

**An Investigation of the Department of Mental Health, Anchor Mental Health Services,
and the Death of Jean Edny Louis**

January 2013

University Legal Services, Inc.
The Protection and Advocacy Program for the District of Columbia

220 I Street, N.E.
Suite 130
Washington, D.C. 20002
202.547.0198 (Phone)
202.547.2657 (TTY)
www.uls-dc.org

University Legal Services

Since 1996, University Legal Services, Inc. (ULS), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia. Congress vested the P&A's with the authority and responsibility to investigate allegations of abuse and neglect of individuals with disabilities. In addition, ULS provides legal advocacy to protect the civil rights of D.C. residents with disabilities.

ULS staff directly serves hundreds of individuals with disabilities annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach, education, and group advocacy efforts. ULS' staff members address a diverse range of client issues, including abuse and neglect, community integration, accessible housing, financial exploitation, access to health care services, discharge planning, special education, and the improper use of seclusion, restraint, and medication.

For more information about this report or to request additional copies, please contact:

Jane Brown
Executive Director
University Legal Services, Inc.
220 I Street, N.E.
Suite 130
Washington, D.C. 20002
202.547.0198 (Phone)
202.547.2657 (TTY)

Or visit our website at www.uls-dc.org

I. Introduction

On June 14, 2011, Jean Edny Louis,¹ a client of Anchor Mental Health Services (Anchor) and Department of Mental Health (DMH) services consumer, was shot and killed by the Metropolitan Police Department (MPD) in the apartment he had lived in for twenty years.² Community groups, including ULS, asked the District of Columbia Council to hold a public hearing to address significant questions stemming from this incident.³ Questions remain unanswered: Why did the MPD officers use deadly force? Did the officers on the scene have adequate (or any) training in interacting with individuals with mental illness? The Council has not responded to our request and MPD has not made a substantive public statement about the incident.⁴

Under our federally mandated capacity to investigate abuse and neglect of individuals with mental illness, ULS sought to review whether Mr. Louis was receiving appropriate mental health services that might have prevented his tragic death.⁵ ULS focused its investigation on the services Mr. Louis received from Anchor, the agency primarily responsible for providing Mr. Louis with community supports and services; assessing whether a crisis prevention plan was necessary; and implementing such a plan.⁶ Mr. Louis had been receiving services from Anchor

¹ “Jean Edny Louis” is the name listed on the Letter of Administration from D.C. Superior Court, Probate Division, appointing Jean Alix Louis, Jean Edny Louis’ brother, as the personal representative of Jean Edny Louis’ estate. See Letter of Administration attached as Exhibit A.

² See DMH Case Summary.

³ See September 22, 2011 letter from the Downtown Cluster of Congregations attached as Exhibit B, and October 7, 2011 letter from ULS, attached as Exhibit C.

⁴ Police Chief Cathy Lanier responded to a general question on the subject (police action dealing with a barricaded mentally ill person) posed by the Council before the 2012 MPD oversight hearing. The reply did not provide any specific information regarding Jean Louis. See Q.44 (p.26), February 24, 2012, letter from MPD to the Council, *available at*

http://dclims1.dccouncil.us/mendelson/archive_pr/COJ%20Performance%20and%20Budget%202012/Later%20Rounds/MPD%20FY12%20Performance%20Responses,%202nd%20Round,%202.24.12.pdf.

⁵ U.S.C. 42 § 10805(a)(1)(A) provides for ULS’ investigative authority.

⁶ Anchor Mental Health Services is a private nonprofit organization affiliated with Catholic Charities that provides mental health services as a DMH certified “core services agency.”

since 2004, if not earlier.⁷ As a core services agency (CSA), Anchor is certified by DMH to serve its clients as a “clinical home ... by providing a single point of access and accountability for diagnostic assessment, medication-somatic treatment, counseling and psychotherapy, community support services, and access to other needed services.”⁸

ULS has requested access to all relevant records from Anchor, DMH, and MPD, as permitted by federal law.⁹ DMH has provided its full record, consisting of an undated Case Summary, written after Mr. Louis’ death, and St. Elizabeths hospital records. Based on references made by DMH to Anchor documents, ULS concludes that Anchor has not provided ULS with a complete record of its case management notes.¹⁰ On October 23, 2012, ULS sent a summary of our investigation’s findings and an invitation for further discussion to Anchor and DMH. ULS did not receive a response from either agency.¹¹ ULS again solicited substantive comments from Anchor and DMH, by providing advance copies of this report on January 23, 2013, with a request for comments by January 25, 2013. DMH responded substantively, and to the extent appropriate, their comments have been incorporated. Anchor again failed to respond, except to issue a general denial of information contained in the report (without specifying what information is incorrect), and to claim that ULS had not provided them enough time to respond

⁷ DMH Case Summary.

⁸ D.C. Code § 21-501(3A).

⁹ See Appendix detailing which documents ULS has requested and received or not received from DMH, Anchor, and MPD.

¹⁰ ULS attempted to contact Anchor about accessing records on multiple occasions. On November 18, 2011, ULS spoke to Anchor on the phone and followed up with an email to confirm our request. Anchor responded via email on November 30, 2011 that it could provide the remaining records in a few days. ULS responded that was acceptable, and Anchor responded via email to confirm that it received our request. That was the last response we have received from Anchor. On December 14, 2012, ULS emailed Anchor to inquire about the remaining records. ULS left a phone message for Anchor on December 27, 2011, sent an email on January 12, 2012, and emailed Anchor’s legal counsel on January 18, 2012. Anchor has not responded to any of our requests for additional records.

¹¹ DMH has informed ULS that we sent the report to the wrong email address for the contact person at the Office of Accountability. However, ULS also sent the report to DMH’s General Counsel, and no response was received from her.

to the issues raised in the investigation (without acknowledging the October 2012 summary submitted and ULS' previous request for a meeting).

II. Summary of ULS' Findings and Recommendations

A. Findings related to DMH

DMH's investigation fails to critically examine the respective roles and interactions of Anchor, DMH, MCS, and the MPD staff when addressing the needs of an individual in psychiatric crisis. The report also fails to cite Anchor for not having any staff available at the scene of Mr. Louis' death or even available via phone.¹² Furthermore there is no reference in the report to DMH discussing the matter with MPD. Finally, DMH does not cite Anchor for failing to meet DMH directives concerning internal investigations of sentinel events.¹³

DMH's report fails to meet the requirements of its own policy, because the report fails to identify any patterns and practices that might warrant improvement, particularly regarding the interactions of DMH, MCS, and MPD staff with individuals in psychiatric crisis.¹⁴ For example, while DMH provides forty-hour blocks of instruction to some MPD officers to certify them as Crisis Intervention Officers (CIO), DMH did not indicate in its report whether the officers on the scene were CIOs.¹⁵ It is also gravely concerning that DMH does not have a policy regarding interactions between DMH staff or DMH certified agency employees and MPD officers.

¹² See infra note 30 and accompanying text. The Anchor case manager was not available via phone and MCS had to find an emergency contact for Mr. Louis in his "PES" files, rather than at Anchor. District regulations require CSAs to be available twenty-four hours a day for their clients in crisis.

¹³ DMH Policy 115.1 at 4a- 4c, Mortality Review, July 15, 2005.

¹⁴ See Section XIII.

¹⁵ As of 2010, 165 MPD officers have received this training. Every cadet receives three hours of mental health training. See Meeting Minutes, Crisis Emergency Services Planning Workgroup, Implementation Update, September 8, 2010, *available at* http://dmh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Minutes_for_Mental_Health_Crisis_Planning_Meeting_9-0-10.pdf.

B. Findings Related to Anchor

After reviewing the records provided by Anchor, ULS concludes that Anchor failed to meet its legal duties as a DMH certified core services agency. First, Anchor failed to adequately support Mr. Louis in the community by setting up essential supports such as a comprehensive, effective crisis plan.¹⁶ Second, Anchor did not provide sufficient support to Mr. Louis during the long standoff with MPD at his home. Finally, Anchor failed to adequately investigate the circumstances of Mr. Louis' death or discuss internally how to prevent similar tragic incidents from occurring in the future.

Section IX of this report makes several recommendations to Anchor and DMH regarding improved case management, recordkeeping, and investigation practices.

III. It is Time for City Council to Demand Answers

Unfortunately, police shootings of individuals experiencing a mental health crisis are far too common,¹⁷ and this is not the first time it has happened in the District.¹⁸ Without more information from Anchor and MPD, ULS cannot fully examine how MPD, DMH, and Anchor interacted with each other or independently when Mr. Louis was in crisis. There is only one way we will learn more about what happened to Mr. Louis and the District's interagency approach, or lack thereof, to assisting individuals with mental illness in crisis. D.C. Council must demand answers from Anchor, DMH, and MPD, at a public hearing, and commit to investigating Mr. Louis' death, with a goal of preventing unnecessary deaths of mental health consumers in crisis.

¹⁶ DMH's Case Summary indicates that Anchor developed a crisis prevention plan on March 3, 2010. Anchor has not provided this plan to ULS.

¹⁷Natasha Lennard, *More Than Half the People Shot by Police are Mentally Ill, Investigation Finds*, Salon.com, December 10, 2012, available at

http://www.salon.com/2012/12/10/half_of_people_shot_by_police_are_mentally_ill_investigation_finds/

¹⁸ See, for example, Jason Cherkis, *David Kerstetter Shooting: D.C. Police vs. Mentally-Distressed Resident*, *Washington City Paper*, Nov. 7, 2008, <http://www.washingtoncitypaper.com/blogs/citydesk/2009/01/26/police-involved-shooting-7th-street-ne/>.

IV. A Brief History of the Events Preceding Mr. Louis' Death

Mr. Louis was hospitalized multiple times and arrested at least once in the eighteen months preceding his death. On October 15, 2010, Mr. Louis was arrested and then transferred from jail to United Medical Center (UMC).¹⁹ On November 12, 2010, Mr. Louis was transferred from UMC to St. Elizabeths. He was discharged from St. Elizabeths on December 15, 2010.²⁰ In May 2011, Mr. Louis was admitted to the District's Comprehensive Psychiatric Emergency Program (CPEP). Mr. Louis was transferred from CPEP to Providence Hospital, where he remained from May 19–31, 2011.²¹ From Providence Hospital, Mr. Louis returned to his apartment. After Mr. Louis returned home, his Anchor case manager attempted to visit twice and called several times, but did not receive a response.²²

On June 13 or 14, 2011, the Mr. Louis' Anchor case manager contacted DMH's Mobile Crisis Services (MCS), "through an email to the Director" (ULS is not certain whether this refers to the director of Anchor or MCS, since we have not had an opportunity to review the email), to request that the team assess Mr. Louis.²³ The case manager briefed the team that she was receiving calls from Mr. Louis' landlord and neighbors that he was "acting bizarre, yelling and screaming periodically day and night," and that she did not believe he was taking his medications. They arranged for a joint home visit at 1:00 PM. MCS assessed Mr. Louis around 1:30 PM to determine whether he required emergency hospitalization, "after attempts to engage and observed acute psychosis by the team."²⁴ When the case manager arrived at Mr. Louis' apartment, MCS informed her that Mr. Louis was psychotic. The case manager was instructed to

¹⁹ Mortality Review Report.

²⁰ Anchor December 2010 Progress Notes.

²¹ Mortality Review Report.

²² Anchor June 2011 Progress Notes.

²³ The Mortality Review Report states June 13 while the Unusual Incident Report indicates June 14, 2011.

²⁴ Unusual Incident Report.

wait downstairs until the police came and to tell them that Mr. Louis was in possession of a screwdriver. When the police arrived, the case manager “informed them of the situation and left.”²⁵ MCS reported that they instructed the case manager to leave because she was eight months pregnant.²⁶

At this point there was no Anchor staff at the scene of the standoff between Mr. Louis and MPD. MCS briefed the police that Mr. Louis displayed a screwdriver in his hand but “Case Manager assured MCS no lethal weapon, e.g. gun, was in Consumer’s possession.”²⁷ MPD attempted to engage Mr. Louis, who was yelling and unresponsive, and eventually ran into the bathroom and barricaded himself behind the door. According to MCS, Mr. Louis struck MPD with the screwdriver twice, tossed out objects and struck another officer. He did not surrender despite the officers’ use of mace spray and “verbal attempts” to get him out of the bathroom. “Eventually, a MPD Emergency Response Team (ERT) came in to intervene.”²⁸ The ERT officers shot and killed Mr. Louis around 6:00 PM.²⁹

During these events, MCS called the Director of Anchor’s CSA. MCS “continually” attempted to reach the case manager, without any noted success. MCS tried to reach other members of Mr. Louis’ team at Anchor to access information for his next of kin.³⁰ Eventually MCS found the information in the “PES” files. MCS left a message with an emergency contact, “Mr. G. Baron,” asking him to call Detective Carter as soon as possible.³¹ Detective Carter was

²⁵ Anchor June 2011 Progress Notes.

²⁶ Unusual Incident Report.

²⁷ Id.

²⁸ Id.

²⁹ Id.

³⁰ CSAs must have a twenty-four hour, seven day a week on call system available to their consumers, staffed by qualified practitioners for emergency, urgent, and routine situations. See D.C. Mun. Regs. tit. 22 §3411.5(a).

³¹ Mr. Louis’ attorney, according to Superior Court Case *United States v. Gaen Louis* No. 2010 CMD 19970.

able to obtain the number of Mr. Louis' brother in Rockville and sent a notification team to inform him of Mr. Louis' death.³²

V. Despite Signs that Mr. Louis Needed Intensive Support, Anchor did not Provide Adequate Case Management Services.

According to Anchor's records, Mr. Louis maintained a stable lifestyle in 2008 and 2009, but his behavior became increasingly "erratic, aggressive, and paranoid" in the eighteen months preceding his death. One psychiatrist reported that "when not medicated Mr. Louis was paranoid, delusional, anxious, spoke rapidly and fearful and could become verbally aggressive" and "was psychotic, unpredictable, and had a history of stopping his meds and therefore a high probability of being involuntarily hospitalized again."³³ In 2010 and 2011, Mr. Louis was arrested once and hospitalized multiple times.

The case manager's notes demonstrate that she was aware that Mr. Louis showed signs of distress in the year preceding his death, but they do not demonstrate that she assisted Mr. Louis in developing a proactive, effective crisis plan. According to DMH's investigation, a March 3, 2010 Anchor treatment note indicates that the case worker and Mr. Louis developed a crisis plan. Anchor has not provided a copy of a crisis plan to ULS. In November 2010, around the time Mr. Louis was hospitalized at St. Elizabeths, the progress notes listed developing a crisis prevention plan as a goal and noted that Mr. Louis was not prepared for a crisis. The notes describe an objective to "identify signs of crisis and verbalize three preventive strategies ... identify family members (who) agree to be accessible supports as needed." There is no subsequent documentation that the case manager and Mr. Louis identified any preventive strategies. The December 2010 Progress Notes repeat that Mr. Louis was not prepared for a crisis and had a goal

³² See Unusual Incident Report. Mr. Louis' brother, Alix Louis, has confirmed with ULS that he was informed of Mr. Louis' death that evening by the police.

³³ Fatality Review, June 28, 2011 (hereinafter Fatality Review).

to adhere to a crisis plan for one year. The corresponding objectives instructed that he should learn warning signs of crisis immediately and call 911, Anchor, or his family if he decompensated. The subsequent notes do not indicate that Anchor followed through on working with Mr. Louis to achieve these objectives.

Anchor also failed to support Mr. Louis in maintaining his physical health. For the six months prior to his hospitalization at St. Elizabeths, Mr. Louis' CPAP (continuous positive airway pressure) machine for sleep apnea was broken.³⁴ In December 2010, Mr. Louis' somatic medication and treatment goal on his Anchor treatment plan was revised to include meeting with a physician at Washington Hospital Center to obtain a new breathing machine for sleep apnea.³⁵ The records do not confirm that the machine was ever fixed.³⁶

Anchor rarely visited Mr. Louis while he was hospitalized at St. Elizabeths. The case manager attended Mr. Louis' first Individual Recovery Plan (IRP) meeting on November 17, 2010, and was informed of the date of the next meeting.³⁷ According to the St. Elizabeths records, Mr. Louis showed signs of improvement after a change in his medication. He was more alert in the morning, spoke more calmly, was less irritable and delusional, demonstrated an improvement in insight, and admitted he had a psychiatric illness and was willing to take his medication. Mr. Louis agreed to begin a day program at the McClendon Center and was discharged voluntarily.³⁸

³⁴ St. Elizabeths Hospital Records for November 12, 2010 to December 15, 2010.

³⁵ Medical/Somatic treatment services are medical interventions including physical examinations; prescription, supervision or administration of mental-health related medications; monitoring and interpreting results of laboratory diagnostic procedures related to mental health-related medications; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention. See D.C. Mun. Regs tit. 22A § 3416.1.

³⁶ Anchor February 2011 Progress Notes.

³⁷ St. Elizabeths Social Work Update November 17, 2010.

³⁸ The McClendon Center is a DMH certified core services agency.

There is no documentation of Anchor assisting Mr. Louis with transitioning from St. Elizabeths to the community. The St. Elizabeths discharge notes do not mention Anchor, nor do the Anchor records refer to Mr. Louis' discharge. Anchor's December Progress Notes merely state that Mr. Louis seemed "stable," without discussing any services or treatment. They do not indicate whether Mr. Louis continued the medication regimen prescribed by the St. Elizabeths psychiatrist. Anchor did not follow up on St. Elizabeths' plan to enroll Mr. Louis in services at the McClendon Center's day program. It was not until February that Anchor revisited the idea of attending the day program at the McClendon Center. At that point, Mr. Louis no longer wanted to attend a day program, stating that he would prefer to work.³⁹

Once discharged from St. Elizabeths, Mr. Louis was scheduled for a monthly appointment with an Anchor psychiatrist. He missed his December appointment and there is no documentation regarding whether or not he went to his January appointment.⁴⁰ Nor is there any documentation as to whether the case manager followed up with Mr. Louis regarding his missed appointments. After he attended an appointment in February, Mr. Louis told his case manager he did not feel that the psychiatrist listened to him. The case manager stated she would go with him to the next appointment in March. Mr. Louis went to the March and April appointments, but there is no record that the case manager accompanied him.⁴¹ At an Individual Recovery Plan (IRP) meeting on March 8, 2011, Mr. Louis stated he was taking his medication and the case manager agreed that he seemed less agitated. Mr. Louis again told the case manager that he felt that his psychiatrist was not listening to him and that one of the medications was upsetting his

³⁹ Anchor February 2011 Progress Notes.

⁴⁰ Anchor December 2010 and January 2011 Progress Notes.

⁴¹ Anchor March and April 2011 Progress Notes.

stomach. Nothing in the record shows that the case manager assisted Mr. Louis with addressing these issues.⁴²

On March 8, 2011, Anchor held a quarterly review of Mr. Louis' IRP with Mr. Louis, the case manager, a clinical manager, and another individual listed as "other." The case manager assisted Mr. Louis in setting up an appointment with a primary care provider, perhaps to address his sleep apnea. At the IRP meeting, Mr. Louis stated he was tired of arguing with his landlord. He also continued to have maintenance issues in his apartment. The case manager wrote that she and Mr. Louis would continue to work with the maintenance office to resolve Mr. Louis' issues with his apartment. Mr. Louis stated that he did not want to attend a day program, he wanted to work, and he agreed to a goal to begin working with an employment agency.⁴³

In April, two months before Mr. Louis died, the case manager observed several full medication bottles in Mr. Louis' apartment, indicating that he was not taking his prescribed medication. Rather than implementing a crisis intervention plan, assisting Mr. Louis with speaking to the psychiatrist as originally suggested, or providing Mr. Louis with more support, the case manager simply warned him he would have to return to the hospital if his symptoms became too severe.⁴⁴

In May, the case manager spoke to Mr. Louis' landlord. The landlord reported Mr. Louis had been a disturbance in the building, "banging at night and having young boys run in and out all night." The case manager wrote in the notes that she unsuccessfully attempted to reach Mr. Louis several times after he was discharged from Providence Hospital on May 31, 2011, including two home visits and several unanswered calls. She reported that Mr. Louis was not

⁴² IRP, March 8, 2011.

⁴³ IRP, December 8, 2010 - December 3, 2011.

⁴⁴ Anchor April 2011 Progress Notes.

taking his medication, although she did not indicate how she knew this without visiting him in person.⁴⁵

Finally, Anchor failed to provide Mr. Louis with the crucial support he required in the hours preceding his death. His case manager went home, and no one from Anchor's staff came to take her place. It appears from the Unusual Incident Report that MCS could not get in touch with the case manager or anyone at Anchor when they needed to find an emergency contact phone number to inform Mr. Louis' family about his death.

VI. Anchor's Vague and Repetitive Progress Notes Demonstrate Anchor's Insufficient Case Management.

The records that ULS has been able to review suggest that Anchor failed to provide Mr. Louis with adequate community support. The Anchor progress notes contain key words, listing "goals" and "objectives." Yet they do not provide any meaningful reflection or description of services that would actually achieve any of the stated goals. DMH Policy also instructs CSAs to implement effective supervisory practices, including internal sporadic reviews.⁴⁶ There is no indication that a supervisor ever reviewed the case manager's notes while she served Mr. Louis.

The monthly progress notes and Annual IRP with Quarterly Review Notes, all authored by the case manager, are vague, incomplete, and repetitive. An IRP dated December 8, 2010 through December 3, 2011, contains minimal notes for one quarterly review on March 8, 2011. If the January 2011 Progress Notes exist, they were not provided to ULS. Moreover, it is not clear that the case manager entered notes contemporaneously with Mr. Louis' treatment.⁴⁷ The progress notes are organized according to month. Each month of progress notes is dated a subsequent month. For example, the progress notes describing Mr. Louis' case management for

⁴⁵ Anchor June 2011 Progress Notes.

⁴⁶ *Id.* at 7b(6).

⁴⁷ DMH has informed ULS that Anchor did keep contemporaneous notes. However, despite our numerous requests, Anchor has not provided these notes to ULS.

June 2011 are dated July 8, 2011, almost a month after his death.⁴⁸

Anchor's progress notes list goals and objectives for "Housing, Rehabilitation & Employment, Social & Recreational, Activities of Daily Living, Psychiatric Medication, Somatic Medication and Treatment." In Mr. Louis' record, the same goals and objectives are repeated every month, as if the entries were simply cut and pasted. There is minimal, if any, description of Anchor's efforts to assist Mr. Louis in completing these goals. For example, under Somatic Medication and Treatment, the listed goal is to meet with a physician to arrange for a new breathing machine for Mr. Louis' sleep apnea. Anchor does not document any appointments with a doctor or hospital to arrange for a new machine. The goal for Activities of Daily Living—have a CSS assistant help Mr. Louis with organizing his apartment—is also repeated each month. The notes do not indicate whether or not a CSS assistant came to the apartment.

VII. Anchor did not Adequately Investigate Mr. Louis' Death.

According to DMH Policy, the purpose of requiring providers to review consumer deaths is to: identify process or systemic issues that may have contributed to a death and, if not corrected, could contribute to others; identify and improve clinical performance practices of individual practitioners/services providers; and identify and address problem areas and implement plans for overall improvement.⁴⁹ Furthermore, an "unexpected death," such as Mr. Louis', requires an immediate investigation and a root cause analysis (RCA).⁵⁰ A RCA is a:

Process for identifying basic or causal factors that underlie variation in expected performance, including the occurrence or possible occurrence of a sentinel event ... The product of the RCA is an action plan that identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future.⁵¹

⁴⁸ The June 2011 Progress Notes contain slightly more detail than the preceding months. Presumably these notes, dated July 8, 2011, were completed after Mr. Louis died.

⁴⁹ DMH Policy 115.1 at 4a- 4c, Mortality Review, July 15, 2005.

⁵⁰ Unexpected occurrences involving death, not related to the natural course of the consumer's illness or underlying condition, are called sentinel because they signal the need for immediate investigation. Id. at 10.

⁵¹ Id.

Anchor's investigation of Mr. Louis' death did not follow DMH Policy Guidelines. The investigation, which consisted of a DMH Mortality Review Report and a Fatality Review, does not identify any systemic issues that may have led to Mr. Louis' death. There is no "action plan" designed to reduce the risk of similar events from occurring in the future. The Mortality Review Report provides an opportunity to discuss the agency's attempts to improve practices under the headings "Improvement Plans; note clinical findings, identified problems and opportunities to improve care," and "Recommendations for Corrective Action Plans." Anchor simply answered "n/a" under each heading. The report concludes that the "clinical record documentation" was "sufficient." Finally, the investigation does not consider Anchor's response to the "sentinel event," and whether staff acted appropriately.

Furthermore, there are inconsistencies among Anchor's documents. The Mortality Review Report states that Mr. Louis stopped taking his medication in March 2011, and his "building" (presumably neighbors or landlord) complained of loud and aggressive behavior.⁵² However, the March 2011 Progress Report does not mention a change in behavior and the IRP notes Mr. Louis' behavior was stable and he was taking his medication.⁵³

Anchor's Mortality Review Report is far less detailed and in some instances inconsistent with the DMH Unusual Incident Report, which was filed by Linda Miller, an MCS staff person. With respect to the immediate events leading up to Mr. Louis' death, MCS's report has more indicia of reliability, because Ms. Miller is the only author of a report who was actually present at the scene. The Mortality Review Report vaguely states that on June 14, 2011, the police "brought in family and friends to try and talk to him." The Unusual Incident Report does not mention any family, and only states that "friends" in addition to MPD and MCS, briefed ERT

⁵² Mortality Review Report.

⁵³ IRP, March 8, 2011.

about the situation. Mr. Louis' brother, Jean Alix Louis, informed ULS that the police told him of his brother's death, and he heard nothing from Anchor.⁵⁴ He had been in contact with Mr. Louis' case manager in the weeks preceding Mr. Louis' death.

Anchor's Fatality Review, dated June 28, 2011, fails to provide a comprehensive review of the events leading up to Mr. Louis' death. The author, an Anchor employee, interviewed staff, reviewed Mr. Louis' file, a service plan (which ULS has not seen) developed on May 3, 2011, and progress notes for the two months preceding his death. Two months is an insufficient history to examine possible causes of crisis and whether Mr. Louis' case manager adequately responded to his needs. For example, progress notes from April and May would not show that Mr. Louis' was hospitalized a few months earlier at St. Elizabeths.

The Fatality Review is labeled as a "root cause analysis" (or RCA), but it makes no effort to determine the root causes of Mr. Louis' death as defined in DMH Policy 115. According to the Fatality Review, Mr. Louis exhibited signs that his mental health was deteriorating in the eighteen months before he died. An Anchor psychiatrist, who had been treating Mr. Louis for the last eighteen months, reported that "when not medicated Mr. Louis was paranoid, delusional, anxious, spoke rapidly and fearful and could become verbally aggressive and "was psychotic, unpredictable, and had a history of stopping his meds and therefore a high probability of being involuntarily hospitalized again."⁵⁵ The Fatality Review does not provide any explanation or hypothesis as to why Mr. Louis might have become less stable.

Moreover, the Fatality Review's only assessment of the quality of case management comes from the case manager, who reported that she had a good relationship with Mr. Louis.

⁵⁴ Jean Alix Louis has been appointed the personal representative of Mr. Louis' estate, Superior Court Probate Case No. 2012 ADM 202.

⁵⁵ See Fatality Review.

Despite evidence that Anchor staff did not develop and implement a meaningful treatment plan that addressed Mr. Louis' needs, or respond in a meaningful way to Mr. Louis' immediate crisis, Anchor's Fatality Review concludes that Anchor met its legal obligation to provide adequate care to Mr. Louis. This document demonstrates Anchor's failure to reflect on why this death occurred and how to prevent future deaths.

VIII. DMH's Investigation of Anchor's Services and Role in Mr. Louis' Death Fails to Recommend any Improvements in Practice.

DMH is charged with:

[F]ostering the development of high quality, comprehensive, cost effective, and culturally competent mental health services and mental health supports, based on recognized local needs, especially for persons with serious mental illness...[and] ensuring that services provided to mental health consumers meet standards established by the Department....⁵⁶

According to the DMH policy that was applicable at the time of Mr. Louis' death, "DMH must investigate MUIs, including deaths with legal implications, or under suspicious circumstances, potential abuse or neglect by staff, a pattern of incidents that could escalate and lead to a serious outcome"⁵⁷

Anchor reported Mr. Louis' death as a Major Unusual Incident (MUI) to DMH's Office of Accountability (OA).⁵⁸ DMH reviewed Anchor's case records, CPEP and MCS treatment and encounter notes, and notes from Mr. Louis' hospitalization at Providence Hospital in May 2011. As described above, ULS' investigation of Anchor's provision of services for Mr. Louis, and its role in the crisis that preceded his death, found major gaps in Anchor's provisions of "high quality mental health services." Even if Anchor wrote a crisis plan, as DMH indicates in its Case Summary, there is no indication that Anchor implemented any part of a crisis plan when Mr.

⁵⁶ D.C. Code § 7-1131.03(d)(4), (6).

⁵⁷ DMH Policy 480.1A § 12b, Summary of Current Policy Violations, December 22, 2005. See DMH Policy 480.1 § 9j, Reporting Major Unusual Incidents (MUIs) and Unusual Incidents (UIs), May 3, 2012 for updated policy.

⁵⁸ See Unusual Incident Report (DMH Form 1243) dated June 14, 2011 (hereinafter Unusual Incident Report) and DMH Mortality Review Report dated approximately June 21, 2011 (hereinafter Mortality Review Report).

Louis was actually in crisis. Moreover, DMH did not cite Anchor for failing to adequately investigate Mr. Louis's death, a sentinel event, according to DMH policy.

IX. Recommendations for Improved Practices for Anchor and DMH

- Anchor should provide staff with mandatory training on the need for and how to implement crisis prevention plans, and how to make appropriate referrals to MPD.
- Anchor should develop effective recordkeeping protocols. Anchor staff should be trained in keeping detailed, contemporaneous notes that do not simply repeat previous entries. Supervisors should supervise and review case managers' recordkeeping and identify any deficiencies in service.
- DMH should provide training to Anchor staff on DMH Policy 115.1 at 4a-4c, Mortality Review, July 15, 2005, to review proper investigation procedures. Investigations of RCAs must identify systemic issues and strategies to prevent future reoccurrence.
- If it has not already done so, DMH should review Anchor's investigation of Mr. Louis' death. ULS requests a meeting with DMH and Anchor to review the investigation.
- Due to the complete lack of information released to date that would show the conduct of the police, ULS is not able at this time to address important questions about police actions, and in particular, about their ability to use best practices to deescalate encounters with individuals in psychiatric distress.⁵⁹ We hope to make recommendations in this area in a future follow-up report, but in the meantime, we reiterate our request to City Council to conduct an investigation of Mr. Louis' death.

⁵⁹ Law enforcement officials across the nation have been developing strategies for interacting with individuals with mental illness, with a focus on using measures other than force. For example, the Council of State Government's Justice Center's landmark Consensus Project Report, released in June 2002, initiated the implementation of practical, flexible criminal justice/mental health strategies through on-site technical assistance; the dissemination of information about programs, research, and policy developments in the field; continued development of policy recommendations; and educational presentations. See Consensus Project Report, *available at* http://consensusproject.org/the_report.

X. Conclusion

The records show that in the months preceding Mr. Louis' death, he was in crisis and required more intensive support from Anchor. Anchor failed to provide the necessary community based services to assist Mr. Louis in maintaining a safe and stable lifestyle. Nor was Anchor fully available when Mr. Louis was in crisis. Finally, it is of great concern that Anchor's investigation of Mr. Louis' death did not identify any deficiencies in Anchor's case management or promptly produce any internal agency discussion regarding how to improve services.

As stated in the introduction to this report, City Council could and should compel MPD, DMH, and Anchor to answer the community's questions. Such a hearing would create a forum for these agencies and stakeholders to learn from the incident and explore how to prevent future deaths. If it chooses to look critically at the events leading to Mr. Louis' death, the District has an opportunity to be a leader among cities, and more importantly, an opportunity to save lives.

Appendix: Records Available for Review

I. DMH Records

ULS has reviewed Mr. Louis' St. Elizabeths records, and an undated Case Summary from DMH. It is our understanding ULS has reviewed DMH's complete record regarding Mr. Louis' death.

II. Anchor Records

Anchor provided an Unusual Incident Report (DMH Form 1243) dated June 14, 2011, that was completed by DMH Mobile Crisis Services (MCS),⁶⁰ a DMH Mortality Review Report dated approximately June 21, 2011, monthly Progress Notes from November 2010 through June 2011 (excluding the month of January 2011), an Annual Individual Recovery Plan (IRP) for December 8, 2010 through December 3, 2011, and a Fatality Review dated June 28, 2011.⁶¹ Shortly after providing these documents, Anchor informed ULS that it would provide additional records from Mr. Louis' file. However, neither Anchor's management nor Anchor's legal counsel has responded to ULS's repeated inquiries about the remaining records.⁶²

III. MPD Records

ULS submitted a request for MPD records under the Freedom of Information Act (FOIA) in September 2011.⁶³ In addition to requesting records concerning the death of Mr. Louis, ULS requested records regarding two additional police related deaths of individuals with mental illness, David Kerstetter, and an unnamed individual, which took place in 2008 and 2009. MPD provided ULS with one document—a two page incident report concerning Mr. Louis' death.

⁶⁰ MCS is DMH's on-call service for adults in psychiatric crisis. More information is *available at* <http://dmh.dc.gov/node/119752>.

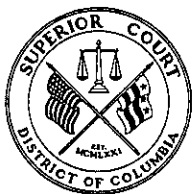
⁶¹ In addition, ULS has reviewed records from St. Elizabeths Hospital, where Mr. Louis was hospitalized from November 12, 2010 to December 15, 2010.

⁶² *See*, supra note 10 for a detailed account of ULS' attempts to communicate with Anchor.

⁶³ *See* D.C. Freedom of Information Act, D.C. Code § 2-532.

MPD initially claimed that it was exempt from releasing the requested records because admitting or denying the existence of an investigation would be an invasion of officer privacy under D.C. Code §§ 2-534 (a)(2) and (a)(3)(c). Subsequently MPD informed ULS that the investigations it was conducting into all three deaths could result in the filing of criminal charges against police officers, accordingly release of the requested documents would violate D.C. Code §§ 2-534(3)(A)(i); (B); and (C). ULS renewed its FOIA request on October 31, 2012. ULS has not received a substantive response.

ULS requested the records regarding the deaths of Mr. Kerstetter and the unnamed individual in order to identify patterns and practices that may be leading to unnecessary deaths of individuals with mental illness. It is of concern that MPD's internal investigations take as long as four to five years, concealing important information from the public about police conduct.



SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

Probate Division

Washington, D.C. 20001

Administration No. 2012 ADM 000202

LETTERS OF ADMINISTRATION

To all persons who may be interested in the Estate of

JEAN EDNY LOUIS, deceased:

Administration of the Estate of the deceased has been granted on 03/13/2012

to JEAN ALIX LOUIS, Personal Representative

(and the will of the deceased was probated on _____).

This administration is is not subject to the continuing supervision of the Court.

The powers of the personal representative are not limited are limited as follows:

The appointment is in full force and effect as of this date.

WITNESS:

DATE: March 13, 2012

Register of Wills
Clerk of the Probate Division

NOTE: Document Invalid Without Embossed Court Seal

Dari Pogach

From: clusterdc@juno.com
Sent: Thursday, September 22, 2011 3:43 PM
To: dcatania@dccouncil.washington.dc.us; Hthomas@dccouncil.us;
jackevans@dccouncil.washington.dc.us; jgraham@dccouncil.washington.dc.us;
jim@grahamwone.com; Kbrown@dccouncil.us; Mbarry@dccouncil.us;
mbowser@dccouncil.us; mbrown@dccouncil.us; mcheh@dccouncil.us;
pmendelson@dccouncil.washington.dc.us; twells@dccouncil.us; yalexander@dccouncil.us
Cc: jean.louis1@comcast.net; ABolden@ReedSmith.com; Dari Pogach
Subject: Council Hearing Requested in the Matter of the Death of Jean Louis in Mt. Pleasant on June 14, 2011

The Downtown Cluster of Congregations
1313 New York Avenue, N.W.
Washington, D.C. 20005

Sept. 22, 2011

Councilmember Phil Mendelson
Chairperson
Committee on Public Safety and the Judiciary
DC City Council
1330 Pennsylvania Avenue, NW
Washington, DC 20004

re: Hearings Request on Fatal Shooting of Jean Louis

Via E-mail & Fax

Dear Chairman Mendelson,

I am writing to request that you hold at your earliest convenience a public hearing on the circumstances surrounding the tragic, and needless, death of Jean Louis in Mt. Pleasant on Tuesday, the 14th of June.

It has been over 3 months since Mr Louis was killed by the SWAT Team of MPD. Yet to date no police report on the fatal shooting has been released. Indeed, more questions have arisen as to the quality of mental health care he received prior to this fatal episode, how police handled prior incidents that may have involved him, and the decisions that were made on that day which resulted in his death.

Your holding a hearing may well help to answer:

- Did the police use the services of mental health workers during the course of the events of that day? Did MPD employ "best practices" in this situation?

- Were any police on the scene especially trained in dealing with the public who exhibit mental health issues?

- What other options were available other than deadly force? Indeed, just how were the police helping him to obtain needed medical care?

- Were any interpreters called in who speak the same language as Mr. Louis?

It is my understanding a similar tragedy occurred two years prior involving another person who was suffering from mental illness. I believe there may be a pattern as to how MPD responds to those who are mentally ill.

In short, I would urge you to hold hearings both to help fully determine the facts of what transpired during this tragedy, and to also hopefully prevent future such tragedies.

Respectfully,

Terrance Lynch
Executive Director

cc: Jean Louis
A. Scott Bolden, Esq,
Dari Pogach, Esq.
City Councilmembers

Penny Stock Jumping 3000%

Sign up to the #1 voted penny stock newsletter for free today!
AwesomePennyStocks.com

UNIVERSITY LEGAL

Protection & Advocacy Program



SERVICES

for the District of Columbia

October 7, 2011

Councilmember Phil Mendelson, Chairperson
Committee on Public Safety and the Judiciary
D.C. City Council
1330 Pennsylvania Avenue, NW
Washington, DC 20004

Dear Councilmember Mendelson:

We are writing to express our support for the Downtown Cluster of Congregations' request for a public hearing regarding the tragic death of Mt. Pleasant resident Jean Louis on June 14, 2011. Mr. Louis was a longtime consumer of Department of Mental Health (DMH) services who was shot by Metropolitan Police Department (MPD) officers in his home. We strongly encourage a public hearing to examine MPD's ability to safely and appropriately interact with individuals with mental illness. Furthermore, to truly understand the circumstances leading to Mr. Louis' death, we must examine whether the D.C. mental health system and individual providers have the appropriate procedures and protocols in place to assist consumers in crisis, particularly when MPD is involved.

With the consent of Mr. Louis' family, University Legal Services has initiated an investigation of this incident. Mr. Louis received the services of an Assertive Community Treatment (ACT) team from Anchor Mental Health Services, a DMH funded provider. A public hearing would provide the opportunity to examine the interventions Anchor pursued in response to Mr. Louis' mental health crisis. It is our understanding that Anchor staff was present in the hours leading up to Mr. Louis' death, but left the scene before he was killed. We seek to determine whether staff was able to work with MPD during this incident, and why they eventually left the scene.

It is not clear whether MPD ever partners with clinicians who are trained to work with individuals with mental illness. As the designated protection and advocacy program for individuals with disabilities in the District of Columbia, University Legal Services (ULS) represents hundreds of D.C. residents each year to obtain appropriate mental health services. We often receive complaints from our clients and mental health consumers regarding their negative experiences with MPD. We are gravely concerned that MPD officers lack the necessary training and support to safely deescalate potentially violent interactions with individuals with mental illness.

In addition to testimony from MPD and Anchor, we believe that DMH must participate in any public hearing regarding MPD's treatment of mental health consumers. We strongly encourage DMH to provide testimony regarding its internal procedures and protocols for handling interactions between its consumers and MPD. Furthermore, does DMH have an internal policy

220 I Street, NE, Suite 130
Washington, D.C. 20002

(202) 547-0198 Fax: (202) 547-2662 TTY: (202) 547-2657

for investigating and/or addressing incidents when its consumers are injured or killed by MPD? If there is such a policy, does it involve oversight of the assigned mental health provider?

Unfortunately, this is not the first time in recent history that a D.C. resident with mental illness has been killed by MPD. In November 2009, David Kerstetter, an individual clearly in the midst of a mental health crisis, was shot by MPD in his home. Despite press coverage and public debate over whether deadly force was necessary, City Council did not hold a public hearing to determine whether the officers who met Mr. Kerstetter at his home had the appropriate training and support to interact with someone in such serious circumstances.

It is time to provide a public forum to discuss whether MPD has the proper training and resources to safely interface with individuals in crisis, and whether DMH and its contract providers are prepared to work with MPD and effectively intervene in these situations. We urge you to hold a hearing as soon as possible so that we can begin the public discourse over the causes of and strategies for preventing further violent and/or deadly incidents between MPD and D.C. mental health consumers.

Sincerely,

A handwritten signature in cursive script, appearing to read "Dari Pogach".

Dari Pogach, Staff Attorney
University Legal Services