IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLANIA

RENEE AND DARIAN PALAKOVIC as Administrators of the Estate of BRANDON PALAKOVIC,	:	
Plaintiffs,	:	
v.	:	**Case No.**
JOHN WETZEL, KENNETH CAMERON, JAMIE BOYLES, JAMEY LUTHER, JAMES HARRINGTON, DR. RATHORE, MICHELLE HOUSER, MORRIS HOUSER, FRANCIS PIROZZOLA, JOHN DOE #1, #2, JOHN DOES #3-6, MHM, Inc.,	:	
Defendants.	:	**ELECTRONICALLY FILED**
	:	**JURY TRIAL DEMANDED**

Complaint

Plaintiffs Renee and Darian Palakovic, administrators of the Estate of Brandon Palakovic, by and through their undersigned counsel, file the following Complaint.

Jurisdiction and Venue

1. This is an action for monetary relief for violations of the Eighth and Fourteenth Amendments of the United States Constitution, 42 U.S.C. § 1983; Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131-12134; and also brought pursuant to 42 Pa.C.S.A. §§ 8301 and 8302.

2. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331, 1343(a)(3) and (4). The Plaintiff further invokes the supplemental jurisdiction of this Court under 28 U.S.C. Section 1367(a) to hear and adjudicate state law claims.

3. Plaintiffs, as Administrators of the Estate of Decedent Brandon Palakovic, and as his surviving Parents, are entitled to bring this action under the Pennsylvania Wrongful Death Act, 42 Pa.C.S.A. § 8301.

4. Plaintiffs are entitled to bring this action on behalf of the Decedent, Brandon Palakovic, under the Survival Act, 42 Pa.C.S.A. § 8302.

5. This Court is the appropriate venue pursuant to 28 U.S.C. § 1391(b)(2) because the events and omissions giving rise to the claims occurred in the Western District of Pennsylvania, principally at the State Correctional Institution at Cresson in Cambria County.

Parties

6. Plaintiffs Renee and Darian Palakovic are citizens and residents of Spring Hill, Tennessee. Mr. and Mrs. Palakovic are the natural parents of Decedent, Brandon Palakovic. On July 7, 2014, the Register of Wills of Perry County, Pennsylvania granted Letters of Administration on the Estate of Brandon Palakovic to Mr. and Mrs. Palakovic. Mr. and Mrs. Palakovic bring this action in their capacity as Administrators of the Estate of Brandon Palkakovic.

7. Defendant John Wetzel is and at all relevant times hereto was Secretary of the Pennsylvania Department of Corrections (PADOC). Defendant Wetzel is sued in his individual and official capacity.

8. Defendant Kenneth Cameron was Superintendent at the State Correctional Institution Cresson ("SCI Cresson"") at all relevant times hereto. Defendant Cameron is sued in his individual and official capacity.

9. Defendant Jamie Boyles was Deputy Superintendent for Facilities Management at SCI Cresson at all relevant times hereto. Defendant Boyles is sued in his individual and official capacity.

10. Defendant Jamey Luther was Deputy Superintendent for Centralized Services at SCI Cresson at all relevant times hereto. Defendant Luther is sued in her individual and official capacity.

11. Defendant Dr. James Harrington was Chief Psychologist at SCI Cresson at all relevant times hereto, and currently is a regional psychologist overseeing mental health services at seven prisons operated by the PADOC. Defendant Harrington is sued in his individual and official capacity.

12. Defendant Dr. Rathore was the head of psychiatric care at SCI Cresson at all relevant times hereto. He was employed by MHM, Inc. for purposes of mental health management of prisoners in custody of the PADOC. Defendant Rathore is sued in his individual and official capacity.

13. Defendant Michelle Houser was a Unit Manager in SCI Cresson's Secure Special Needs Unit (SSNU) and Special Needs Unit (SNU) at all relevant times hereto. Defendant Houser is sued in her individual and official capacity.

14. Defendant Morris Houser was a manager of the Mental Health Unit (MHU) at SCI Cresson at all relevant times hereto. Defendant Houser is sued in his individual and official capacity.

15. Defendant Francis Pirozzola was Security Captain at SCI Cresson at all relevant times hereto. Defendant Pirozzola is sued in his individual and official capacity.

16. Defendant Shawn Kephart is Director of the Treatment Services Bureau of the PADOC, and at all relevant times was responsible directing, monitoring, and assisting SCI Cresson in the delivery of prisoner treatment programs, including mental health care programs. Defendant Kephart is sued in his individual and official capacity.

17. Defendant John Doe #1 was upon information and belief a Correctional Officer at SCI Cresson who issued Brandon Palakovic the misconduct report prior to his death. Defendant John Doe #1 is sued in his individual and official capacity.

18. Defendant John Doe #2 was upon information and belief a Hearing Examiner at SCI Cresson who sentenced Brandon Palakovic to solitary confinement in the RHU prior to his death in disregard of Brandon's mental health and the minor nature of the offense. Defendant Doe #2 is sued in his individual and official capacity.

19. Defendants John Does #3-6 were Correctional Officers employed in the RHU at SCI Cresson at all relevant times hereto who participated in creating hostile living conditions characterized by verbal and physical abuse, punitive behavior modification policies and practices, and deliberate refusal to aid prisoners in obtaining needed mental health care. Defendant John Does are sued in their individual and official capacities.

20. Defendant MHM, Inc. is under contract with the PADOC to provide mental health care services to prisoners throughout the system, including at SCI Cresson at all relevant times hereto. Defendant MHM, Inc. is sued in its individual and official capacity

Statement of Facts

Death of Brandon Palakovic

21. Brandon Palakovic ("Brandon" or Palakovic") was convicted of burglarizing an occupied structure in Perry County, Pennsylvania and sentenced to 16-48 months of imprisonment. Brandon was sent to SCI Cresson, located in Cambria County, in June 2011.

22. For 13 months, Brandon was repeatedly subjected to solitary confinement via placement in the prison's Restricted Housing Unit (RHU),[1] characterized by extreme deprivations of

[1] The terms "solitary confinement," "isolation," and "Restricted Housing Unit (RHU)" are used interchangeably in this complaint and refer to the same conditions of confinement.

social interaction and environmental stimulation, abusive staff, and inadequate to non-existent mental health care.

23. PADOC Secretary John Wetzel and subordinate officials and personnel were aware that such conditions cause severe psychological harm, exacerbate pre-existing mental health problems, and generated the majority of suicides, suicide attempts, and acts of self-harm at SCI Cresson and throughout the entire PADOC.

24. Defendants created and sustained conditions of solitary confinement in the RHU that subjected Brandon Palakovic to torture, causing him to take his own life on July 17, 2012, at the age of 23. Defendants transformed a 16-48 month term of imprisonment into a death sentence.

25. Brandon had a history of mental health issues as a child. He had been institutionalized for mental health reasons on four occasions since age 11. He had been given the following diagnoses during his childhood: Depressive Disorder; Oppositional Defiant Disorder; Attention-Deficit Hyperactivity Disorder; Parent-Child Relational Problems; Disruptive Behavior Disorder; Mood Disorder; Bi-Polar Disorder. Brandon also had a learning disability.

26. While incarcerated at SCI Cresson, Brandon was on the mental health roster, indicating that he had a need for mental health care.

27. Brandon was prescribed the anti-depressant Celexa while at SCI Cresson.

28. According to clinical studies, suicidal thoughts and impulses are some of Celexa's side effects.

29. Brandon spent multiple 30-day stints in solitary confinement in the RHU during his incarceration at SCI Cresson.

30. Upon information and belief, Brandon was repeatedly placed in solitary confinement without any objective assessment of whether he posed a security risk to other prisoners or staff.

31. Prisoners with mental health needs such as Brandon were routinely placed in solitary confinement for non-violent, less serious rule violations.

32. Mentally ill, psychologically vulnerable prisoners were routinely placed in solitary confinement without any objective assessment of their actual security risk.

33. In the RHU, where Brandon was confined leading up to and at the time of his death, prisoners were held in solitary confinement in small cement cells for approximately 23-24 hours each day. Solitary confinement cells at Cresson were less than 100 square feet in size, with a steel door that contained a slot in the middle that food and other items were passed through. There are small slit-windows in the middle of the doors, allowing minimal visibility onto the cellblock.

34. Prisoners in the RHU for disciplinary reasons are not permitted phone calls. Property is limited to one record-center box.

35. Social interaction and environmental stimulation are severely reduced in the RHU.

36. RHU prisoners are permitted one hour of exercise time in an outdoor cage slightly larger than their cell five days a week.

37. Although Brandon had "a history of self-harm and suicide attempts, he continued to be placed in isolation, eventually leading to his death." *See SCI Cresson Findings Letter* at 13, U.S. Dept. of Justice, May 31, 2013 (hereafter "*DOJ Cresson Report*").

38. Brandon experienced decompenation during his times in solitary confinement, as he was unable to cope with the conditions in the RHU due to his mental health needs, causing psychological deterioration.

39. Less than two weeks before his death, Brandon requested one-on-one counseling with a psychiatrist. The psychiatrist ignored Brandon's request and did not provide Brandon with any treatment. *Id.* at 13

40. Psychology staff visited Brandon in December of 2011 and May of 2012. He was ordered for a June psychiatric visit, but this visit did not occur until 11 days before his suicide on July 16. *Id.*

41. Brandon also expressed concern that his medications were not working. *Id.*

42. The level of mental health care provided to Brandon was grossly deficient, manifesting a deliberate indifference to his serious medical need for mental health care. Interviews in clinically appropriate settings were inadequate or non-existent.

43. Mental health staff only provided Brandon with medication for his mental health needs, refusing other forms of necessary treatment.

44. Prisoners reported that Brandon had started talking to non-existent people and that other prisoners had given him the nickname "Suicide."

45. Four days before his death, Brandon was again placed in solitary confinement for a minor rules violation that was eligible for informal resolution instead of disciplinary time.

46. Defendants John Does 1 and 2 were responsible for sentencing Brandon to the RHU prior to his suicide despite his having a mental health condition that placed him at heightened risk of harm when held in solitary confinement.

47. These Defendants placed him in solitary confinement although Brandon did not pose a threat to the safety or security of staff or prisoners.

48. Defendants John Does 1 and 2 failed to take into account the extent that Brandon's behavior was the consequence of serious mental illness.

49. Placing Brandon in the RHU deprived him of access to services, program opportunities, and other activities accorded to general population prisoners.

50. Defendants John Doe #1 and #2 failed to make a reasonable accommodation of Brandon's serious mental illness, such as allowing for consideration of a prisoner's mental health status in prison disciplinary proceedings.

51. Defendants Wetzel, Cameron, Boyles, Luther, and Harrington all upheld policies and practices of sentencing prisoners to solitary confinement based on behavior that was caused by mental illness and intellectual disability.

52. These Defendants discriminated against the mentally ill and intellectually disabled by depriving them of access to services, programs, and other activities accorded to general population prisoners.

53. Defendants' policies and practices failed to make a reasonable accommodation for prisoners with serious mental illness and intellectual disability, such as allowing for consideration of a prisoner's mental health status in prison disciplinary proceedings.

54. On July 16, 2012, Brandon Palakovic committed suicide in the RHU at SCI Cresson by hanging. He was pronounced dead on July 17, 2012 at Altoona Regional Hospital in Blair County.

United States Department of Justice Investigation of SCI Cresson – Systemic Constitutional Violations of the Rights of the Mentally Ill in Solitary Confinement

55. On December 1, 2011, the United States Department of Justice (DOJ) announced that it was opening an investigation into "allegations that SCI Cresson provided inadequate mental health care to prisoners who have mental illness, failed to adequately protect such prisoners from harm, and subjected them to excessively prolonged periods of isolation, in violation of the Eighth

Amendment to the U.S. Constitution."[2] Brandon Palakovic was confined at SCI Cresson when the DOJ launched its investigation, and he would die before it was completed.

56. The DOJ investigation was carried out by the Special Litigation Section of the Civil Rights Division pursuant to its authority under the Civil Rights of Institutionalized Persons Act (CRIPA). The investigation put each Defendant on notice of the serious harm inflicted on mentally ill prisoners at SCI Cresson.

57. PADOC officials were told at the outset that the focus of the investigation "was on whether Cresson engages in a pattern or practice of subjecting prisoners with serious mental illness to unnecessarily long periods of isolation, failing to prevent suicide and other self-harm, and failing to provide prisoners with adequate mental health treatment." *DOJ Report* at 4.

58. The DOJ conducted a site visit from March 19-22, 2012, interviewing administrative staff, security staff, medical and mental health staff, and prisoners. They reviewed copious documentation pertaining to the subject of the investigation. DOJ met with PADOC leadership and Defendant Cameron on October 10, 2012 to report their concerns. *Id.* at 4-5

59. Defendants had received notice after notice of unconstitutional conditions at SCI Cresson, yet even by October 2012 the PADOC had failed to address the DOJ's "central concerns." *Id.*

60. Brandon, who had a serious mental illness and was repeatedly subjected to solitary confinement, committed suicide more than 7 months after Defendants were placed under investigation for precisely the type of treatment that caused Brandon's death.

61. This was not the first suicide in SCI Cresson's RHU. Fourteen months earlier, on May 6, 2011, a prisoner who had been diagnosed by the PADOC with "delusional disorder and

[2] Department of Justice Office of Public Affairs, "Justice Department Opens Investigation into Two Western Pennsylvania State Correctional Institutions," December 1, 2011.

personality disorder with paranoid and narcissistic features" committed suicide in SCI Cresson's RHU after being warehoused for approximately nine consecutive months in solitary confinement in two PADOC prisons.

62. One month prior, on April 6, 2011, this prisoner had threatened self-harm and suicide. Nevertheless, "he received virtually no out-of-cell time." Although a psychiatrist described him as "still paranoid delusional" during a cell-side visit, he was not provided any treatment. Ten days after the cell-side visit, he committed suicide. *Id.* at 9-10.

63. In addition to the May 2011 suicide, Defendants were further put on notice of the obvious nature of the harms inflicted on mentally ill prisoners when placed in solitary confinement and denied mental health treatment. In 2011, 14 of the 17 documented suicide attempts at SCI Cresson occurred in the solitary confinement units. Further, "[SCI] Cresson's records show that in 2011, there were dozens of incidents involving prisoners on the mental health roster engaging in self-harm in the isolation units, while just two such incidents occurred in the general population." *Id.* at 9.

64. The DOJ investigation discovered a wide array of policies and practices that were responsible for systemic deficiencies in SCI Cresson's treatment of mentally ill and intellectually disabled prisoners. These policies and practices include:

a. Serious mental illness was "punished rather than treated" at SCI Cresson. Staff working in the solitary confinement units were "encouraged to use punitive behavior modification plans to address behaviors that are derivative of prisoners' serious mental illness." *Id.* at 15.

b. Deprivations of basic human needs were frequently employed by staff as a response to behaviors caused by mental illness, including deprivations of mattresses, warm food, reading materials, out-of-cell time, showers, phone calls and visits. *Id.* at 16.

c. A culture of abuse flourished in the solitary confinement units, as "officers and staff [were] frequently hostile and cruel toward prisoners, even while knowing that these prisoners are more vulnerable because of their serious

mental illnesses or intellectual disabilities." This cruelty includes SCI Cresson officials "countenanc[ing] the frequent, unnecessary, and excessive use of force on prisoners with serious mental illness housed in the isolation units." *Id.*

d. There was "a system-wide failure of security staff to consider mental health issues appropriately and a marginalization of the concerns of the mental health staff." This was a contributing causal factor to the "unconstitutional use of prolonged and extreme isolation on prisoners with serious mental illness." *Id.* at 20.

e. The mental health care program was "fragmented and ineffective." There was "a dearth of mental health treatment for prisoners throughout [SCI Cresson]; the absence of a secure residential treatment unit for prisoners who require such placement; and inadequate coordination among mental health care providers." *Id.* at 23.

f. The prison was insufficiently staffed with enough mental health professionals to meet the mental health care needs of the prisoner population. *Id.*

g. SCI Cresson suffered from "[p]oor screening and diagnostic procedures" that contributed to "system-wide inadequacies." Mental health needs of prisoners on the mental health roster were "routinely understated" and "under-classified" in such a manner as to diminish or deny the seriousness of their condition. *Id.* at 24.

h. Psychiatric and psychology staff were not integrated, utilized different and overlapping records, held duplicative meetings, and failed to transcribe or memorialize meetings and decisions made therein, thus contributing to a dysfunctional system that undermined continuity of care. *Id.* at 25.

i. Deficient oversight mechanisms, including the failure to collect necessary information on critical incidents, such as acts of self-harm, impaired SCI Cresson's ability to remedy patterns of harm. "The severity of the harm and its concentration in the isolation units should have prompted the Prison to track this information." *Id.* at 26.

65. These systemic deficiencies were responsible for SCI Cresson's failure to adhere to the minimal components of a constitutional prison mental health care system. SCI Cresson did not have:

a. A systematic program for screening and evaluating prisoners to identify those in need of mental health care;

b. A treatment program that involves more than segregation and close supervision of mentally ill prisoners;
c. Employment of a sufficient number of trained mental health professionals;
d. Maintenance of accurate, complete and confidential mental health treatment records;
e. Administration of psychotropic medication only with appropriate supervision and periodic evaluation; and
f. A basic program to identify, treat, and supervise prisoners at risk for suicide.

66. All Defendants were aware of the risks presented and harms inflicted by an inadequate system of mental health care based on the record of self-harm, suicide attempts, and suicides in the solitary confinement units at SCI Cresson, along with the obvious nature of the risks and harms of depriving seriously mentally ill and intellectually disabled prisoners of social interaction, environmental stimulation, and mental health care.

67. The PADOC's Access to Mental Health Care Policy explicitly states that "placement in RHU/SMU/LTSU [i.e. solitary confinement]" could increase the potential for suicide due to the inherent stress of such confinement. Access to Mental Health Care, Policy 13.8.1, § 2.H(1)(c)(8).

68. Despite this awareness, Defendants failed to take remedial measures, instead displaying a deliberate indifference and engaging in willful misconduct.

69. SCI Cresson's lack of a systematic program for screening and evaluating prisoners in need of mental health care caused officials to understate, delay, and ignore Brandon Palakovic's need for mental health care during his confinement at SCI Cresson.

70. SCI Cresson substituted solitary confinement for treatment by repeatedly placing Brandon Palakovic in solitary confinement in the RHU on account of his serious mental illness.

71. SCI Cresson failed to employ sufficient numbers of mental health professionals to provide mental health treatment to prisoners in need. As a consequence, Brandon Palakovic was deprived of needed treatment.

72. For months at a time Brandon was denied any meaningful or clinically appropriate interaction with mental health staff. The occasions that he did engage in an interview with mental health staff were rendered meaningless by the lack of subsequent, sustained treatment.

73. SCI Cresson failed to keep appropriate records of the mental health needs of prisoners, including Brandon Palakovic. Records were dispersed, duplicative, and not shared with all necessary staff members. The failure to properly maintain an integrated system of records available to critical mental health and security staff was a contributing cause in Brandon Palakovic being placed in solitary confinement on account of his mental health status.

74. SCI Cresson failed to administer medication under appropriate supervision and periodic evaluation. Brandon Palakovic was provided medication without periodic evaluation. Although Brandon Palakovic told staff that he did not think his medication was working, this report was ignored.

75. SCI Cresson did not have a basic program to identify, treat, and supervise prisoners at risk for suicide. Brandon Palakovic had a history of self-harm and suicide attempts and he was not provided treatment or supervision. The lack of a suicide prevention program was a contributing cause in the death of Brandon Palakovic.

Discrimination on the Basis of Disability

76. SCI Cresson denied prisoners with serious mental illnesses and intellectual disabilities the opportunity to participate in and benefit from a variety of prison services and activities, such as classification, security, housing, and mental health services. These same prisoners were also unnecessarily provided with unequal, ineffective, and different or separate opportunities to benefit from classification, security, housing, and mental health services. *Id.* at 31.

77. Brandon Palakovic was denied access to prison services and activities, including classification, security, housing, and mental health services on account of his serious mental illness and intellectual disability.

78. SCI Cresson unlawfully isolated and warehoused prisoners with serious mental illness and/or intellectual disabilities in solitary confinement units, failing to individually assess such prisoners concerning the risk they actually and objectively pose to others. *Id.* at 31.

79. Brandon Palakovic was repeatedly warehoused in solitary confinement without any individual assessment as to whether he posed an actual and objective risk to others.

80. SCI Cresson failed to reasonably modify its policies, practices, and procedures in order to avoid discriminating against prisoners on the basis of disability. *Id.* at 31.

81. Brandon Palakovic was discriminated against on the basis of his disabilities.

Role of Defendants in Unconstitutional Conduct

82. Defendant John Wetzel is the Secretary of PADOC. Defendant Wetzel was responsible for authorization, implementation, and oversight of the policies and practices governing the PADOC, including those policies and practices pertaining to solitary confinement and the RHU, disciplinary proceedings and punishment, medical and mental health care, staffing, and suicide prevention.

83. Defendant Wetzel was aware of the psychologically painful conditions in SCI Cresson's solitary confinement units, the high rate at which prisoners with mental illness were placed there, the high rate of self-harm, suicide attempts and suicides, and the lack of adequate if any mental health treatment.

84. Defendant Wetzel was aware and approved of the widespread policy and practice throughout the PADOC, including SCI Cresson, of warehousing prisoners in solitary confinement in the RHU on account of their mental illness and/or intellectual disability.

85. Despite his knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant Wetzel deliberately failed to take necessary corrective action.

86. Defendant Kenneth Cameron was Superintendent at the State Correctional Institution (SCI) Cresson. Defendant Cameron was responsible for authorization, implementation, and oversight of the policies and practices governing SCI Cresson, including those policies and practices pertaining to solitary confinement and the RHU, disciplinary proceedings and punishment, medical and mental health care, staffing, and suicide prevention.

87. Defendant Cameron was aware of the psychologically painful conditions in SCI Cresson's solitary confinement units, the high rate at which prisoners with mental illness were placed there, the high rate of self-harm, suicide attempts and suicides, and the lack of adequate if any mental health treatment.

88. Defendant Cameron was aware and approved of the policy and practice at SCI Cresson of warehousing prisoners in solitary confinement on account of their mental illness and/or intellectual disability.

89. Despite his knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant Cameron deliberately failed to take necessary corrective action.

90. Defendant Jamie Boyles was Deputy Superintendent for Facilities Management at SCI Cresson. Defendant Boyles was responsible for implementation and oversight of the policies and practices governing SCI Cresson, including those policies and practices pertaining to solitary confinement and the RHU, disciplinary proceedings and punishment, medical and mental health care, staffing, and suicide prevention.

91. Defendant Boyles was a member of the Program Review Committee (PRC), which was responsible for oversight of the RHU, including review of the appropriateness of placement in the RHU for individual prisoners.

92. Defendant Boyles was aware of the psychologically painful conditions in SCI Cresson's solitary confinement units, the high rate at which prisoners with mental illness were placed there, the high rate of self-harm, suicide attempts and suicides, and the lack of adequate if any mental health treatment.

93. Defendant Boyles was aware and approved of the policy and practice at SCI Cresson of warehousing prisoners in solitary confinement on account of their mental illness and/or intellectual disability.

94. Despite his knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant Boyles deliberately failed to take necessary corrective action.

95. Defendant Jamey Luther was Deputy Superintendent for Centralized Services at SCI Cresson. Defendant Luther was responsible for implementation and oversight of the policies and practices governing SCI Cresson, including those policies and practices pertaining to solitary confinement and the RHU, disciplinary proceedings and punishment, medical and mental health care, staffing, and suicide prevention.

96. Defendant Luther was a member of the Program Review Committee (PRC), which was responsible for oversight of the RHU, including review of the appropriateness of placement in the RHU for individual prisoners.

97. Defendant Luther was aware of the psychologically painful conditions in SCI Cresson's solitary confinement units, the high rate at which prisoners with mental illness were placed there, the high rate of self-harm, suicide attempts and suicides, and the lack of adequate if any mental health treatment.

98. Defendant Luther was aware and approved of the policy and practice at SCI Cresson of warehousing prisoners in solitary confinement on account of their mental illness and/or intellectual disability.

99. Despite her knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant Luther deliberately failed to take necessary corrective action.

100. Defendant Dr. James Harrington was Chief Psychologist at SCI Cresson. As Chief Psychologist, Defendant Harrington was responsible for policies and practices of psychological services throughout the entire prison, including in the RHU.

101. Defendant Harrington authorized and enforced policies and practices of warehousing mentally ill and/or intellectually disabled prisoners in solitary confinement, depriving them of necessary treatment, understating and under-classifying mental health needs, inadequate supervision and monitoring of prisoners on the mental health roster, and responding to requests for mental health care.

102. Defendant Harrington instructed his subordinates to abide by such policies and practices, and prohibited mental health staff from speaking with prisoners in solitary confinement for more than 1-2 minutes at a time through solid steel doors.

103. Despite his knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant Harrington deliberately failed to take necessary corrective action.

104. Defendant Rathore was the head of psychiatric care at SCI Cresson. He was employed by MHM, Inc. for purposes of mental health management of prisoners in custody of the PADOC.

105. As Chief Psychiatrist, Defendant Rathore was responsible for policies and practices of psychiatric services throughout the entire prison, including in the solitary confinement units.

106. Defendant Rathore authorized and enforced policies and practices of warehousing mentally ill and/or intellectually disabled prisoners in solitary confinement, depriving them of necessary treatment, understating and under-classifying mental health needs, inadequate supervision

and monitoring of prisoners on the mental health roster, and responding to requests for mental health care.

107. Defendant Rathore failed to provide mental health treatment and psychiatric care to prisoners at SCI Cresson, instead replacing such necessary care with inadequately supervised medication regimens.

108. Defendant Rathore conducted his job in accordance with MHM, Inc.'s policy that limited his role to dispensing medication.

109. Despite his knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant Rathore deliberately failed to take necessary corrective action.

110. Defendant Michelle Houser was a Unit Manager in SCI Cresson's Secure Special Needs Unit (SSNUU) and Special Needs Unit. Defendant Houser authorized and enforced a system of warehousing the mentally ill and/or intellectually disabled in the SSNU.

111. Defendant Houser enforced policies and practices that failed to identify or respond to mental health needs of prisoners, failed to identify, treat, and supervise prisoners on the mental health roster, and failed to operate a suicide prevention program.

112. Defendant Houser authorized and encouraged a culture of abuse wherein staff would engage in physical and verbal abuse of prisoners, subject them to deprivations of basic human needs, and deprive them of necessary mental health care.

113. By overseeing dysfunctional and non-therapeutic units that were purportedly treatment units, Defendant Houser played a contributing causal role in the unavailability of mental health treatment at SCI Cresson, which harmed prisoners such as Brandon Palakovic.

114. Despite her knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant Houser deliberately failed to take necessary corrective action.

115. Defendant Morris Houser was a manager of the Mental Health Unit at SCI Cresson. Defendant Houser was responsible for policies and practices pertaining to the identification, tracking, treatment, and supervision of prisoners on the mental health roster at SCI Cresson.

116. Defendant Houser authorized and enforced policies and practices of warehousing mentally ill and/or intellectually disabled prisoners in solitary confinement, depriving them of necessary treatment, understating and under-classifying mental health needs, inadequate supervision and monitoring of prisoners on the mental health roster, and responding to requests for mental health care.

117. Despite his knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant Houser deliberately failed to take necessary corrective action.

118. Defendant Francis Pirozzola was Security Captain at SCI Cresson. Defendant Pirozzola authorized and enforced policies and practices of warehousing mentally ill and/or intellectually disabled prisoners in solitary confinement.

119. As head of Security, Defendant Pirozzola played a substantial role in implementing and shaping the prison's RHU policies and practices. Defendant Pirozzola enforced a punitive approach to the mentally ill and intellectually disabled that subjected them to isolation on the basis of their disability.

120. As head of Security, Defendant Pirozzola did not permit mental health concerns to influence classification practices, resulting in psychologically vulnerable prisoners being subjected to 23-24 hour per day solitary confinement.

121. Defendant Pirozzola participated in the culture of abuse that thrived in the solitary confinement units at SCI Cresson, authorizing and permitting excessive use of force, deprivation of basic human needs, and deprivation of mental health care for prisoners in solitary confinement.

122. Despite his knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant Pirozzola deliberately failed to take necessary corrective action.

123. Defendant Shawn Kephart is Director of the Treatment Services Bureau of the PADOC, and at all relevant times was responsible for directing, monitoring, and assisting SCI Cresson in the delivery of prisoner treatment programs, including mental health care programs.

124. Defendant Kephart was responsible for policies and practices of mental health care throughout the entire PADOC, including in the solitary confinement units.

125. Defendant Kephart authorized and enforced policies and practices of warehousing mentally ill and/or intellectually disabled prisoners in solitary confinement in the RHU, depriving them of necessary treatment, understating and under-classifying mental health needs, inadequate supervision and monitoring of prisoners on the mental health roster, inadequate response to requests for mental health care, and an inadequate suicide prevention program.

126. Despite his knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant Kephart deliberately failed to take necessary corrective action.

127. Defendant John Doe #1 was upon information and belief a Correctional Officer at SCI Cresson who issued Brandon Palakovic the misconduct report prior to his death.

128. Defendant John Doe #1 issued the misconduct that sent Brandon to the RHU without taking into consideration Brandon's mental illness, or whether Brandon presented an objective threat to others.

129. Despite his knowledge of the risks and harms posed to mentally ill prisoners in solitary confinement, John Doe #1 failed to take necessary corrective action.

130. Defendant John Doe #2 was upon information and belief a Hearing Examiner at SCI Cresson who sentenced Brandon Palakovic to solitary confinement in the RHU prior to his death in disregard of Brandon's mental health and the minor nature of the offense.

131. Despite his knowledge of the risks and harms posed to mentally ill prisoners in solitary confinement, John Doe #2 failed to take necessary corrective action.

132. Defendants John Does #3-6 were Correctional Officers employed in the RHU at SCI Cresson at all relevant times hereto who participated in creating hostile living conditions characterized by verbal and physical abuse, punitive behavior modification policies and practices, and deliberate refusal to aid prisoners in obtaining needed mental health care.

133. Despite their knowledge of the risks and harms posed to prisoners subjected to such hostile living conditions, John Does #3-6 failed to take necessary corrective action.

134. Defendant MHM, Inc. is under contract with the PADOC to provide mental health management services to prisoners throughout the system, including at SCI Cresson at all relevant times hereto.

135. Defendant MHM, Inc. was responsible for policies and practices of psychiatric care throughout the entire PADOC, including in the solitary confinement units.

136. Defendant MHM, Inc. authorized and enforced policies and practices of warehousing mentally ill and/or intellectually disabled prisoners in solitary confinement, depriving them of necessary treatment, understating and under-classifying mental health needs, inadequate supervision and monitoring of prisoners on the mental health roster, inadequate response to requests for mental health care, and an inadequate suicide prevention program.

137. Defendant MHM, Inc. authorized and enforced policies that failed to provide mental health treatment to prisoners. Instead of treatment or psychiatric care, MHM, Inc. merely dispensed medication, failing to supervise prisoners, performing perfunctory and clinically inappropriate interviews, and ignoring the obvious risks of harm such policies and practices entail.

138. Defendant MHM, Inc. authorized and enforced policies that enabled and permitted prisoners to be discriminated against on the basis of disability, denying them mental health services

and subjecting them to solitary confinement in lieu of treatment. Despite its knowledge of the risks and harms posed by these policies, practices, and conditions, Defendant MHM, Inc. deliberately failed to take necessary corrective action.

Causes of Action

COUNT I – Deliberate Indifference to the Deprivation of Basic Human Needs

139. Plaintiffs re-allege paragraphs 1-138 as if fully stated herein.

140. All Defendants violated Brandon Palakovic's right to be free from cruel and unusual punishment under the Eighth and Fourteenth amendments of the U.S. Constitution by placing him in conditions of solitary confinement that are known to cause harm to psychologically vulnerable individuals like Brandon. On account of his mental health vulnerabilities, Brandon's solitary confinement deprived him of the basic human needs of environmental stimulation, social interaction, mental health, and physical health. All Defendants were deliberately indifferent to these deprivations.

COUNT II – Deliberate Indifference to Serious Medical Needs

141. Plaintiffs re-allege paragraphs 1-138 as if fully stated herein.

142. All Defendants violated Brandon Palakovic's right to be free from cruel and unusual punishment under the Eighth and Fourteenth amendments of the U.S. Constitution through their deliberate indifference to his serious medical need for mental health care.

COUNT III – Discrimination on the Basis of Disability

143. Plaintiffs re-allege paragraphs 1-138 as if fully stated herein.

144. All Defendants violated Brandon Palakovic's rights under the Americans with Disabilities Act by denying him access to services, programs, and activities available at SCI Cresson on account of his serious mental illness.

145. All Defendants violated Brandon Palakovic's rights under the Americans with Disabilities Act by refusing to make a reasonable accommodation that would enable Brandon to have access to services, programs, and activities available to prisoners without serious mental illness.

COUNT IV – Wrongful Death

146. Plaintiffs re-allege paragraphs 1-138 as if fully stated herein.

147. The following individuals are eligible to recover damages as a result of Brandon Palakovic's death pursuant to 42 Pa. C.S.A. § 8301: Renee and Darian Palakovic.

148. During his lifetime, Brandon Palakovic did not commence any action for the injuries that caused his death and no other action has been filed to recover damages for the wrongful death of decedent.

149. At all relevant times, all Defendants committed acts of willful misconduct and acted with reckless indifference, carelessness, and negligence in regard to the rights of Brandon Palakovic.

150. As the direct and proximate result of the acts and omissions of all Defendants, Plaintiffs have suffered the following damages:

a. Expenses of administration related to Brandon Palakovic's death; and

b. All other damages permissible in a wrongful death action.

151. As a direct and proximate result of Defendants' acts and omissions described in this complaint, Plaintiffs seek punitive damages.

COUNT V – Survival Action

152. Plaintiffs re-allege paragraphs 1-138 as if fully stated herein.

153. Plaintiffs brings this survival action pursuant to 20 Pa. C.S.A. § 3373 and 42 Pa. C.S.A. § 8302.

154. As a direct and proximate result of Defendants' acts and omissions, all Defendants are liable for the following damages:

a. Brandon Palakovic's pain and suffering during his confinement in the PADOC, including prior to and at the time of his death;

b. Brandon Palakovic's total estimated future earning power;

c. Brandon Palakovic's loss of retirement and Social Security income;

d. Brandon Palakovic's other financial losses suffered as a result of his death;

e. Brandon Palakovic's loss of the enjoyment of life.

Prayer for Relief

WHEREFORE, Plaintiffs request that the Court grant the following relief:

A. Award compensatory damages;

B. Award punitive damages;

C. Grant attorneys' fees and costs;

D. Such other relief as the Court deems just and proper.

Jury Trial Demand

Plaintiffs demand trial by jury in all claims so triable.

Respectfully submitted,

/s/ Bret D. Grote
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