plans through membership on the Three Person Review Committees that review and approve these plans. When the CAB was concerned about implementation of Individual Support Teams (IST), it was able to review individual IST reports. In assessing compliance during the certification process, the CAB, through me as Executive Director, has had access to the Department's Enterprise Information System (EIS) in order to review unmet needs and other problems of individual class members. Access to information about individuals has been routine as part of assessing compliance. Because of this broad access to information, the CAB has been able to identify issues that may have gone unnoticed without the CAB's oversight and bring them to the attention of the Department.

13. The legislation that was negotiated between the Parties includes provisions for a successor to the CAB, known as the Maine Developmental Services Oversight and Advisory Board. This Board will have access to individual information only under limited circumstances defined in statute and will need to rely largely on reports based on aggregate data. The CAB and Class Counsel would not have agreed to these restrictions without Defendants' agreement to a Next Court Order providing for a Class Representative with greater access to Class Member information. Without a Class Representative or the continuation of a Board focused only on the Class, external oversight and Department accountability will be substantially reduced. The Maine Developmental Services Oversight and Advisory Board, as designed, will not have the mission or the capacity to serve as an effective oversight body for Class Member rights and interests under the Decree.

14. Based on information provided to the CAB by the Department and through Consent Decree negotiation discussions, I have become aware of concerns that remind me of the problems the CAB identified in the late 1980's, when the Department failed to follow through with the promises of the Pineland Decree. Although a crisis system has been developed, some of the state-operated crisis homes that replaced crisis admission to Pineland are often fully occupied by people awaiting funding for a new home. When crisis beds are occupied by people on a waiting list, those beds are not available to people in true crisis. Providers are reporting to the CAB that closure of the Home and Community Based Waiver is jeopardizing some class member homes when housemates leave and vacancies cannot be filled. Providers also report that frequency and quality of community inclusion activities are being negatively impacted by budget cuts. Homes where three or four people share a van may need to go on group outings that remind me

of group van rides at Pineland. When people have to go into the community in groups, they are unable to participate in activities in which the individual is interested.

Dated at Augusta, Maine this 5th day of November, 2009.

/s/ Nancy Thomas

Nancy Thomas

STATE OF MAINE

KENNEBEC, ss:

November 5, 2009

Personally appeared the above-named Nancy Thomas, and made oath that the foregoing statements by her are true and correct and are made on the basis of her personal knowledge, information and belief, and to the extent that statements are based on information and belief, she believes them to be true. Before me,

/s/ Maria Kelly

Notary Public/Attorney-at-Law

My Commission Expires: 01/2/13