

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL**

**REPORT OF SPECIAL EVALUATION:
SUFFICIENCY OF DISTRICT AGENCY SERVICES
PROVIDED TO
A DISTRICT RESIDENT**

January 2012



**CHARLES J. WILLOUGHBY
INSPECTOR GENERAL**

This public version has been redacted in accordance with the District of Columbia Freedom of Information Act (D.C. Code §§ 2-531-540 (2011)): 1) D.C. Code § 2-534(a)(2) – personal privacy information, and 2) D.C. Code § 2-534(a)(6)(A) – information exempted from disclosure by other laws. Other confidentiality laws include 45 CFR Parts 160 and 164 (Health Insurance Portability and Accountability Act) and D.C. Code §§ 7-1201.01-1208.07 (Mental Health Information).

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



February 1, 2012

The Honorable Vincent C. Gray
Mayor
District of Columbia
Mayor's Correspondence Unit, Suite 316
1350 Pennsylvania Avenue, N.W.
Washington, D.C. 20004

Dear Mayor Gray:

Please find enclosed a copy of *Report of Special Evaluation: Sufficiency of District Agency Services Provided to A District Resident*. The unredacted version of this report was delivered to your office on January 31, 2012. In order to create a version that adheres to District confidentiality laws and therefore can be released to the public, the Office of the Inspector General (OIG) does not identify the District resident who is the subject of the report. Furthermore, the OIG has redacted information that is protected by applicable personal privacy and mental health provisions within the D.C. Code, as well as information protected by the Health Insurance Portability and Accountability Act. The enclosed report will be available on the OIG's website at www.oig.dc.gov.

The purpose of this special evaluation was to analyze how District government entities responded to the social service needs and living conditions of a long-time District resident found dead in his home in August 2011. To conduct this review, OIG analysts interviewed over 30 people, many of whom had interacted directly with the resident; reviewed District laws, policies, and procedures, and case files and emails from District agencies; and gathered information from subject matter experts with relevant knowledge of and expertise in adult protective services and the indications, etiology, and investigation of self-neglect.

As I noted in the letter that accompanied the full report, the significant concerns resulting from our evaluation will necessitate follow-up to the OIG's recommendations by the affected District agency managers. I request that information pertaining to corrective actions that you direct as well as responses you receive from the agencies be provided to me as soon as possible.

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If you have questions about this report or if we can be of further assistance, please feel free to contact me on (202) 727-2540.

Sincerely,


Charles J. Willoughby
Inspector General

CJW/ef

cc: **See Distribution List**

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The Inspections and Evaluations (I&E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness, and economy in operations and programs. I&E's goals are to help ensure compliance with applicable laws, regulations, and policies, identify accountability, recognize excellence, and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.

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ACRONYMS AND ABBREVIATIONS

ACRONYMS AND ABBREVIATIONS

APS	Adult Protective Services
ASW	Administrative Search Warrant
CPEP	Comprehensive Psychiatric Emergency Program
CPS	Child Protective Services
DCRA	Department of Consumer and Regulatory Affairs
DCOA	D.C. Office on Aging
DCMR	District of Columbia Municipal Regulations
DCSC	D.C. Superior Court
DDOE	District Department of the Environment
DHS	Department of Human Services
D/DHS	Director/Department of Human Services
D/DMH	Director/Department of Mental Health
DMH	Department of Mental Health
DPW	Department of Public Works
EOM	Executive Office of the Mayor
FEMS	Fire and Emergency Medical Services Department
FI	Forensic Investigator
HUH	Howard University Hospital
I&E	Inspections and Evaluations
MCS	Mobile Crisis Services
MOCRS	Mayor's Office of Community Relations and Services
MOU	Memorandum of Understanding
MPD	Metropolitan Police Department

ACRONYMS AND ABBREVIATIONS

NOI	Notice of Infraction
NOV	Notice of Violation
OAG	Office of the Attorney General
OCME	Office of the Chief Medical Examiner
OIG	Office of the Inspector General
ONE	[Mayor's] Office of Neighborhood Engagement
OUC	Office of Unified Communications

EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Background

On August 1, 2011, Neighbor #1 was worried about the District Resident who lived next door and who was his long-time friend. Neighbor #1 knocked on the District Resident's front door with a baseball bat in order to get his attention if he was inside, but received no answer. Neighbor #1 had gone to places that the District Resident frequented, such as a nearby drugstore, but no one had seen him. Neighbor #1's concern intensified, and he contacted the Metropolitan Police Department (MPD), which dispatched officers to the District Resident's house.

When MPD arrived, an officer looked through the front door mail slot and saw the District Resident lying on the floor. Officers entered, found the District Resident unresponsive "directly inside the doorway" lying on multiple layers of papers, and notified the Fire and Emergency Medical Services Department (FEMS) and the Office of the Chief Medical Examiner (OCME). FEMS personnel examined the District Resident and found no signs of life. The OCME forensic investigator (FI) noted that the District Resident was wearing shoes, socks, one pair of black sweatpants, one pair of black pants, one pair of dark blue pants, one black hooded coat, one black cable sweater, and one pair of underwear. The temperature inside his house was 86.2 degrees. The shaded area on the front porch was 93.4 degrees. The maximum temperature that day was 100° F.

According to the FI:

The decedent is not dressed appropriately for the current weather conditions as he was wearing multiple layers . . . during a week with multiple hyperthermia alerts . . . There is a strong odor of urine upon examination of the decedent.

The FI also noted:

The entire downstairs of the residence is extremely cluttered and filled with various items so that one must walk on top of the items to traverse from room to room. There is a makeshift toilet located in the hallway that leads to the kitchen. There is no refrigerator noted on scene by this investigator. The kitchen is filled with hundreds of 24-ounce cans of Budweiser. There are also multiple Natural Light 12-ounce beer cans throughout the residence. This FI proceeds upstairs and notes three bedrooms. The upstairs bathroom has the toilet tank lid sitting on top of the toilet seat. There is a large pile of toilet paper present on the floor. The bathtub has multiple deceased rodents in it, with several in the drain. [See Appendix 1 for photographs.]

This District resident of 52 years and retired White House employee was pronounced dead at 3:50 p.m. that day. A "partial autopsy" was performed on August 2, 2011, and the manner of his death was documented in the autopsy report as "Accident."

EXECUTIVE SUMMARY

* * *

Prior to the discovery of the District Resident's body, Neighbor #1 had become concerned because he knew that the District Resident habitually wore excessive layers of winter clothing, despite the record-breaking, extreme heat of that summer. Both Neighbor #1 and the District Resident's sister-in-law, who lives in Mississippi, also knew that after retirement, the District Resident had begun to exhibit bizarre behavior at his residence. His daily behavior had become abnormal; for example, the District Resident defecated and urinated on his front porch, and stored his waste in buckets on that same porch. In addition, the District Resident had gone from a modest indulgence in beer and pipe smoking to sitting on his porch drinking beer and smoking cigarettes excessively all day and into the night. The District Resident ate almost nothing, and what he did eat lacked nutritional value. He was malnourished and sometimes dehydrated, and had been taken to the hospital more than once complaining of hunger. Both the interior and exterior of the District Resident's house were in a state of extreme neglect, as evidenced by overgrown weeds, broken windows, and rodent infestation.

Objective, Scope, and Methodology

Objective. The District Resident's case garnered widespread public attention because of the stark contrast between his 39 years as an orderly and well-regarded White House employee, a friend, and a neighbor, and what appeared to be a precipitate decline into disorderly and dangerously unhealthy living conditions and aberrant behavior. The extreme circumstances of what became the District Resident's lifestyle, the apparent precariousness of his physical health, and doubts expressed about his mental health generated questions about the sufficiency of well-intentioned efforts by District agencies to help effect a different outcome for the District Resident, and also about their ability to do so under current operational guidelines and regulations. Consequently, the Office of the Inspector General (OIG) initiated this review and evaluation of the services offered and rendered to the District Resident to determine any need for change and improvement in the manner such services are dispensed by District agencies, or in the policies, procedures, and regulations that govern their actions.

Scope. The inspection team reviewed and evaluated the activities of and efforts by all District agencies involved in trying to mitigate the District Resident's unacceptable living conditions and the threats to his health.

Methodology. The team interviewed 30 District agency employees, family, friends, and neighbors; reviewed policies, procedures, case files, emails, correspondence, and other documentation from agencies whose representatives interacted both with the District Resident and with each other; and reviewed District laws, municipal regulations, and other information specific to the circumstances of the District Resident's case. The team also reviewed practices in other jurisdictions and consulted with experts in the area of self-neglect to solicit informed opinions on best practices in addressing the complexities of providing assistance to those who, like the District Resident, resist offers of assistance.¹

¹ The team consulted Dr. Jane Thibault, a gerontologist and Clinical Professor Emerita at University of Louisville's School of Medicine. She provided clinical services at the University of Louisville's Geriatric Evaluation and Treatment Unit for over 30 years and has expertise on self-neglect. The team also spoke with Dr. Patricia A.

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Select Findings and Recommendations

A complete delineation of findings and recommendations is contained in the “Findings and Recommendations” section of this report. Following are summaries of findings and related recommendations.

Adult Protective Services (APS) did not make a sufficient case that the District Resident suffered from self-neglect when submitting the complaint referral form for guardianship, in part because of lapses in its investigation of the case. (Page 36) APS’s complaint referral form to the D.C. Office of the Attorney General (OAG) regarding guardianship included inaccurate and insufficient documentation. For example, the form: erroneously stated that the District Resident did not have any electricity or running water; noted that the District Resident dressed in layers of clothing but did not mention that the District Resident wore the same clothing for approximately 2 ½ years; and apart from classifying the District Resident as a hoarder, APS did not present evidence to substantiate its assertion. **Recommendation:** That the Director/Department of Human Services (D/DHS) implement policies and procedures to ensure accurate and complete preparation of complaint referral forms for guardianship and conservatorship that are supported by a thorough and quality-assured investigation, including the submission of supporting documentation, as appropriate.

The APS-OAG complaint referral process for petitioning D.C. Superior Court to appoint a guardian or conservator has deficiencies and may not serve the best interests of clients like the District Resident. (Page 37) On February 15, 2011, APS sent a referral to OAG communicating a request to pursue appointment of a temporary guardian and a conservator. The OAG attorney assigned to assist APS issued a “DECISION NOT TO PETITION” memorandum dated March 21, 2011, which stated, in part: “I have decided not to file a petition at this time.... The subject is able to make a knowing and voluntary decision to refuse services....” Consequently, an opportunity to initiate a legal proceeding involving an array of trained and objective professionals to review the District Resident’s behaviors, condition, and rights was closed off. However, it appears that the D.C. Code language regarding guardianship was not intended to restrict a petition decision to a single entity: “In any case . . . involving self-neglect, if an APS worker has good cause to believe that an adult is incapacitated, the APS worker, [Department of Human Services], **or** [emphasis added] the Attorney General may . . . [p]etition the Court for appointment of a guardianship” **Recommendation:** That APS consider drafting policy and procedures clarifying at a minimum the role and statutory authority of social workers, so that APS workers may petition D.C. Superior Court for guardianship and/or conservatorship separately from the OAG in accordance with DHS’s authority under D.C. Code § 7-1905(c-1).

APS was not aware of all of the District Resident’s interactions with emergency service agencies and his hospitalizations. (Page 39) When emergency services are provided to clients of human service agencies such as APS, Department of Mental Health (DMH), Department of Health (DOH), and D.C. Department on Aging (DCOA), these agencies do not have access to

Bomba, a geriatrician who is vice president and medical director of Geriatrics Excellus BlueCross BlueShield and MedAmerica Insurance Company. The team consulted with her because of her expertise on elder abuse and self-neglect.

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either the information obtained during these interactions, or on how the matter was resolved. Such information could influence service providers' case management activity and treatment. There is no central database that all emergency service and human service agencies can access to report and obtain this information. APS was unaware of critical medical information from Howard University Hospital (HUH) that would have allowed social workers to attempt to assist the District Resident in following through with discharge recommendations and to determine a potential cause for his aberrant behavior. **Recommendations:** (1) That the Executive Office of the Mayor (EOM) and City Administrator expeditiously implement the Health and Human Services Integrated Case Management Initiative² and consider including MPD, FEMS, OAG, and hospital representatives on the Initiative's executive committee. Client data from these agencies, when appropriate, should also be incorporated in the integrated case management system. (2) That APS obtain access to hospital records for clients whenever possible to allow for thorough assessment and treatment.

Although well-intentioned, the EOM/Office of Neighborhood Engagement (ONE)-coordinated multi-agency intervention at the District Resident's house was not effectively planned, communicated, or executed, and was not productive. (Page 42) On July 1, 2010, ONE arranged for approximately 15 representatives from 8 District agencies and 1 community-based organization to serve an administrative search warrant (ASW) at the District Resident's house. It later noted that employees from different agencies attempted to strategize on how best to assist the District Resident while at his front door, but this proved ineffective. One employee opined that the agencies should have strategized prior to visiting the District Resident's home. This employee also stated that "it was good that everyone was involved, but there was no clear plan." **Recommendation:** That the City Administrator and agencies involved in such cases collaborate on and implement an operational strategy for interdisciplinary intervention that includes:

- identifying, based on objective criteria, who should take ownership for directing, coordinating, and documenting case-related actions, from beginning to end; and
- a process for developing and executing case management and treatment plans, establishing an interagency communication plan, completing outcome evaluations, and compiling related documentation to be used for official reviews, lessons learned, and quality assurance monitoring.

D.C. Code language regarding taking individuals into custody for emergency observation and diagnosis impedes providing needed assistance in cases like the District Resident's. (Page 45) An FD-12 is an Application for Emergency Hospitalization form used to allow an Officer-Agent to conduct involuntary commitment actions for a person who is believed to be mentally ill in accordance with the D.C. Code. **[Information redacted in accordance with District law.]** The team noted that the laws of some other jurisdictions have language allowing a more flexible standard for commitment. **Recommendations:** (1) That the EOM and the D.C. Council consider modifying D.C. Code § 21-521 to incorporate language on involuntary commitment, similar to that in Virginia or other jurisdictions, to accommodate

² Mayor's Order 2011-169, Title 1 – Health and Human Services Integrated Case Management Initiative (Oct. 5, 2011).

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“gray-area” cases, such as the District Resident’s case, where existing language impedes efforts to provide the type of assistance called for by the severity of the conditions. (2) That the Director/DMH (D/DMH) train and certify APS social workers as FD-12 Officer-Agents and monitor their certification status.

Conclusion

A lot of help offered but numerous obstacles encountered. More than 70 District employees participated in some manner in the 2 ½ year effort to help the District Resident. During this period, APS employees went to the District Resident’s house on at least 17 different occasions. DMH personnel went to the house at least nine times. MPD and FEMS were each dispatched eight different times to assist the District Resident, sometimes in response to the same call for help. Despite the significant application of human resources, this was a particularly difficult case to resolve successfully for a number of reasons:

- total lack of cooperation by the client;
- rigidity and ambiguities in laws and protocols that define self-neglect and mental illness;
- apparent reluctance of employees to focus on the District Resident’s obviously aberrant behavior and their inability to more aggressively seek creative solutions; and
- lack of a clearly designated individual or agency to take ownership of this type of case in order to ensure the efficient and effective use of City resources and increase the likelihood of a more satisfactory outcome.

To their credit, almost all of the District agency employees involved in this case exhibited a professional interest and willingness to assist the District Resident throughout the period of his distress and that of his neighbors. Employees communicated with each other readily through emails and meetings, and collaborated on visits to the District Resident and on repairs to his house. Despite a lack of both training and experience in dealing with the District Resident’s relentless resistance to assistance, EOM employees often took on an informal role as organizer—but not leader—of the multi-agency efforts.

Considerable discussion but action stymied. The interagency email dialogue and other discussions and meetings on the District Resident case were extensive and well-intentioned. (See Appendix 2 for samples.) However, communication did not translate into specific actions that might have helped the District Resident. For example, participants did not exercise sufficient due diligence in order to make a persuasive case when seeking guardianship to change the District Resident’s bleak circumstances. The APS complaint referral form to the OAG contained inaccuracies (e.g., the District Resident had no electricity or running water); was insufficiently documented (e.g., lacked a full discussion about his clothing, abuse of alcohol and cigarettes, and hospitalizations); and did not include testimony from social and mental health workers. In addition, APS’s complaint referral form did not include photographs of the District Resident and his property that would have given a court first-hand and graphic evidence of his self-neglecting, aberrant behavior.

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Each of the participants involved in the case represented elements of the District government established and funded to positively change the status quo of citizens like the District Resident, whose living conditions should have been unacceptable to reasonable people applying reasonable standards; standards they also would apply to themselves and to their own families. Unfortunately, neither EOM employees nor most of the mental health and social service professionals seemed willing to look beyond the most conservative interpretation of the terms “mental illness” and “self-neglect,” despite what they observed and what common sense must have signaled to them about the ineluctable ramifications of his aberrant behavior. As one agency participant noted, given the District Resident’s behavior, common sense should have raised an alarm.

Finally, it does not seem reasonable that the significant time and resources expended wrestling with the problems caused by the District Resident’s unusual and aberrant behavior resulted in saving the offending property, but not the property owner, who had been a productive, tax-paying good neighbor and friend. It is a sad commentary that the collective efforts so dutifully exerted by so many had no effect on the egregious and dangerous living conditions in which the District Resident placed himself.

**DISTRICT RESIDENT'S
BIOGRAPHIC PROFILE AND BEHAVIORS**

DISTRICT RESIDENT'S BIOGRAPHIC PROFILE AND BEHAVIORS

As a White House employee, the District Resident served 39 years in significant positions under 10 Presidents. He lived in a middle-class northwest neighborhood in Ward 4 and was well respected by his neighbors. Unfortunately, for reasons that likely will remain unclear, his life took a tragic turn after retirement. The following narrative notes key aspects of the District Resident's life, from his arrival in the District in 1959 to his death on August 1, 2011. Much of it is based on the first-hand observations from his next-door neighbor (who also was his best friend), other neighbors, and sister-in-law.

Education, Relationships, and Personality

The District Resident relocated to the District from Columbus, Mississippi to complete his high school education. Following graduation, he attended Howard University where he met Neighbor #1 in 1963. Neighbor #1, like the District Resident, was a serious student, and they became close friends and eventually neighbors for 37 ½ years. The District Resident lived with his aunt, whose house was next door to Neighbor #1's. The District Resident's aunt died in 1976, but the District Resident continued to live there and received the deed to the house in 1978.

Neighbor #1 described the District Resident as an introvert in college who did not associate with other students, male or female. He called him a "very intelligent man" who "studied Socrates and could speak on the subject for hours." He was "smart and knowledgeable," and, according to Neighbor #1, should have been a member of Mensa.³

Neighbor #1 said that the District Resident had been a "sharp dresser" who was "immaculate and meticulous." According to the District Resident's sister-in-law, the District Resident used to visit his family in Mississippi at least twice a year. However, after his mother's death in 2001, the District Resident stopped those visits. The District Resident's consumption of beer reportedly increased after his mother's death.

White House Employment

The District Resident began working full-time in the White House Office of Records Management as a management analyst, and subsequently advanced to the Classification Section of the office where he handled sensitive materials seen by the President. He retired in March 2009, telling his sister-in-law, without elaboration, that he had "called it quits." According to his sister-in-law, the District Resident had said in the past that if there were layoffs in his division, he would retire so that individuals with families could keep their jobs. She stated that she discussed the circumstances of his retirement with his White House supervisor, who said that the District Resident had retired voluntarily. *[Information redacted in accordance with District law.]* According to Neighbor #1, prior to his retirement, the District Resident would

³ "Members of American Mensa range in age from 2 to 102. They include engineers, homemakers, teachers, actors, athletes, students and CEOs, and they share only one trait — high intelligence. To qualify for Mensa, they scored in the top 2 percent of the general population on an accepted standardized intelligence test." <http://www.us.mensa.org/AML/?LinkServID=1B7529B7-DFE3-A3E1-174B3D5CB1A3B9EF> (last visited Nov. 29, 2011).

DISTRICT RESIDENT'S BIOGRAPHIC PROFILE AND BEHAVIORS

leave home at 2:00 a.m. in order to shower and dress at his office, which perhaps is an indication that his decline began before retirement.

Good Friend, Good Neighbor

As next-door neighbors, the District Resident and Neighbor #1 were such good friends that they developed a security system to check on each other's safety. According to Neighbor #1, whoever arrived home first would lean a broom against the storm door to let the other know he was there. The first to awake each morning called the other to ensure that all was well. Neighbor #1 stated that they had keys to each other's houses. A good neighbor to all, the District Resident had been known to come home from work and sweep the sidewalk on his block. Neighbors would tell their children not to litter because the District Resident would have to sweep it up.

Unusual and Aberrant Behavior After Retirement, Medically-Related Episodes

Withdrawal from personal contacts. Soon after his retirement in March 2009, neighbors noticed that the District Resident "just stopped" sweeping in his block. In addition, he became reclusive and withdrew from his family, friend, neighbors, and former White House colleagues. His family tried to maintain contact with him after he retired. The District Resident's sister-in-law said that she wrote him monthly, but he never responded. She believed that in the summer following his retirement, the District Resident's telephone service was disconnected, and he began using pre-paid cellular phones or Neighbor #1's telephone to communicate with them. When his sister-in-law asked why his home telephone service was disconnected, the District Resident said that he did not have a need for a home telephone. His family found his response to be unusual because he had maintained home telephone service for many years. His sister-in-law stated that she last spoke with the District Resident in June 2011, and when she asked him how he was doing, he said "talk to you later" and ended the call.

Decline in appearance and personal hygiene. [Information redacted in accordance with District law.] The District Resident's physical appearance changed drastically. Previously considered to be a "sharp dresser," he had begun wearing multiple layers of the same clothing daily and never changed. Neighbor #1 said for 2 ½ years the District Resident wore the same three pair of pants, two shirts, a sweater, two coats, a hoodie, and a hat.⁴ His personal hygiene declined dramatically as well, and Neighbor #1 once refused to give the District Resident a ride to the bank because his smell could make one "vomit." He stated that he bought the District Resident some clothes and encouraged him to take a shower at a nearby recreation center⁵ but the District Resident told him, "I can't. I had a breakdown."

Excessive smoking and drinking, hoarding. In addition to changes in his physical appearance and personal hygiene, the District Resident exhibited behavior that, based on what family and acquaintances had observed during most of his adult life, was abnormal and unsanitary. During the years prior to his retirement, he was known as a moderate drinker who

⁴ Neighbor #1 stated that when the District Resident was found dead, the only difference in his attire was that he had added a new pair of pants to the same old clothing.

⁵ At the time, Neighbor #1 believed that the District Resident's water service had been disconnected.

DISTRICT RESIDENT'S BIOGRAPHIC PROFILE AND BEHAVIORS

occasionally smoked tobacco from a pipe but never smoked cigarettes. He would buy a six-pack of beer, and it would last a week. Now, neighbors observed him sitting on his front porch for as many as 18 hours a day smoking cigarettes constantly and drinking beer. He would go to a nearby liquor store up to four times a day for a six-pack. One next-door neighbor stated that she believed the District Resident may have been hoarding because debris from his property was spreading onto her property, and there was a continuing rodent problem.

Defecating, urinating on front porch; spreading human waste. The District Resident began to defecate and urinate into buckets on his front porch, and would do so even in the sight of others. He purchased a toilet seat cushion, attached it to the top of a bucket, and used it as a toilet. A neighbor recalled a "horrible smell" coming from his property. Neighbor #1 witnessed the District Resident throwing fecal matter into Neighbor #1's front yard. He confronted his friend, and the District Resident asked Neighbor #1, "How do I know you didn't do it?" Afterwards, the District Resident began emptying buckets of waste into the alley behind his and his neighbors' houses to avoid detection. There was fecal matter around and on the District Resident's property, and mice from the District Resident's property would enter Neighbor #1's house and the house on the other side of the District Resident. Another neighbor stated that the District Resident would sweep away the waste on his porch floor, but smudge marks would remain. The District Resident's and Neighbor #1's use of brooms outside the front doors of their houses as a security system stopped when the District Resident's broom collected fecal matter. Neighbor #1's grandchildren visited him and saw the District Resident urinating on the porch. Neighbor #1's daughter was concerned about their exposure to this behavior and contacted the Ward 4 D.C. Councilmember. Neighbor #1 begged the District Resident to get some help and told him that it hurt to see his friend "dying." The District Resident simply replied: "I'm sorry."

Rodent infestation, deteriorating living conditions. Neighbor #1 stated that he was concerned about broken windows and other defects, including a broken front door lock, in the District Resident's house because bats and rodents had entered and posed a threat to his own house and that of the District Resident's other next-door neighbor who had children. In addition, a broken window and lock would pose a safety threat to the District Resident. That neighbor also believed that the District Resident's property was a health and safety hazard because of the rodents. The neighbor stated that the back window of the District Resident's house was completely broken. Her husband offered to fix the window, but the District Resident declined when he was told her husband would have to go inside the District Resident's house to repair it. Another neighbor, who also had children, stated that she observed mice from the District Resident's property entering her home through the radiator beside her front door. She noted that his lawn grass was overgrown, and there was trash on his front porch.

Utilities on but unused; food, hydration deficiencies. Because the District Resident had stopped taking showers and a living room lamp that had been on every night for years was now always off, Neighbor #1 assumed that the District Resident's water and electrical services had been disconnected. He discovered, however, that the District Resident simply was not using them. The District Resident did not cook and did not have a refrigerator. His primary sustenance appeared to derive from Doritos and green tea. According to Neighbor #1, the

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District Resident never accepted food,⁶ and was malnourished and dehydrated. Neighbor #1 recounted an incident when a homeless man who was working for Neighbor #1 brought the District Resident some food from a homeless shelter, and the District Resident refused it. Neighbor #1 stated that during the 2011 summer of record high temperatures, he would freeze water in containers and slide them onto the District Resident's porch hoping that he would melt the ice, drink the water, and stay hydrated. However, the District Resident would let the ice melt but not drink the water. Another next-door neighbor stated that she once called emergency medical services when she found the District Resident on the ground apparently gasping for air.

Physical complaints and hospital visits. Following the District Resident's retirement from the White House, he had a number of health-related incidents that indicated physical problems, including hunger, which was called to the attention of District medical entities by either the District Resident himself or his neighbors:

- March 19, 2010: A neighbor reported that the District Resident fell and could not stand up. Fire and Emergency Medical Services Department (FEMS) and Metropolitan Police Department (MPD) personnel responded but the District Resident refused hospital transport.
- April 3, 2010: The District Resident's sister-in-law called 911, and MPD conducted a "check on welfare"⁷ visit.
- April 4, 2010: Neighbor #1 called 911 to report that the District Resident had fallen; FEMS transported the District Resident to Howard University Hospital (HUH), and he was admitted.
- April 10, 2010: Neighbor #1 called 911; the District Resident was transported to HUH.
- April 13, 2010: Adult Protective Services (APS) called FEMS's "Street Calls" Program,⁸ and the District Resident was transported and admitted to HUH.
- April 16, 2010: FEMS transported the District Resident from MPD's 4th District Station to Providence Hospital.
- April 19, 2010: FEMS transported the District Resident to Washington Hospital Center.
- June 9, 2011: MPD conducted a check on welfare in response to a report of the District Resident wearing layers of winter clothing and reportedly having no water or electricity.

⁶ Another next-door neighbor stated that she once offered the District Resident some vegetables she had grown in her garden and he accepted them.

⁷ MPD Special Order SO-10-02, entitled "Check on Welfare Calls for Service" (eff. Feb. 22, 2010), states on page 1: "In these types of calls, a member of the public or a representative from a government agency contacts the police to check on the status of another member of the public."

⁸ FEMS's Street Calls program performs "mobile outreach and intervention for high-volume individual users of 911 services, including the homeless, mentally ill, and chronic public inebriates." [Http://fems.dc.gov/DC/FEMS/Divisions/Emergency+Medical+Service/EMS+Task+Force+-+Recommendations/Recommendation+5](http://fems.dc.gov/DC/FEMS/Divisions/Emergency+Medical+Service/EMS+Task+Force+-+Recommendations/Recommendation+5) (last visited Nov. 22, 2011).

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- July 21, 2011: MPD conducted a check on welfare visit in response to a report of the District Resident sitting on his porch drinking beer and smoking cigarettes while dressed in four layers of clothing.

The District Resident's sister-in-law also reported that the District Resident was taken to HUH in December 2009 and January 2010 as a result of dehydration and malnutrition.⁹

Casual mention of suicide. In March 2011, the District Resident informed Neighbor #1 about a lien on his house apparently related to the Department of Consumer and Regulatory Affairs's (DCRA) assessment of its structural condition. The District Resident asked Neighbor #1 to represent him in the matter, but Neighbor #1 declined. When Neighbor #1 asked the District Resident what he might do to resolve the issue, the District Resident replied, "Suicide.com. That will end it all." Neighbor #1 reported the District Resident's comment to APS, the Executive Office of the Mayor (EOM), and the Department of Mental Health (DMH). EOM #1, Director of EOM's Office of Neighborhood Engagement (ONE) contacted MPD and EOM called 911. The Office of Unified Communications (OUC) dispatched four MPD units, each carrying a single officer. An ambulance carrying two emergency medical technicians was also dispatched and went to the scene. EOM #2, ONE's Ward 4 Community Liaison, called DMH's Mobile Crisis Services (MCS) after receiving news that MPD was on-site.

Family, Neighbors, Others Seek Help for the District Resident

Sister-in-law. The District Resident's sister-in-law stated that after he retired in March 2009, contact with his family diminished. Ultimately, they began to contact Neighbor #1 to check on him. At one point, after not hearing from the District Resident for a long time, his sister-in-law contacted MPD and asked that they check on him. Officers were dispatched to the house, and reported that the District Resident was "okay." She contacted the local church the District Resident attended and asked that a priest visit him. His sister-in-law stated that a priest visited the District Resident and told him he would pray for him and his condition. The sister-in-law also was in contact with employees at EOM and the Department of Human Services (DHS) about obtaining a court order so that the District Resident could receive care. She stated that these employees told her they were concerned about the District Resident, but they could not pinpoint what was going on with him mentally. The District Resident's sister-in-law reported that her last telephone conversation with the District Resident occurred during the final week of June 2011.

Neighbor #1. The District Resident's best friend and next-door neighbor, Neighbor #1 stated that in 2009, he emailed EOM as well as contacted the following District agencies seeking help for the District Resident: the Office of Homeless Services in DMH, APS under DHS, the D.C. Office on Aging (DCOA), DCRA, the Department of Health (DOH), FEMS, MPD, and the Department of Public Works (DPW). Neighbor #1 stated that they all responded but "[n]o one did anything." They observed the District Resident but did not intervene. Neighbor #1 stated that more than once, MPD came to the District Resident's house with lights flashing and sirens blasting, which made the District Resident hostile.

⁹ No records were available to confirm these events.

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Neighbor #1 stated that he talked to EOM #2 about guardianship for the District Resident. He believes that EOM #2 worked very hard on the District Resident's case. He stated that EOM #2 was considered the "lead" on the case. According to EOM #2, Neighbor #1 was in communication with the EOM frequently in 2009 and the first half of 2010, and after that about twice per month. Neighbor #1 also indicated that he contacted OUC. Neighbor #1 stated that in March and April 2010 FEMS employees went to the District Resident's home and took him to a hospital. Neighbor #1 stated that FEMS forcibly removed the resisting District Resident from his porch.

Neighbor #1's daughter. Neighbor #1's daughter emailed the Ward 4 Councilmember on June 23, 2009, regarding the unsanitary conditions at the District Resident's home. She reported that the District Resident had numerous containers of human waste that caused an "intolerable smell and increased rodent activity." Neighbor #1's daughter expressed concerns for the District Resident's mental health and noted instances of the District Resident urinating on his porch and throwing waste between his house and her father's house. The Ward 4 Councilmember's office helped resolve this issue in July by having DCRA remove the buckets of urine and waste. However, Neighbor #1's daughter reported to the Councilmember's office on July 23 that the District Resident had begun to accumulate buckets of waste once again, and repeated her concern for the District Resident's mental health. DCRA monitored the situation, and reported that as of September 9, the District Resident had cleaned the porch himself.

Neighbor (home-owner) #2. Neighbor #2 owned one of the properties next to the District Resident's house and rented it to Neighbor #3. The District Resident's neighbor emailed photographs of the District Resident's property to EOM #2 showing its condition, his habit of defecating and urinating on the porch, and the beer cans and trash on the porch. Neighbor #2 stated that she sent no other complaint because Neighbor #1 and another neighbor had already contacted several agencies. Neighbor #2 also believed that the District Resident was hoarding because his debris was spreading onto her property, and there was a continuing rodent problem.

Neighbor (tenant) #3. Neighbor #3 stated that rodents from the District Resident's house would enter hers through the radiator beside her front door. She stated that she once called 911 when she found the District Resident on the floor of his porch gasping for air.

The District Resident's Former Supervisor. The District Resident's former supervisor stated that he contacted APS about the District Resident's situation, which he observed during a visit to his house. The District Resident's former supervisor visited the District Resident's house because after the District Resident retired, the former supervisor found items that were left behind at the White House and came across utility bills, which suggested non-usage. The former supervisor became concerned. During the visit, the District Resident's former supervisor saw that the District Resident appeared to have been wearing the same clothes for a long time, had not bathed, and had poor hygiene. He noted that this was a significant difference from the time he worked with the District Resident. He stated that the District Resident's lawn was overgrown, and the porch was in disrepair.

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Social Worker #1. While conducting a home visit in the District Resident's neighborhood in June 2011, Social Worker #1¹⁰ noticed the District Resident sitting on his front porch in winter clothing on a very hot summer day. She noted the condition of the property, including stains from mopped-up feces, empty beer cans and potato chip containers, and papers. Social Worker #1 "felt strongly that there was a safety issue" with the District Resident and emailed EOM #2 and DMH's Director of Adult Services:

This clinician is concerned about [the District Resident's] health as he most likely had a heat stroke and/or a seizure last summer which precipitated the 911 call. There are many 90 degree days approaching and if [the District Resident] is dressed as he was today I fear he could have another medical emergency. In addition, the [neighbor] next door has 5 children, two under the age of 3. The urine and feces, along with the mice, present a health concern not only to [the District Resident] but also to his neighbors. I implore you work with DMH to provide [the District Resident] with the appropriate level of care. As it stands now, he would appear to meet the criteria for an FD-12^[11] for an evaluation, and possibly extended observation and/or admission.

¹⁰ The District Resident was not Social Worker #1's client.

¹¹ An FD-12 form is completed when a person who is believed to be mentally ill is detained and taken into custody for involuntary emergency admission to a public or private hospital.

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CHRONOLOGY OF DISTRICT AGENCY ATTEMPTS TO ASSIST A DISTRICT RESIDENT – 2009 to 2011

During the 2 ½ years prior to his death, the District Resident’s aberrant behavior and neglect of his property was reported repeatedly to many District agencies by Neighbor #1, other neighbors, his sister-in-law, and his former White House supervisor. From May 2009 to June 2011, 11 District government entities and a D.C. Councilmember’s office were involved in discussions, primarily via email, about what to do and/or in taking action they hoped would resolve the District Resident’s multitude of problems. The District entities involved were:

- Adult Protective Services (Department of Human Services);
- Comprehensive Psychiatric Emergency Program (Department of Mental Health);
- D.C. Office on Aging;
- Department of Consumer and Regulatory Affairs;
- Department of Health;
- Department of Public Works;
- Fire and Emergency Medical Services Department;
- Mayor’s Office of Neighborhood Engagement, formerly known as Mayor’s Office of Community Relations and Services (MOCRS) (Executive Office of the Mayor);
- Metropolitan Police Department;
- Mobile Crisis Services (Department of Mental Health); and
- Office of the Attorney General.

Unfortunately, none of the government communication or action resulted in mitigating the District Resident’s deplorable living conditions or in halting his behavior, which could possibly have led to improvement in his physical condition.

May 2009

EOM Responds to Neighbor’s Email; MCS Visits House

On May 20, 2009, 2 months after the District Resident retired, Neighbor #1 emailed EOM #3, an Office of Neighborhood Engagement (ONE) Ward 4 Outreach and Services Specialist.¹² Neighbor #1 wrote that he was following up on a May 18, 2008,¹³ conversation with EOM #3 regarding the District Resident’s “mental and physical state.” Neighbor #1 reported that the District Resident was urinating and defecating in buckets on his porch, storing 15 to 20 buckets of excrement, and the trash on the District Resident’s front porch had become a refuge for rats and mice.

¹² ONE’s website states that it “serves as the Mayor’s primary constituent services organization by providing rapid and complete responses to constituent requests, complaints and questions. This office is a key resource for the community as it supplies a direct link between District Residents, their Mayor, and the Government of the District of Columbia.” [Http://one.dc.gov/DC/ONE](http://one.dc.gov/DC/ONE) (last visited Oct. 19, 2011).

¹³ The Office of the Inspector General (OIG) team was unable to locate records dating back to 2008.

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EOM #3 forwarded this email to an employee in DMH's Office of Homeless Services, DMH #1, who contacted Neighbor #1 on May 20 to obtain supplemental information about the District Resident. DMH #1 learned from Neighbor #1 that the District Resident had lived alone since 1976, was eccentric, had always been a recluse, was college educated, and had worked at the Old Executive Office Building.¹⁴ Neighbor #1 added that the District Resident's porch and house were cluttered, and that the District Resident was "apologetic, but is not changing." DMH #1 transferred the case to DMH's Mobile Crisis Services (MCS)¹⁵ unit.

An MCS social worker (DMH #2) and addiction treatment specialist (DMH #3) conducted a home visit¹⁶ with the District Resident on the evening of May 21. They arrived at 9:30 p.m. and met with him on the porch.¹⁷ **[Information redacted in accordance with District law.]**

The MCS employees attempted a follow-up home visit on May 26. They arrived and remained on-site for approximately 25 minutes. **[Information redacted in accordance with District law.]**

Following the home visit, MCS contacted EOM and DCRA to coordinate a home inspection and further assessment of the District Resident on May 27, 2009. MCS employees made a second call to EOM and DCRA employees on May 28, 2009, regarding a group visit to the District Resident's home but apparently received no response.

July 2009

APS Opens Case; DCRA Inspects Exterior of House, Abates Conditions on Porch

On July 9, Neighbor #1 contacted APS and spoke with an intake worker, APS #1. **[Information redacted in accordance with District law.]** The referral was assigned to an APS intake worker, APS #2, that same day.

On July 10, the Deputy Director of the D.C. Office on Aging (DCOA) contacted Neighbor #1's daughter, in response to emails she had sent to EOM regarding the District Resident's storage of buckets of waste and his urinating and defecating on his porch. A DCOA social worker was assigned to the case, and she contacted APS to learn whether the agency had a case open on the District Resident. APS informed the DCOA social worker that APS #2 was assigned to the case. Consequently, based on APS involvement, the DCOA social worker closed the case the same day.

¹⁴ The official name for the Old Executive Office Building is the Eisenhower Executive Office Building and is located next to the White House.

¹⁵ According to DMH's website, "Mobile crisis services teams respond to adults throughout the District who are experiencing a psychiatric crisis whether in the homes or on the street and who are unable or unwilling to travel to receive mental health services." [Http://dmh.dc.gov/dmh/cwp/view,a,3,q,515833,dmhNav,%7C31250%7C.asp](http://dmh.dc.gov/dmh/cwp/view,a,3,q,515833,dmhNav,%7C31250%7C.asp) (last visited Oct. 19, 2011).

¹⁶ A home visit occurs when a health professional travels to a client's home to check on his/her welfare, offer assistance, or provide treatment.

¹⁷ DMH #2 is a night shift employee.

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On July 14, a DCRA inspector conducted an inspection of the exterior of the District Resident's house. DCRA's Office of Customer Service informed the Ward 4 Councilmember's office of the outcome in an email that states:

According to the inspector's report, the inspection revealed weeds greater than ten (10) inches in height in the entire yard, trash/debris on the front porch and an odor of waste and urine. A Notice of Violation (NOV) was cited on the property under 14 [District of Columbia Municipal Regulations] DCMR Section 800.9, the premises are maintained in violation of the Housing Code so as to create a danger to the health, welfare or safety of the occupants, or public and/or to constitute a public nuisance. The violations carries [sic] a potential fine of \$500.00.

DCRA conducted a hazardous waste clean-up for the fecal matter in buckets at the house and the District Resident was fined \$500, charged a \$90 inspection fee, and billed \$2,292.95 for the clean-up that day.

Two days later, on July 16, 2009, DMH #2 and DMH #3 visited the District Resident's home in response to an email from Neighbor #1 to EOM and DMH. *[Information redacted in accordance with District law.]*

On July 17, 2009, APS #2 made an unannounced visit to the District Resident's home. APS #2's case notes recount this interaction and state, "A gentleman was viewed wandering the street, who the worker later learned was [the District Resident]. Worker attempted to speak with the client, but he eventually walked away." *[Information redacted in accordance with District law.]*

That night, DMH #2 returned to the District Resident's home and observed that DCRA had cleaned it up. DMH #2 reported that he spoke with the District Resident who said he was "grateful the porch mess was cleaned up, and it won't happen again." *[Information redacted in accordance with District law.]*

According to a DCRA employee's email, an inspector did a re-inspection of the District Resident's property on July 30 and observed that violations cited on July 14 (e.g., excessive vegetative growth, trash and debris) had not been abated. The inspector recommended the case be reviewed and approved for enforcement by the Ward 4 Inspections Unit supervisor.

August - December 2009

DCRA Ends Activities at House; APS Attempts Visits; Former White House Supervisor Emails Concerns to APS

According to the same DCRA employee's email, on August 20, a DCRA rehabilitation specialist approved the District Resident's case for abatement. However, a few weeks later on

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September 9, DCRA reportedly observed that the District Resident apparently had abated the excessive vegetative growth, trash and debris previously cited. As a result, on September 11, 2009, DCRA closed its investigation of the District Resident's house and "did not find cause for further action."

APS #2 made a second home visit to the District Resident's residence on October 21, but did not receive a response. APS #2 left a business card for the District Resident.

On December 30, the District Resident's former supervisor emailed APS and requested intervention for the District Resident. The former supervisor had visited the District Resident during the summer and was concerned by his appearance and minimal use of water and other utilities. APS #2 received the District Resident's former supervisor's email, and the case note stated, "[The former supervisor] advised that the District Resident has family members, which the worker did not know."

January 2010

APS Contacts Family Member, Neighbor

On January 7, APS #2 emailed the District Resident's former supervisor and informed him that he was the APS social worker assigned to the District Resident's case. The former supervisor recommended that APS #2 contact Neighbor #1 and Priest #1 at Nativity Catholic Church. The former supervisor also informed APS #2 that the District Resident attended this church, and that Priest #1 had attempted a home visit with the District Resident.

According to APS #2's case notes, 3 weeks later, on January 28, APS #2 spoke with the District Resident's sister-in-law. The sister-in-law informed APS #2 that the family was in communication with the District Resident and "has been meaning to come to the area to assess the client and his situation, but has been unable, due to the illness of her husband." APS #2 attempted a third home visit with the District Resident later that day, but received no response. APS #2, however, spoke with a next door neighbor, and left a business card for the District Resident as well as a note requesting that the District Resident call him.

February 2010

APS Transfers Case to Continuing Services

According to APS #2's case notes, on February 1, Priest #1 informed APS #2 that he did not know the District Resident, but he had received a call from the District Resident's former supervisor requesting that he visit the District Resident. Priest #1 stated that he went to visit the District Resident, but received no response.

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APS #2 completed a Risk Assessment and Case Summary form¹⁸ for the District Resident on February 3. *[Information redacted in accordance with District law.]*

The District Resident's case was transferred to APS Continuing Services. A Continuing Services social worker, APS #3, was assigned to the case and received it the following day. APS #3 attempted the first home visit on February 12, but the District Resident was not home.

March 2010

MPD, FEMS Dispatched After Neighbor Finds the District Resident Face Down on Porch

On March 3, APS #3 met with the District Resident at his home. They spoke at his door because the District Resident would not let APS #3 enter the house. *[Information redacted in accordance with District law.]* APS #3 gave the District Resident a business card, informed him that she would visit him again, and departed.

On March 19, Neighbor #3 called 911 because she found the District Resident on his front porch lying face down. MPD and FEMS units were dispatched to check on the District Resident's welfare. The police report noted that the District Resident did "not know why he was lying face down on his front porch . . . [He] was wearing 3 jackets and sweating a lot. No reason to believe there was any criminal offenses." *[Information redacted in accordance with District law.]* Although he appeared to be in need of assistance, the District Resident refused transport to a hospital.

April 2010

Responses to Numerous Medical Emergencies, Health Concerns

During an April 2 telephone call, APS #3 told the District Resident's sister-in-law that the District Resident had been resisting APS services, and that she had only been able to speak with the District Resident on the porch because the District Resident would not let APS #3 enter the home. The District Resident's sister-in-law reported that she and her husband planned to visit the District Resident within the next 2 weeks; however, that visit never took place.

On April 3, the District Resident's sister-in-law spoke with OUC because she was concerned about the District Resident. OUC dispatched an MPD unit to check on the District Resident's welfare, and the officer reported that he was on his front porch and "ok." The next day, April 4, Neighbor #1 called FEMS because the District Resident had fallen. When FEMS medics arrived, they helped lift the District Resident from the front porch into an ambulance. The District Resident was transported and admitted to HUH.

On April 5, APS #3, accompanied by an APS contracted psychologist, attempted a home visit with the District Resident. The goal was for the APS contracted psychologist to assess the

¹⁸ Within 5 days of the initial home visit, APS social workers must complete a Risk Assessment and Case Summary form that assesses the client's level of risk.

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District Resident's mental capacity. When they arrived at the District Resident's house, he was still at HUH. Following this unsuccessful visit, APS #3 called DCRA #1, DCRA's Chief Building Official, and left a voicemail informing him of the "deplorable state" of the District Resident's residence.

After 4 days in HUH, the District Resident was discharged on April 8. According to an FEMS incident chronology report, on April 10, at approximately 5:45 a.m., Neighbor #1 telephoned 911 on behalf of the District Resident. **[Information redacted in accordance with District law.]** FEMS responded, and again transported the District Resident to HUH, where he arrived at approximately 6:20 a.m.

APS #3 and the contracted psychologist made a follow-up visit to the District Resident's residence on April 12. **[Information redacted in accordance with District law.]** Following this visit, APS #3 updated her supervisor. Per APS #3's request, her supervisor accompanied her on a home visit on April 13. When they arrived, the District Resident complained of leg pains, and they contacted FEMS's Street Calls Program. When Street Calls paramedic, FEMS #1, arrived at the District Resident's house, FEMS #1 observed buckets of urine and feces on the District Resident's front porch and was "alarmed." When FEMS #1 peered into the District Resident's home, it appeared that there was fecal matter on his steps, and she also noticed fecal matter on the District Resident's clothes. **[Information redacted in accordance with District law.]**

The District Resident was admitted to the emergency room, and APS #3 and her supervisor spoke with HUH Social Worker #1. **[Information redacted in accordance with District law.]** HUH Social Worker #2 contacted APS #3 on April 15 and informed APS #3 that the District Resident would be discharged that evening. APS #3 received the discharge papers. **[Information redacted in accordance with District law.]**

Sometime on the night of April 15/16, the District Resident arrived at MPD's Fourth District Station. On April, 16 at 12:21 a.m., an MPD customer service employee called 911 and requested "EMS to respond to the station for a 69 year old black man suffering from stomach pains." FEMS transported the District Resident to Providence Hospital. The District Resident was eventually discharged and returned home.

On April 19, an MPD cruiser contacted OUC for assistance. The officer stated, "Sir, can you have the board (inaudible) respond to the front of [address redacted], adult black male, conscious and breathing, complaining about leg and stomach pains. Says he want[s] to be seen by fire department." FEMS arrived and transported the District Resident to Washington Hospital Center.

CHRONOLOGY OF DISTRICT AGENCY ATTEMPTS TO ASSIST A DISTRICT RESIDENT – 2009 to 2011

May 2010

Response to Environmental Concerns Because of Sanitation Issues

On May 7, APS #3 contacted the Director of DCRA and requested an immediate assessment of the District Resident's residence regarding the issue of the District Resident using his front porch as a bathroom and storing buckets of feces.

When APS #3 conducted a home visit on May 19, she observed that the District Resident's porch was clean. The District Resident stated that he had cleaned the porch and was in the process of cleaning inside of the home. The District Resident denied APS #3 access into his home to assess its condition.

One week later on May 25, Neighbor #1 sent an email to EOM regarding the District Resident's unsanitary living conditions, mental health, and physical health and safety. This email states:

My Neighbor, [], also a senior citizen, . . . has been acting strangely since shortly before his retirement in March 2009. It appears that his condition has worsened over the past 16 months. In March 2009, I noticed that [the District Resident] was urinating and defecating on his front porch. As [a] result of my complaints, several persons from the DC Government in bio-hazard suits and a plainclothes officer forcefully removed 15-20 water buckets containing feces, urine and cigarette butts from [the District Resident's] porch. It does not appear that much more has been done. However, during the past 3-4 months, he has been urinating and defecating on his front porch In addition, [the District Resident's] deplorable living habits (which also includes random trash, debris, overgrown landscaping, clutter-filled home) have resulted in rodents entering the connecting homes. Also, I fear the possibility of complete destruction of my home by fire because [the District Resident] obviously has mental health issues and his home is filled with trash and debris standing several feet off the floor on every foot of his home, and he drinks a lot of beer and sometimes chain-smokes cigarettes. Finally, the exterior of his house, especially the rear is in a state of disrepair. Most of the windows on the first level are out, and I am afraid that animals will enter his home and attack him. During May 2009, I reported this matter to . . . [Advisory Neighborhood Commission] ANC Commissioner; . . . the Mayors [sic] Office; Department of Mental Health; and the Department of Adult Protective Services. The conditions, not only continue to exist, but have worsened. Not too long ago, I [] was told by a person at the Department of Adult Services that as long as [the District Resident] is not "a danger to himself or to others," there is not much they can do. I believe that

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the unhealthy and unsanitary conditions constitute a public nuisance and pose an imminent danger to [the District Resident] and to his adjacent neighbors.

[Information redacted in accordance with District law.]

June 2010

DCRA Obtains Administrative Search Warrant

DCRA conducted an inspection of the exterior of the District Resident's house on June 2. One week later on June 9, EOM #2 and representatives from DCOA, DCRA, DHS, DMH, FEMS, and MPD met at the District Resident's house to attempt an inspection. The District Resident refused access and the inspection was cancelled. While on the property, however, the team observed a bucket of feces similar to that described by Neighbor #1. **[Information redacted in accordance with District law.]**

On June 10, a DCOA employee contacted the Department of Public Works (DPW) to see what assistance DPW could provide with assessing the situation and determining next steps. DPW assigned an Environmental Crimes Investigator, DPW #1, to the case because the situation might have been determined to be an "imminent danger to the public." On this same day, a concerned neighbor contacted DCRA "to inspect for possible hoarding, feces on the front and rear of the property, trash and debris."

A DCRA Inspector, DCRA #2, met with representatives from several District government entities, including MPD and EOM. An MPD officer photographed the porch area, which included a bucket containing cigarette butts and feces, items of clothing, and debris. The officer also observed vegetative overgrowth in the yard and exposed wood surfaces on the porch's roof and columns.

DCRA returned on June 17 and observed that the trash and debris had been removed but other violations observed on June 10 remained. Consequently, DCRA #2 issued a Notice of Violation (NOV)¹⁹ for the District Resident's house that stated:

An accumulation of trash has existed on the premises for more than seven (7) calendar days so as to constitute an insanitary [sic] and unhealthy condition by creating a harbor or concealment (including a hiding place for vermin or humans), a deposit or accumulation of refuse or trash, a harbor for rodents and vermin, a refuse for snakes, rats or other rodents, a noxious or unpleasant odor, or a fire hazard.

¹⁹ Title 1 DCMR § 2803.2 provides that "When the [District] is seeking a civil fine, it must file a Notice of Infraction or a Notice of Violation, as authorized by law"

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This NOV also noted a rotted porch column, excessive vegetative growth, and exposed exterior wood surfaces not painted or covered with a preservative.

On June 21, DPW #1 reported to a supervisor that she spoke with Neighbor #1 and the District Resident's sister-in-law. DPW #1 wrote:

[The District Resident] retired last year 2009 after 43 years of service after working for the Executive Suite of the White House as an Analyst. What she [the sister-in-law] recalls, [the District Resident] did not have a lot of furniture in [the] house but, [the District Resident] read a lot. She also offered to pay [the District Resident's] electric & water if need be to have it restored. I drove by there last week, could not see the back yard due to a garage privacy. The front of the property there was some overgrowth which shades/covers the stair going up to the house. [Neighbor #1] was out of town at the time I visited . . . , I will make contact with [Neighbor #1] today to see if I can get a closer look

(Prior to this conversation with [Neighbor #1], I contact [sic] Department of Health and they also have someone in place if and when [the District Resident] will need temporary housing.) How would you like for me to proceed?

On June 30, 2010, an OAG employee informed involved agencies via email that DCRA obtained a search warrant allowing access to the premises: "It cannot be used for other agencies to have unlimited access. In light of the situation, of course, it is essential to have other pertinent and required members present to ensure safety and quality control, namely MPD, Mental Health and/or Fire."

July 2010

Multi-agency Intervention Attempted

On July 1, representatives from numerous District government entities, including DCRA, FEMS, EOM, DCOA, DHS, and MPD arrived at the District Resident's house to serve the ASW. However, the warrant was not executed because DCRA's Chief Building Official convinced the District Resident to grant access to his home. **[Information redacted in accordance with District law.]** According to EOM #2, "DCRA's inspector did not locate more than one bucket of human waste on the porch and were unable to determine its origin and did not remove. DCRA determined utilities were in service, [and] toilets were not functioning. Mice, trash, and debris were observed by investigators." FEMS and DCRA determined the house was safe for habitation. **[Information redacted in accordance with District law.]** This interagency team determined the following next steps: APS would coordinate clean-up, DCRA would install smoke detectors and fix the toilet, and MCS would continue to monitor his condition. DCRA successfully installed a smoke detector on-site that day.

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On July 28, DCRA arrived to conduct a 30-day re-inspection and to abate the violations cited on the District Resident's property. DCRA requested that the District Resident sign documentation allowing a contractor to clean and make repairs, but he refused. As a result, the DCRA abatement team only abated the excessive vegetative growth as well as overgrown trees in the front and rear of the property. A DCRA contractor repaired the District Resident's rotted roof and porch, and DCRA again had to remove waste. The abatement resulted in a \$2,500 fine and a \$180 inspection fee. DCRA #2 forwarded the case to DCRA #3, who requested another inspection of the property in 30 days and then forwarded the case to DCRA's enforcement division.

August 2010

Attempts to Gain Access to House Rebuffed

During August 2010, additional attempts were made to gain access to the District Resident's home. DCRA case notes indicate that DPW #1 was scheduled to conduct an inspection of the District Resident's home on August 10, 2010, but records do not indicate that this inspection occurred.

APS #3 visited the District Resident on August 30, but he denied APS #3 entrance into his home and refused APS services. APS #3 noted that APS was waiting for the District Resident to consent to a heavy duty house cleaning, and she was coordinating this service with DCRA because DCRA was scheduled to have a contractor repair the client's toilets.

September - November 2010

Frustrated Attempts to Intervene

September 7: DCRA contacted OAG to obtain another ASW, but it was never obtained. DCRA internally discussed the District Resident's case and how to proceed given the refusal to grant access to his home. A September 10 report notes:

[I]nspectors have made repeated attempts to gain access which have been refused. Will issue NOV for other code violations ie smoke detectors, use ASW to gain access and have Enforcement abate, cleaning up stairs leading to bathroom so toilet can be repaired; may work with [FEMS] to declare imminent danger.

September 21: DCRA #2 made a final attempt to gain entry to the District Resident's home for an inspection and to obtain permission to have his toilet repaired. The case note from this visit states that if the District Resident refused entry, DCRA would obtain an ASW.

September 27: APS #3 attempted a home visit with the District Resident, but he was not at home. APS #3 left her business card for him to call her back.

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October 13: DCRA mailed a Notice of Infraction (NOI) to the District Resident for fines and penalties because “[e]xposed exterior wood surfaces are not being kept painted or covered.”

October 20: APS #3 visited the District Resident, and he did not let her enter the house. The District Resident told APS #3 that he was still cleaning the house, and the District Resident again refused APS #3’s request for APS to clean the house.

November 17: APS #3 visited the District Resident again and spoke with him on the front porch. The District Resident refused cleaning services and stated that assistance from APS was not needed. ***[Information redacted in accordance with District law.]***

December 2010

APS Closes Case

APS #3 returned to the District Resident’s home on December 6. Once again, the District Resident stated to APS #3 that he did “not need any assistance from APS and can take care of himself.” APS #3 wrote, “Client has refused APS services and services from DCRA to have his toilets repaired [sic].” APS closed the case in its registry and archives on December 10.

[Information redacted in accordance with District law.]

January 2011

APS, Other Agencies Re-Start Efforts as the District Resident’s Aberrant Behavior Continues

In January 2011, the Office of Administrative Hearings issued three Final Orders to the District Resident for failure to respond to three NOIs that DCRA issued on October 13, 2010. The fines and penalties totaled \$6,000. APS emailed DMH #4 (Director of MCS at DMH) on January 14, stating:

[the District Resident] is back to putting human waste in buckets on his front porch and at times just urinating or defecating on the porch. [The District Resident] is also refusing to pay his electricity, which is not turned on, even though he has the funds to solve this issue. [The District Resident] retired as an Analyst from the White House in 2009 and his family resides in Mississippi. Can coordination with Department of Health and DCRA be explored again due to possible health code violations, since [the District Resident] has refused APS services?

[Information redacted in accordance with District law.]

At the end of January, EOM #2 reengaged the agency personnel who previously assisted with the case because his habits had not changed. In a January 31 email to DMH #4 and EOM

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#1, she asked, “What kinds of strategies or solutions are available to evaluate [the District Resident] based on his environment (for example, hoarding behavior) and/or [] hygienic practices?” DMH #4 replied:

For us to have someone detained for emergency hospitalization (FD-12) we must assess them to be likely to injure self/and or others as a result of a mental illness. And if we are able to prove this, the individual would be transported by law enforcement to [the Comprehensive Psychiatric Emergency Program] CPEP or a community hospital that accepts involuntary patients (currently: United Medical Center, Providence Hospital, Washington Hospital Center, or Psychiatric Institute of Washington). The psychiatrist at the psychiatric facility then assesses the individual to see if they need to stay for treatment. We can have our MCS psychiatrist come with a team to assess [the District Resident] again whenever the time is appropriate.

February 2011

Interagency Dialogue Shows Difficulty in Resolving Case

The agencies that had thus far been unsuccessful in making any headway on the case continued their email dialogue, which often focused on regulatory restrictions that limited their ability to intervene. (See Appendix 2 for sample emails.) For example, on February 1, a District Department of the Environment (DDOE) employee noted:

[I]n order for us [the District Department of the Environment] to have jurisdiction, [the District Resident] must handle a ‘hazardous waste’ as defined by [D]CRA and our regulations. I did not see anything in the email traffic suggesting that [the District Resident] has handled a hazardous waste. Even if the conditions justify an emergency action, it is MPD, not DDOE, that carries out emergency actions. Apparently, MPD has done this in the past at [the District Resident’s] house.

This email was later forwarded to an MPD employee (MPD #1) who responded:

[H]ave we asked the office of aging to assist in this matter for outreach . . . apparently DMH has stated he is NOT in need of mental health servicesWhat is it that u are asking MPD to do – for we would not arrest this subject due to him defecating [sic] in his house – we can go talk to him and see what is going on

MPD #1 later noted that MPD could not assist in this situation “if dmh deemed him not a hazard to himself . . . mpd can't deem unfit nor is this activity criminal.” MPD #1 also noted that other agencies may be able to assist the District Resident, writing that “[w]e need office of aged to see

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if they have a case file on him and what they are going to do for services . . . also can DCRA cite him or DOH for the public health issues at health . . . we can go with dcra or Dept of Aged.”

A February 2 email from MPD #1 to EOM #1 stated, “[W]e really need to find out how dmh came to their assessment as well . . .” **[Information redacted in accordance with District law.]** MPD #1 sent another email to employees at multiple District agencies noting:

[Information redacted in accordance with District law.]

MPD has no grounds to deem him a public safety threat either . . . however I would think that his actions deem that he may be a danger to himself if he is sitting or living in feces (but I was not on scene to know scope of this . . . but unfortunately if DMH-trained professionals deem this not a danger we cannot . . . thus cant remove him) . . . so if APS has any resources or recommendations we would love to get the neighbors a solution . . .

[Information redacted in accordance with District law.]

On February 3, the APS/MCS joint home visit with the District Resident took place. EOM #2 planned a meeting for February 8, 2011, with the involved District agencies, telling them that she hoped they could:

1. Evaluate the conditions of [the District Resident’s] home (we will have a hard time getting access inside and may want to evaluate getting an administrative warrant)
2. Evaluate the capacities of [the District Resident’s] ability to care for himself.
3. Evaluate solutions to *immediately and permanently* address the issues of defecation and urination in public/on his porch.
4. Abate and enforce *any* violations on the interior/exterior of the home.

However, after determining that an ASW would be needed to get inside, DCRA informed the agencies that it would have to go through OAG to obtain an ASW. EOM #1 emailed the OAG and requested that it provide DCRA an ASW to assess the District Resident’s house. On February 7, EOM #2 cancelled the February 8 meeting because an ASW had not been obtained; this meeting was not rescheduled.

A February 8 email from DMH #5 to APS #3 stated, “[DMH #4] decided to email the District for another group (DCRA, MPD, EOM) inspection since it does not appear they ever did a warr[a]nt to enter the home. Here we go again! Once we find out condition of inside [his] home, maybe we can take action.”

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On February 15, APS submitted a Complaint Referral Form to an OAG attorney communicating a request to pursue guardianship for the District Resident.

March 2011

OAG Attorney Decides Not File Petition for Guardianship

On March 21, the OAG attorney sent APS a memorandum stating that it would not file a petition for guardianship and/or conservatorship for the following reasons: “The subject is able to make a knowing and voluntary decision to refuse services,” and “[t]he subject objects to the investigation and the objection is not prompted by fear or intimidation instilled by another.” APS #3 emailed an update on the case to EOM #2 and representatives from the involved agencies on March 24. She wrote:

APS met with DMH Mobile Crisis Unit and their psychiatrist Dr. [] last month . . . APS has also consulted with our Attorney [] regarding guardianship. [The OAG attorney] reported that APS cannot proceed with guardianship . . . APS also requested this month for DMH Mobile Crisis Unit to visit [the District Resident], after a concern from a neighbor . . . [The District Resident] also has not adhered to DCRA assistance or directives.

April 2011

DCRA Repairs Exterior of House

On April 29, a DCRA contractor repaired exposed wood surfaces at the District Resident’s house. As a result, DCRA fined the District Resident \$500, charged a \$90 inspection fee, and sent a repair bill for \$6,487.63.

June 2011

After 2 ½ Years, No Action to Change the District Resident’s Critical Situation

On June 9, Neighbor #1 contacted 311 and was transferred to 911 regarding the District Resident wearing layers of winter clothing as the hot summer approached. Neighbor #1 also reported, erroneously, that the District Resident did not have any water or electricity. MPD conducted a check on welfare and observed the District Resident sitting on his front porch and wearing “long sleeved clothing.” The officer noted, “Contact was made and C-1 [the District Resident] advised he was healthy and staying hydrated, and that the clothing he had on kept the sun off of his skin.”

On June 13, Neighbor #2 emailed EOM #2 and complained that the poor upkeep and condition of the District Resident’s property contributed to a rodent problem in her house. EOM #2 forwarded this email to employees at multiple agencies who were familiar with the case. On June 14, the DHS/APS Chief responded to this email stating, “the circumstances surrounding this

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case cannot be addressed by APS APS has been unable to determine capacity. Because we have been unable to determine capacity, this decreases our ability to petition the Court for guardianship.”

EOM #2 responded:

If [the District Resident] continues to urinate and defecate (and allegedly dispose of it into neighbors’ trash can and in the public space), I feel this is a public health risk. Additionally, he lives in an attached row home and purportedly smokes cigarettes in his home which I have observed to be full of debris that could catch fire.

MCS #2 asked whether MCS and other involved agencies should convene at the District Resident’s home. EOM #2 replied that she wanted to have a meeting with the agencies about . . . cases in Ward 4 “to include [District Resident].”

On June 22, EOM #2 and a DMH employee (DMH #6) received an email regarding the District Resident from Social Worker #1, a therapist at a community-based organization.²⁰ Social Worker #1 wrote:

On 6/8/2011 [t]his clinician observed . . . [the District Resident], on his front porch wearing heavy winter clothes and coat. On 6/15/2011, this clinician returned . . . and saw [the District Resident] on his porch again in heavy clothing. This clinician asked her [source] . . . for any additional information on [the District Resident]. She indicated that [the District Resident] urinates and defecates on his front porch in a bucket, that his home is severely cluttered and that the mice come from his home into hers. She stated that he doesn’t seem to eat regularly but lives mainly off potato chips. Last summer . . . she observed [the District Resident] on the ground writhing and gasping [The District Resident] was subsequently taken to the hospital and admitted. When asked if she knew if anyone was helping [the District Resident], she replied that people came to make repairs to his home, but she has not seen any follow through since then.

This clinician is concerned about [the District Resident’s] health as he most likely had either a heat stroke and/or a seizure last summer which precipitated the 911 call. There are many 90 degree days approaching and if [the District Resident] is dressed as he was today I fear he could have another medical emergency. In addition, the participant . . . next door has 5 children, two under the age of 3. The urine and feces, along with the mice, present a

²⁰ The District Resident was not Social Worker #1’s client.

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health concern not only to [the District Resident] but also to his neighbors. I implore you work with DMH to provide [the District Resident] with the appropriate level of care. As it stands now, he would appear to meet the criteria for an FD-12 for an evaluation, and possibly extended observation and/or admission.

DMH #6 responded to the email on June 24, 2011, and informed Social Worker #1 that there was a record of the District Resident in the system, but that he was not connected to a DMH Core Service Agency. DMH #6 asked whether anyone at the community-based organization is an Officer-Agent,²¹ if the District Resident has exhibited behavior that is likely to harm himself or others, and whether MCS or APS should assess him.

Social Worker #1 emailed EOM #2 on June 29, 2011, to note her interaction with the District Resident that day. She wrote:

[the District Resident was] wearing the heavy winter coat again. I asked if he was cold. He didn't answer but in turn asked if I was cold. I said I was surprised to see him in a heavy coat. He said it was due to the wind and asked if I could feel it. I said I only felt a gentle breeze but that it would get hot later and I was worried he may get heat stroke. He said he wouldn't get heat stroke and he said I should make sure I don't get heat stroke. The bucket with feces was still on the porch

After learning that the District Resident continued to use the bathroom on his porch rather than use a toilet within his home, EOM #2 emailed her EOM colleagues about DCRA's lack of follow-up. This email notes:

In the case of [the District Resident], another hoarding case, DCRA was instrumental in obtaining an administrative search warrant to allow access to the property for an inspection. However, DCRA failed to follow up with abatement of a non-functioning toilet (because it was not included in the warrant, [the District Resident] refused entry and DCRA was not able to fix them). I believe that due diligence was not served in this case, and without DCRA's partnership this case will never close. I'm seeing a discouraging pattern from DCRA. Continued lack of communication, failure of inspectors to follow up or provide updates, and continued resistance to assist us in our efforts to address hoarding issues. DCRA has been part of the hoarding work group since its inception However, I have seen no action

²¹ A person who has been certified by DMH to detain an individual when there is reason to believe that person is likely to harm self or others due to mental illness. 22-A DCMR § 7601.

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to indicate that DCRA is fully invested in our partnership nor an effort to better our relationship.

On June 30, a hoarding meeting was held at the D.C. government's Wilson Building with representatives from numerous government agencies. When Ward 4 hoarding cases were discussed (including that of the District Resident), the meeting participants decided that EOM/MOCRS would contact the appropriate agencies to arrange for any follow-up needed.

EOM #2 left her position in June 2011, and the dialogue regarding the District Resident among her former interagency colleagues apparently ceased.

July 2011

MPD Checks on the District Resident's Welfare After Neighbor Raises Concerns

On July 21, Neighbor #1 contacted 311 and was transferred to 911 to report that the District Resident was sitting on his porch drinking beer and smoking cigarettes while dressed in four layers of clothing, including a winter coat and hood. Again, MPD conducted a check on welfare, and the same officer from the June 9th check observed the District Resident sitting on his front porch wearing long-sleeved clothing. This police report similarly noted that the District Resident "advised he was healthy and staying hydrated, and that the clothing he had on kept the sun off his skin."

Neighbor #1 stated that the last time he spoke with the District Resident was on Friday, July 29, 2011. A hyperthermia alert was in effect on July 28, 2011, and during the last week of July, Washington, D.C. experienced consecutive days of high heat and humidity (See Table 1 on the following page). Neighbor #1 indicated that he was concerned for the District Resident's health because the District Resident wore multiple layers of clothing during this time. Neighbor #1 recalled that he tried contacting EOM #2 and a ONE Ward 4 Community Liaison, to share his concerns and see if someone would check on the District Resident's welfare.

August 2011

MPD, FEMS, and OCME Find the District Resident Dead Inside His House

A hyperthermia alert was activated on August 1 because the heat index reached 98 degrees. Neighbor #1 had not seen the District Resident in 3 days and went looking for him. When he could not find him, he contacted the police. MPD responded to the District Resident's house and did not receive a response when they knocked on the door. A police officer looked through the door's mail slot and saw the District Resident lying on the floor. The officer gained entry to the house and found the District Resident deceased. FEMS and OCME were dispatched to the scene. The District Resident was taken to OCME and pronounced dead at 3:50 p.m. OCME conducted a partial autopsy on August 2, 2011.

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Table 1: July 2011 Temperature Data²²

Date	Maximum Temperature	Max Heat Index
7/24/2011	97°	103.5°
7/25/2011	93°	103.2°
7/26/2011	95°	94.8°
7/27/2011	93°	90.8°
7/28/2011	95°	100.7°
7/29/2011	104°	107.3°
7/30/2011	97°	96.1°
7/31/2011	99°	95.9°

²² Data compiled from Weather Underground *available at* <http://www.wunderground.com/history/airport/KDCA> (last visited Jan. 20, 2012).

FINDINGS AND RECOMMENDATIONS

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1. APS did not make a sufficient case that the District Resident suffered from self-neglect when submitting the complaint referral form for guardianship, in part because of lapses in its investigation of the case.

APS's complaint referral form to OAG for guardianship had inaccurate and insufficient documentation. For example, APS erroneously stated, "Client does not have any electricity or running water" The District Resident did in fact have electricity and water service, but he was not using his utilities, apparently by choice. The complaint referral form also noted that the District Resident "dresses in layers of clothing" However, APS did not mention that the District Resident wore the same clothing for approximately 2 ½ years.

The OIG team observed that APS neglected to convey the District Resident's reported abuse of alcohol and constant cigarette smoking while sitting on his front porch for 16-18 hours daily. APS also stated in its complaint referral form, "Client is also a [] and refuses to allow [anyone] beyond the door to see his home" Apart from classifying the District Resident as a "[]," APS did not present evidence to substantiate its assertion. Of additional significance is that the complaint referral form did not provide a detailed history of the District Resident, and the OAG attorney was unaware of the details of his successful tenure as a White House employee and his rapid decline. Also, the APS complaint referral form did not provide information regarding the two occasions when the District Resident was hospitalized.

[Information redacted in accordance with District law.]

APS's investigation was not thorough, and did not provide sufficient evidence to substantiate the District Resident's self-neglect. ***[Information redacted in accordance with District law.]*** APS's policies and procedures note that "[a]s part of the investigation, photographs of the alleged victim and his/her surroundings . . . may be made."²³ APS's policies and procedures also provide, "[p]hotographs may be needed to document the condition of the client and/or the living environment"²⁴ On July 1, 2010, APS, along with numerous other District agencies, were part of a collaborative effort to assist the District Resident. The District Resident granted permission to DCRA, FEMS, and MPD officials to enter his home to conduct an inspection. DCRA led the inspection and documented its effort by taking photographs of both the exterior and interior of the District Resident's house. However, APS did not acquire copies of the photographs nor take photographs to attach to the complaint referral form as evidence that might convincingly depict the District Resident's deplorable living conditions.

APS lacks comprehensive policies and procedures for preparing referral forms. According to the OAG attorney responsible for reviewing referral forms, it is the social worker's responsibility to investigate the case and to provide documentation. APS's policies and procedures recommend attaching supporting documentation to a referral; however, they do not provide examples of the documentation that should be attached. Part VII of the complaint referral form submitted to OAG, entitled, "Witnesses," lists the names of the District Resident's sister-in-law, a DMH social worker, and Neighbor #1. However, APS could have requested that

²³ DHS, Adult Protective Services, Standards, Procedures and Guidelines, Chapter 2 Intake and Investigations (Rev. Nov. 27, 2007) at 34.

²⁴ *Id.* at 35.

FINDINGS AND RECOMMENDATIONS

other District agency officials who were directly involved in the District Resident's case participate in the guardianship proceeding and submit supporting documents. DCRA, MPD, and FEMS officials were inside of the District Resident's home and could have testified about his living conditions.

D.C. Code § 21-2041 (g) notes that “[f]or any individual alleged to be incapacitated, any current social, psychological, medical, or other evaluation used for diagnostic purposes or in the development of a current plan of treatment or any current plan of treatment shall be presented as evidence to the court.” The team received conflicting information regarding whether or not APS provided OAG the District Resident's risk assessment as evidence. **[Information redacted in accordance with District law.]** The OAG attorney recalled only receiving the referral form and a February 2011 assessment by DMH. **[Information redacted in accordance with District law.]** APS could have made a more compelling case for guardianship had the District Resident's risk assessment been attached to the complaint referral form as additional evidence in support of self-neglect.

Recommendation:

That the Director/Department of Human Services (D/DHS) implement policies and procedures to ensure accurate and complete preparation of complaint referral forms for guardianship and conservatorship that are supported by a thorough and quality-assured investigation, including the submission of supporting documentation, as appropriate.

2. The APS-OAG complaint referral process for petitioning D.C. Superior Court to appoint a guardian or conservator has deficiencies and may not serve the best interests of clients like the District Resident.

D.C. Code § 7-1905(c – 1)(1)(Supp. 2008) states that in a case involving self-neglect, if an APS worker has “good cause to believe that an adult is incapacitated,” the APS worker, DHS, or the Attorney General may petition the D.C. Superior Court (DCSC) for appointment of a guardianship of the adult or a conservator of the estate of the adult.

When a petition proceeds from APS to the court, the process, according to DCSC, is as follows:

- DCSC's Probate Division/Legal Branch reviews the petition to ensure necessary documents have been submitted and minimum legal requirements are met;
- a hearing date is scheduled approximately 1 month from acceptance of the petition;
- a judge appoints counsel for the subject, and may also appoint an examiner²⁵ and a visitor;²⁶

²⁵ “‘Examiner’ means an individual qualified by training or experience in the diagnosis, care, or treatment of the causes and conditions giving rise to the alleged incapacity, such as a gerontologist, psychiatrist, or qualified mental

FINDINGS AND RECOMMENDATIONS

- the counsel and any appointed examiner/visitor visit the subject;
- the subject is personally served with a Notice of Initial Hearing;
- the judge holds a hearing, at which the petitioner and witnesses, counsel for the subject (usually with the subject), and the visitor and/or examiner are present;
- the judge hears all evidence and decides whether to appoint a guardian; and
- if appointed, the guardian, within 90 days, develops a guardian plan and submits it to DCSC. The DCSC guardianship plan template states: “This plan should be developed in consultation with the ward, family members when possible, and with input from any other community agencies involved in providing services to the person.” A guardian is required to visit his ward at least once every 30 days, and submit a Report of Guardian to DCSC every 6 months.

Under a 2007 memorandum of understanding (MOU), OAG is to, among other things, meet with the assigned APS social worker within 5 days of receipt of an APS complaint referral form (referral), and “petition for relief as provided under the Adult Protective Services Act of 1984.” In the District Resident’s case, however, the following actions related to a petition to the court took place:

- The social worker submitted a referral to the OAG attorney, dated February 15, 2011, communicating a request to pursue appointment of a temporary guardian and a conservator. *[Information redacted in accordance with District law.]* APS cited the District Resident’s refusal to use his utilities (electricity and running water), his home environment and his use of “pails and buckets” for urination and defecation on his front porch, and other aspects of his behavior such as dressing in layers of clothing regardless of the season. *[Information redacted in accordance with District law.]* The OAG attorney assigned to APS stated that she made follow-up calls 1 month after receipt of the referral, and made a decision on the petition in March 2011. She stated that this was a typical timeframe for such cases, and she wanted to see if APS could obtain a “capacity report.”
- The OAG attorney’s “DECISION NOT TO PETITION” memorandum, dated March 21, 2011, stated: “I have decided not to file a petition at this time for the following reasons: . . . (x) The subject is able to make a knowing and voluntary decision to refuse services . . . (x) The subject objects to the investigation and the objection is not prompted by fear or intimidation instilled by another.” There is no additional information given for the decision not to file the petition. The attorney told the team that if a social worker does not provide enough information regarding capacity, the request for guardianship is denied. According to the District Resident’s case social worker, the attorney told her that there was not enough evidence to justify guardianship.

retardation professional.” D.C. Code § 21-2111 (7) (Supp. 2011). See Appendix 3 for a “Report of Examiner” template for additional insight into the scope of an examiner’s assessment and possible conclusions.

²⁶ DCSC defines the role of a visitor as functioning as an independent investigator and reaching conclusions regarding the circumstances surrounding the subject.

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- The MOU’s “Statement of Purpose” is to establish “the terms and conditions under which OAG shall provide legal services to DHS/FSA/APS for impaired adults, age eighteen (18) and older, who are victims of abuse, neglect or exploitation by a third party, or self-neglect.” According to the OAG attorney, however, under the current MOU with APS, she is responsible for deciding whether to petition the Court for guardianship.

Consequently, after District officials spent nearly 2 years directing significant resources in futile attempts to help the District Resident, an opportunity to initiate a legal proceeding involving an array of trained and objective professionals to review his behaviors, condition, and rights in order to provide assistance was closed off. However, it appears that the D.C. Code language was not intended to restrict a petition decision to a single entity: “In any case . . . involving self-neglect, if an APS worker has good cause to believe that an adult is incapacitated, the APS worker, [DHS], **or** [emphasis added] the Attorney General may . . . [p]etition the Court for appointment of a guardianship”

Recommendation:

That APS consider drafting policy and procedures clarifying at a minimum the role and statutory authority of social workers, so that APS workers may petition DCSC for guardianship and/or conservatorship separately from the OAG in accordance with DHS’s authority under D.C. Code § 7-1905(c-1).

3. APS was not aware of all of the District Resident’s interactions with emergency service agencies and his hospitalizations.

When emergency services, such as hospitalizations and check on welfare visits, are provided to citizens who are clients of human service agencies (e.g., APS, DMH, DOH, and DCOA), these agencies are not made aware of what prompted the emergency service response, what information was obtained during the interaction, or how the matter was resolved. As noted in a previous OIG report (see OIG report No. 09-I-0029, *infra*), such information could influence service providers’ case management activity and treatment. Currently, there is no central database that emergency service and human service agencies can access to report and obtain this information.

Between March 19 and April 19, 2010, MPD and/or FEMS personnel were dispatched to assist the District Resident seven times. Five of these emergency responses resulted in the District Resident’s transport and/or admission to a hospital, and two involved an MPD check on welfare. (See Table 2 on the following page.)²⁷

²⁷ The team noted that two additional MPD check on welfare visits occurred on June 9, 2011, and July 21, 2011. These visits were in response to the District Resident wearing multiple layers of clothing during the summer.

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Table 2: Requests for Emergency Services	
March 19, 2010	A neighbor reported that the District Resident fell and could not stand up. MPD conducted a check on welfare and FEMS responded, but the District Resident refused a hospital transport.
April 3, 2010	The District Resident’s sister-in-law called 911, and MPD conducted a check on welfare visit.
April 4, 2010	Neighbor #1 called 911 to report that the District Resident had fallen. FEMS transported the District Resident to HUH, and he was admitted.
April 10, 2010	Neighbor #1 called 911 and the District Resident was transported to HUH.
April 13, 2010	APS called FEMS’s Street Calls Program, and the District Resident was transported and admitted to HUH.
April 16, 2010	FEMS transported the District Resident from MPD 4 th District to Providence Hospital.
April 19, 2010	FEMS transported the District Resident to Washington Hospital Center.

During the team’s review of APS case notes, it appeared that APS was aware of only two of the five hospital transports. The District Resident’s sister-in-law informed the team that the District Resident was admitted to the hospital on more than one occasion because he was hungry and wanted to obtain meals. Likewise, it appears that APS was not aware of the March 2010 and April 2010 check on welfare visits by MPD. If APS had been informed of all interactions the District Resident had with emergency service personnel, it could have requested additional capacity assessments. In addition, information regarding the District Resident’s repeated need for emergency service assistance also could have been included in APS’s complaint referral form for guardianship to further demonstrate the District Resident’s inability to meet basic human needs and lack of capacity to make healthcare decisions. Finally, this information may have aided APS in making a stronger case for a self-neglect determination.

In its *Report of Special Evaluation: Interactions Between an At-Risk Family, District Agencies, and Other Service Providers (2005-2008)* (OIG No. 09-I-0029, Issued Apr. 2009), the OIG noted lack of coordination between District government agencies when providing services to an at-risk family, and the need for “a new environment of control and connectivity.”²⁸ The team noted that Mayor’s Order 2011-169, Title 1 – Health and Human Services Integrated Case Management Initiative (Initiative) (Oct. 5, 2011) was put forth to establish an integrated case management system to coordinate public benefits, services, and supports to District individuals or families who display risk factors across health and human services agencies. Coordination would include, among other things, integrated case management and coordination of activities. The Initiative also establishes an executive committee consisting of health and human services agency representatives that will “[r]eview and evaluate the District’s current health and human services data systems to provide recommendations so [sic] the Mayor regarding the creation of a ‘single or combined data-system’ to be created, housed, and implemented by the Mayor’s designee”²⁹

²⁸ *Id.* at 8.

²⁹ *Id.* at 3.

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As of December 2011, the Initiative had not been implemented. Given the lack of information sharing between human and emergency services agencies in this case, this committee should also include emergency services agency representatives, such as FEMS, MPD, OAG, and hospitals. Likewise, information from selected emergency services agencies should be included in the integrated case management system. **[Information redacted in accordance with District law.]** APS was unaware of critical medical information from HUH that would have allowed social workers to attempt to assist the District Resident in following through with discharge recommendations and determine a potential cause for his aberrant behavior.

[Information redacted in accordance with District law.]

Recommendations:

1. That the EOM and City Administrator expeditiously implement the Health and Human Services Integrated Case Management Initiative and consider including MPD, FEMS, OAG, and hospital representatives on the Initiative's executive committee. Client data from these agencies, when appropriate, should also be incorporated in the integrated case management system.
2. That APS obtain access to hospital records for clients whenever possible to allow for thorough assessment and treatment.

[Information redacted in accordance with District law.]

4. **APS closed the District Resident's case in December 2010, but it appears that: 1) the case did not meet any of the criteria for doing so; 2) documentation was not completed according to case closure procedures; and 3) the closure may have been against best practices for self-neglect cases.**

APS policies and procedures entitled "Closing Cases in Continuing Services"³⁰ provide: "Within 30 working days, the social worker shall complete all required case documentation and close the case. Required case documentation includes: the Risk Assessment, the Closing Summary, the *Notice of Case Action* (DHS 701) and all final entries in the APSIS system."

The team reviewed the District Resident's December 9, 2010, "Risk Assessment and Case Summary" and noted that on the last page of where it reads "Case Disposition," the form states "Click here." Apparently no one completed this section. Also, the team did not receive from APS a "Closing Summary."

APS policies and procedures list eight criteria for closing a case in continuing services.³¹ The team concluded that none of the reasons appear to apply to this case.³² **[Information**

³⁰ APS Standards, Procedures, and Guidelines (Rev. Nov. 27, 2007) at 94.

³¹ *Id.* at 95.

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redacted in accordance with District law.] Due to incomplete documentation in the case file, the team’s ability to reconstruct case events and assess the outcome was impeded.

[Information redacted in accordance with District law.]

APS did not have criteria in its policies and procedures to justify closing the District Resident’s case and, contrary to what was indicated in his Risk Assessment, he continued to refuse “essential services” and engage in self-neglect. APS policies and procedures provide that a case may be closed if a “client dies.” However, there is no mechanism for conducting a fatality review. Other social service agencies in the District, such as the Child and Family Services Agency’s Child Protective Services (CPS) division, conduct fatality reviews.³³ APS should implement such reviews.

Recommendations:

1. That the D/DHS ensure APS social workers complete all required case documentation when closing a case.
2. That the D/DHS ensure APS social workers prove and document at least one of the eight criteria listed in its policies and procedures for closing a case in continuing services.
3. That the D/DHS provide APS social workers with ongoing training on assessment, services, and case management for clients who self-neglect, from a professionally recognized resource in the field of self-neglect and elder care.
4. That the D/DHS establish an APS fatality review committee to identify and assess situations when clients’ deaths are violent, accidental, unexpected, or unexplained and make recommendations for systemic improvement, prevention, and public education.
5. **Although well-intentioned, the EOM/ONE-coordinated multi-agency intervention at the District Resident’s house was not effectively planned, communicated, or executed, and was not productive.**

According to its website, “ONE serves as the Mayor's primary constituent services organization by providing rapid and complete responses to constituent requests, complaints and

³² One of the criteria states, “The client refuses to cooperate with the provision of services and the Office of the Attorney General finds that there is insufficient cause for court intervention.” *Id.* at 95. However, APS closed the District Resident’s case in December 2010 and submitted its Complaint Referral Form to the OAG attorney on February 15, 2011. Thus, the aforementioned criteria for case closure did not apply to the District Resident’s case in December 2010.

³³ CPS conducts fatality reviews (in part) to “[i]dentify and characterize the scope and nature of child deaths in the jurisdiction, particularly those that are violent, accidental, unexpected, or unexplained” D.C. Code § 4-1371.03 (b)(1) (2008).

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questions.”³⁴ ONE achieves this goal by coordinating multi-agency initiatives that address residents’ social service needs when appropriate. On July 1, 2010, EOM #2 arranged for approximately 15 representatives from 8 District agencies and 1 community-based organization to serve an ASW at the District Resident’s house. A DMH employee noted that employees from different agencies attempted to strategize on how best to assist the District Resident, while at his front door, but this proved ineffective. The employee believed the agencies should have strategized prior to visiting the District Resident’s home. This employee also stated that “it was good that everyone was involved, but there was no clear plan.” Numerous interviewees expressed concerns about multiple individuals converging upon the District Resident’s home all at once, and some questioned whether ONE employees were trained to handle complex cases such as the District Resident’s.

DPW #1 sent a June 25, 2010, email to the involved agencies to inquire about previous attempts to assist the District Resident and noted the following:

[Y]ou mentioned previous attempts were ineffective, at that time was it a group of representatives, if so, which representatives were present? or if a one-on-one conversation took place with [the District Resident]? If in fact a group of representatives were present, it may have petrified him. It may be important to reach out to him independently if in fact this has not taken place.

When asked about the effectiveness of the ONE multi-agency “convergence” upon the District Resident’s home, a team consultant stated that the District Resident might have been overwhelmed with numerous agency personnel at his house. However, she recognized the importance of interdisciplinary teams. She noted that intervention without a plan is not beneficial. She stated, “It is more important that many people work together beforehand and strategize – not all show up at once without a plan.”

One District employee stated that, “unfortunately, EOM became the lead,” and “the people at EOM are not social workers.” He added that they should “refrain from coordinating emergency services and social services.” Another individual stated that “it would have made more sense for someone with mental health training” to have led the case. Because ONE is responsible for connecting residents to District services, it is important that employees have written policies and procedures to refer to and that they receive social service-related training.

Recommendation:

That the City Administrator and agencies involved in these kinds of cases collaborate on and implement an operational strategy for interdisciplinary intervention that includes:

- identifying, based on objective criteria, who should take ownership for directing, coordinating, and documenting case-related actions, from beginning to end; and

³⁴ [Http://one.dc.gov/DC/ONE](http://one.dc.gov/DC/ONE) (last visited Nov. 16, 2011).

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- a process for developing and executing case management and treatment plans, establishing an interagency communication plan, completing outcome evaluations, and compiling related documentation to be used for official reviews, lessons learned, and quality assurance monitoring.

6. **APS policies and procedure do not provide sufficient guidance on how to conduct comprehensive collateral interviews.**

According to the American Bar Association Commission on Law and Aging and American Psychological Association's "Assessment of Older Adults with Diminished Capacity, A Handbook for Psychologists," "[c]linicians accustomed to working with older adults . . . know the value of conducting collateral interviews in order to ascertain the older adult's insight and areas of concern."³⁵ According to Dr. Thibault, collaterals are important sources of information in self-neglect cases – "Collateral information, especially for gathering information re[garding] baseline behavior, rate and characteristics of escalation, and effects on collaterals are essential."

APS policies and procedures provide at page 32: "[an] investigation continues until the social worker obtains sufficient information to determine the validity of the allegation(s)." It also states that, "[i]n addition to interviewing the alleged victim, the social worker pursues collateral sources of information during the investigation. Only if none exists is the social worker solely dependent upon the alleged victim's statements for determining the validity of the allegation(s)." *Id.*

Other jurisdictions' policies and guidelines provide more details. For example, Tennessee's APS policy manual provides that intake employees "do not simply answer the phone – **they actually conduct investigative interviews.** Gathering of critical and complete information will not only ensure that appropriate clients are served, but will also help intake staff feel comfortable in screening out those referrals that are not appropriate."³⁶ Tennessee's policies and procedures also outline what questions can be asked to assess various adult abuse scenarios. As noted by Tennessee's policies and procedures, "[c]ollaterals and witnesses can often provide valuable information that is germane to the investigation They may provide a 'missing link' in the investigation Prior to interviewing these individuals, APS should think through what information they already have and what information is needed"³⁷

According to Minnesota's APS policies and procedures,³⁸ the following should be obtained from the abuse reporter:

³⁵ *Id.* at 43, available at <http://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf> (last visited Nov. 29, 2011).

³⁶ Tennessee Department of Human Services, Adult Protective Services Policy Manual (Apr. 2011) at 5, available at <http://www.tn.gov/humanserv/adfam/aps-manual.pdf> (last visited Nov. 29, 2011).

³⁷ *Id.* at 24.

³⁸ Minnesota Department of Human Services, Guidelines to the Investigation of Vulnerable Adult Maltreatment (Feb. 2010) at 23, available at http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_139381.pdf (last visited Nov. 15, 2011).

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Contact the reporter.

- Verify that the reporter knows a case has been opened[;]
- Ask questions that have surfaced so far, as to clarify information[;]
- Obtain more specific information if necessary[;]
- Assess the attitude of the reporter in regards to the [vulnerable adult[;]
- Inquire about additional contacts[;]
- Ask about support systems[;]
- Obtain reporter's impression of [vulnerable adult's] decision-making skills[;]
- Inquire about special needs[; and]
- Inquire about Power of Attorney/Guardianship or Conservatorship and their involvement with the [vulnerable adult].

APS clinicians conducted telephone interviews with collaterals in an effort to obtain information concerning the District Resident. While some pertinent information was gathered, other facts were not. APS #2 reported that he interviewed Neighbor #1 several times over the phone in July 2009, but this was not documented in APSIS. According to case notes, he did not obtain information regarding the District Resident's family until speaking with the District Resident's former supervisor on January 23, 2010. Having this collateral information sooner may have expedited the case, as the family may have provided additional relevant information.

Recommendation:

That the D/DHS update its policies and procedures regarding interviewing collateral contacts and provide regular training on conducting effective collateral interviews.

7. D.C. Code language regarding taking individuals into custody for emergency observation and diagnosis impedes needed assistance in cases like the District Resident's.

An FD-12 is an Application for Emergency Hospitalization form used to allow an Officer-Agent to conduct involuntary commitment actions for a person who is believed to be mentally ill in accordance with D.C. Code § 21-521, which reads as follows:

An accredited officer or agent of the Department of Mental Health of the District of Columbia, or an officer authorized to make arrests in the District of Columbia, or a physician or qualified psychologist of the person in question, who has reason to believe that a person is mentally ill and, because of the illness, is likely to injure himself or others if he is not immediately detained may,

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without a warrant, take the person into custody, transport him to a public or private hospital, or to the Department, and make application for his admission thereto for purposes of emergency observation and diagnosis.

[Information redacted in accordance with District law.] The team noted that the laws of some other jurisdictions have language that allows a more flexible standard for commitment.

[Information redacted in accordance with District law.]

A DMH employee told the team that cases like the District Resident fall into a “gray area,” and include individuals who suffer from self-neglect, dementia, or brain injuries. He noted that there should be another tool for handling these types of cases or improvements should be made to the existing processes.

The team reviewed involuntary commitment laws in other jurisdictions and observed that Virginia’s General Assembly amended the phrase “imminent danger to oneself or others” in its law because it was considered unduly restrictive. The new commitment criteria³⁹ relax the “imminent danger” requirement:

- (a) the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future,
 - (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, OR
 - (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs

The team learned through interviews that APS currently does not have the capacity to hospitalize clients against their will using the FD-12 process. A DMH employee who trains FD-12 Officer-Agents and monitors their certification status informed the team that DMH is evaluating who else should be added to the cadre of employees who can obtain FD-12 certification. She stated that adding APS to the list would be nice because DMH works closely with the agency. Moreover, an APS social worker opined that because APS social workers investigate self-neglect and abuse, they should be trained as FD-12 Officer-Agents.

³⁹ Bruce J. Cohen, Richard J. Bonnie, and John Monahan, *Understanding and Applying Virginia’s New Statutory Civil Commitment Criteria* (Jun. 4, 2008) at 2, available at <http://www.dbhds.virginia.gov/OMH-MHReform/080603Criteria.pdf> (last visited Nov. 29, 2011).

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Recommendations:

1. That the EOM and the D.C. Council consider modifying D.C. Code § 21-521 to incorporate language on involuntary commitment, similar to that in Virginia or other jurisdictions, that would accommodate “gray area” cases such as the District Resident where existing language impedes efforts to provide the type of assistance called for by the severity of the conditions.

2. That the Director/DMH (D/DMH) train and certify APS social workers as FD-12 Officer-Agents and monitor their certification status.

CONCLUSIONS

CONCLUSIONS

Conclusions

A lot of help offered but numerous obstacles encountered. More than 70 District employees participated in some manner in the 2 ½ year effort to help the District Resident. **[Information redacted in accordance with District law.]** During this period, APS employees went to the District Resident’s house on at least 17 different occasions. DMH personnel went to the house at least nine times. MPD and FEMS were each dispatched eight different times to assist the District Resident, sometimes in response to the same call for help. Despite this significant investment of human resources, this was a particularly difficult case to resolve successfully for a number of reasons:

- total lack of cooperation by the client;
- rigidity and ambiguities of laws and protocols that define self-neglect and mental illness;
- apparent inability or reluctance of employees to focus primarily on the District Resident’s obviously aberrant behavior rather than his communication skills when assessing his need for more aggressive attempts at intervention through guardianship or the FD-12 process;
- no thorough solicitation of background information on the District Resident’s work history, lifestyle, and living conditions prior to his decline or contacts with MPD, FEMS, and hospitals since his decline; and
- lack of a clearly designated individual or office with the authority to take ownership of this type of case in order to ensure the efficient and effective use of District resources and increase the likelihood of a more satisfactory outcome.

To their credit, almost all of the District agency employees involved in this case exhibited a professional interest and willingness to assist the District Resident throughout the period of his distress and that of his neighbors. They communicated with each other readily on the case through emails and meetings, and collaborated on visits to the District Resident and on repairs to his house. Despite a lack of both training and experience in dealing with the District Resident’s relentless resistance to assistance, EOM employees often took on an informal role as organizer—but not recognized leader—of the multi-agency efforts.

How do you help someone clearly in need who refuses your help? Many of the agency employees trying to help the District Resident seemed to have been distracted from his clearly self-neglecting behavior by the high quality of his educated communication with them. Although refusing to even minimally acknowledge that his behavior was dangerous and unusual, he displayed a courteous, confident, non-threatening demeanor while denying there were any problems at all. Despite what some employees saw all around them, the District Resident’s articulate and well-presented refusals to accept help were interpreted as indicators of “capacity” and self-determination. One social worker seemed to exemplify this distraction by describing the District Resident as having “an elegance about him.” The intelligence the District Resident displayed in brief verbal exchanges with prospective caregivers may have contrasted with stereotypical views many of us have of the homeless people that the District Resident seemed to

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be emulating, and may have influenced the assessments. More than one person commented that the District Resident's aberrant behavior and refusal of assistance simply reflected an individual's assertion of his right to live however he wanted to. For example, a participant asked the team hypothetically: "Do we have the right to tell people how to live out the rest of their life?" As an indication of the variety of interpretations given to the term "self-neglect," a social worker noted that the District Resident had poor hygiene, but said that was a choice and not self-neglect. In reference to the District Resident's use of his front porch for a bathroom, a social worker stated that some individuals grow up on a farm where it was normal to use an outhouse or to relieve oneself outdoors.

According to consultants to the team, self-neglect and capacity in the elder community are complex issues that are difficult to assess. APS social workers need specific training in these areas. Social workers also need to be empowered to address cases like the District Resident, and this empowerment can only be achieved through knowledge and appropriate tools. As stated by Dr. Kenneth Weiss, "[i]t may very well be that [the District Resident], with his preserved intellect, was able to convince the evaluators that he was making a lifestyle choice. Of course, one can alter lifestyle, but this radical change is almost always seen in the context of a mental illness."⁴⁰

Considerable discussion about what to do but action stymied. The interagency email dialogue and other discussions and meetings on the the District Resident case were extensive and well-intentioned. However, communication did not translate into specific actions that might have helped the District Resident. For example, in the case of seeking guardianship, some participants charged with doing so did not conduct sufficient due diligence in order to make a persuasive case for using the guardianship process to change the District Resident's bleak circumstances. The APS guardianship complaint referral form to OAG contained inaccuracies (e.g., the District Resident had no electricity or running water); was insufficiently documented (e.g., lacked a full discussion about his clothing, abuse of alcohol and cigarettes, and hospitalizations); and did not include testimony from social and mental health workers, his best friend and neighbor, and photographs of the District Resident and his property that would have given a court first-hand and graphic evidence of the District Resident's self-neglecting, aberrant behavior. With regard to using the FD-12 (Application for Emergency Hospitalization), the team has recommended consideration of adjustment to the relevant laws that will enable a more positive response to these difficult cases.

Unfortunately, most of the mental health and social service professionals seemed unwilling to look beyond the most conservative interpretation of the terms "mental illness" and "self-neglect," despite what they had observed and what common sense must have signaled to them about the ineluctable ramifications of the District Resident's aberrant behavior. As one participant noted, given his behavior, common sense should have raised an alarm:

- publicly defecating, urinating, and storing his urine and feces on his front porch;

⁴⁰ Dr. Kenneth J. Weiss is in the private practice of forensic psychiatry in Bala Cynwyd, PA, and is Clinical Associate Professor in Psychiatry and Associate Director, Forensic Psychiatry Fellowship Program, University of Pennsylvania School of Medicine, Philadelphia, PA.

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- dietary negligence and alcohol abuse;
- dressing in and apparently never removing layers of heavy winter clothing during extremely hot temperatures and heat exposure warnings.

Dr. Thibault notes that *behavior* should be one of the primary criteria used when addressing self-neglect cases because very intelligent individuals such as the District Resident are able to pass dementia and other assessments. She stated that urinating and defecating in a bucket on the front porch are “way out of the cultural norm.” In addition, Dr. Thibault cites information from friends, family, and acquaintances (called “collaterals”) as important in assessing self-neglect, as they help establish an individual’s “baseline” of behavior, or his “typical” behavior. In the District Resident’s case, his baseline would include his 39 years as a White House employee, not the 2 ½ years of decline D.C. government employees observed while trying to assess him.

Each of the participants involved in the case represented elements of the District government established and funded to positively change the status quo of citizens like the District Resident, whose living conditions should have been unacceptable to reasonable people applying the reasonable standards they would apply to themselves and to their own families. While commending the government officials’ desire and effort to make a difference in this case, the OIG encourages officials and employees in agencies with direct or indirect responsibility for assisting residents like the District Resident and his neighbors to be more aggressive in implementing concrete actions to avoid negative outcomes. It does not seem reasonable that the significant time and resources expended wrestling with the problems caused by the District Resident’s unusual and aberrant behavior resulted in saving the offending property, but not the life of the property owner. It is a sad commentary that the collective efforts so dutifully exerted by so many had no effect on the egregious and dangerous living conditions in which the District Resident placed himself.

APPENDICES

APPENDIX 1

(Photos of exterior and interior of the District Resident's house)

APPENDICES

Porch and entrance of the District Resident's house (August 1, 2011)



APPENDICES

Interior photographs of the District Resident's house (August 1, 2011)



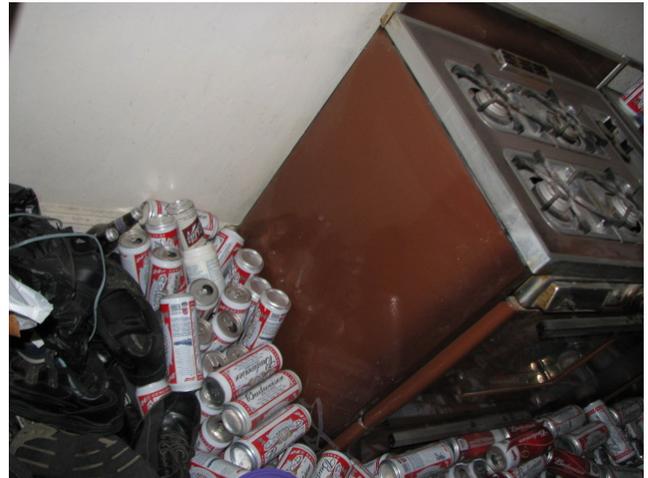
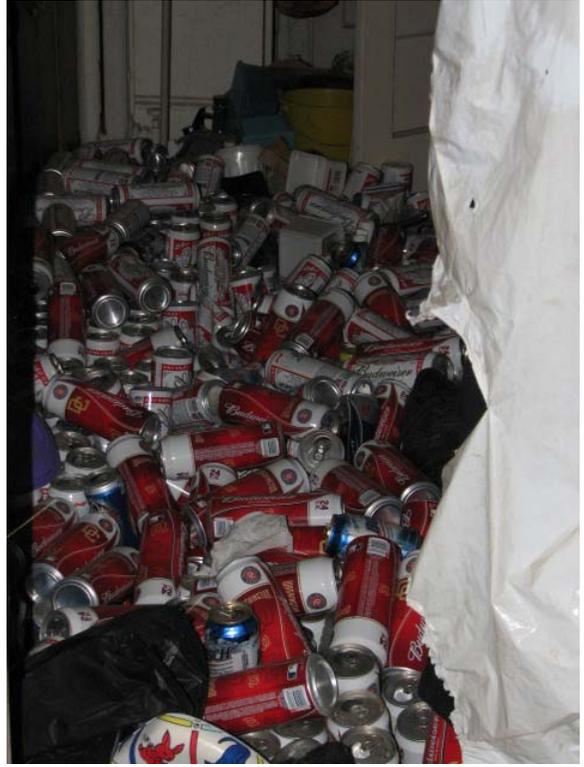
APPENDICES

Interior photographs of the District Resident's house (August 1, 2011)



APPENDICES

Interior photographs of the District Resident's house (August 1, 2011)



APPENDICES

Bathroom photographs and thermostat (August 1, 2011)



APPENDIX 2

(Sample of emails sent to and from District government entities that show the duration and scope of the dialogue from 2009 to 2011)

APPENDICES

From: [REDACTED]
Sent: Tuesday, June 23, 2009 10:33 AM
To: [REDACTED]
Subject: Unsanitary conditions at [REDACTED]

Good Morning Councilmember [REDACTED]

My father, who is a senior citizen, has a next-door neighbor of 40 years who seems to have declined in mental stability and has created unsanitary conditions for himself and my dad. For the past year, his neighbor [REDACTED] has had numerous containers of human waste and old newspapers on his front porch. In this summer heat, the human waste is causing an intolerable smell and increased rodent activity. My father does not have central air and likes to have his front door open or sit on his front porch, but cannot do so at this time due to the stench. In addition, there have been occasions when his neighbor has thrown the waste between the two houses and has been seen urinating on his porch. Further, his front shrubbery is overgrown and rodents have been seen going under his house. All of this impacts my father because they live in row houses. I contacted the DC Dept of Consumer & Regulatory Affairs Inspection & Violation Office and my father contacted various other DC government agencies, all to no avail. My father has asked his neighbor to clean the area but he just tries to suppress the smell with ammonia, which makes it worse. I am concerned about the safety of his neighbor as well as the conditions in which my father is forced to live. I would appreciate any assistance you can provide at this time. Please feel free to reach me via this email address or the numbers below.

Thank you and have a good day.

[REDACTED]
[REDACTED]

From: [REDACTED] (COUNCIL)
To: [REDACTED] (COUNCIL)
Sent: Fri Jul 10 14:09:58 2009
Subject: FW: Unsanitary conditions at [REDACTED]

From: [REDACTED]
Sent: Friday, July 10, 2009 2:09:28 PM
To: [REDACTED] (COUNCIL)
Subject: FW: Unsanitary conditions at [REDACTED]
Auto forwarded by a Rule

Hello,

I sent the attached email a couple of weeks ago and received a notice that a member of your staff is assigned to the matter. However, there has yet to be any action taken regarding the matter. This concerns me for many reasons, including the fact that I find DC becoming more of a "reactive" city rather than a "proactive" one and I was told that Councilmember [REDACTED] is very active and effective. Again, I am concerned for the mental stability and welfare of my father's elderly neighbor, who resides at [REDACTED] and sits on his porch daily wearing winter attire

APPENDICES

(coat, sweater, hat, etc.) in summer heat, makes consistent runs to the liquor store for beer, wanders the neighborhood aimlessly, and URINATES and DEFACATES in buckets that sit on his porch. My father is also a seasoned citizen but one who takes pride in his home and the time he can spend on his porch socializing with his grandchildren and neighbors. Again, he does not have central air and many times it is cooler on his porch than it is in his home. I am OUTRAGED by the lack of action regarding this matter by all of the agencies that have been contacted regarding it. Please refer to the letter below for my specific concerns and I would like a response regarding an actual date of action to address the matter.

Thank you.

[REDACTED]

From: [REDACTED] (COUNCIL) [mailto:[REDACTED]]
Sent: Friday, July 10, 2009 2:22 PM
To: [REDACTED] (COUNCIL); [REDACTED]; [REDACTED] (COUNCIL); [REDACTED] (DCOA); DCRA, Ward4
Subject: Re: Unsanitary conditions at [REDACTED]

[REDACTED]

Thank you for writing about this important matter. Which District agencies have you contacted regarding this matter(we can follow-up with them). Would you happen to have a phone number for your neighbor? Do you know of any family that he may have?

Again, thank you for bringing this matter to our attention. We will follow-up with steps we will take in working with District agencies

I look forward to any additional information that you may have

Best regards,

[REDACTED]
Director of Community Outreach
Office of Ward 4 Councilmember [REDACTED]
[REDACTED]
[REDACTED]

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From: [REDACTED]
Date: 5/25/2010 6:21:07 PM
To: "mayor@dc.gov" <mayor@dc.gov>
Cc:
Subject: Webform.Mayor

Re: Unsanitary and Unhealthy Conditions at [REDACTED]

Dear Mr. Mayor:

I am requesting your assistance in what I consider a private and public nuisance. I am a senior citizen, who lives in an end house of three attached houses on [REDACTED] with [REDACTED] being the middle house. My Neighbor, [REDACTED] also a senior citizen, lives in [REDACTED] and has been acting strangely since shortly before his retirement in March 2009. It appears that his condition has worsened over the past 16 months.

In March 2009, I noticed that [REDACTED] was urinating and defecating on his front porch. As result of my complaints, several persons from the DC Government in bio-hazard suits and a plainclothes officer forcefully removed 15-20 water buckets containing feces, urine and cigarette butts from [REDACTED] porch. It does not appear that much more has been done. However, during the past 3-4 months, he has been urinating and defecating on his front porch without regard for who is on the porch of the two houses attached to his. In fact, he has even put a toilet seat on the buckets specifically for this purpose and will use it anytime. I have frequent visitors, including my two minor granddaughters, and the other adjacent neighbor has four children under the age of 6 who have to witness such disrespect. [REDACTED] has several buckets on his porch containing urine, cigarettes, feces and stained toilet tissue and newspaper, and he dumps the contents of these buckets in his front yard and in the alley adjacent to my home. [REDACTED] utilities have been cut off since February or March 2009.

In addition, [REDACTED] deplorable living habits (which also includes random trash, debris, overgrown landscaping, clutter-filled home) have resulted in rodents entering the connecting homes. Also, I fear the possibility of complete destruction of my home by fire because [REDACTED] obviously has mental health issues and his home is filled with trash and debris standing several feet off the floor on every foot of his home, and he drinks a lot of beer and sometimes chain-smokes cigarettes. Finally, the exterior of his house, especially the rear is in a state of disrepair. Most of the windows on the first level are out, and I am afraid that animals will enter his home and attack him.

During May 2009, I reported this matter to [REDACTED]; [REDACTED], the Mayors Office; [REDACTED] Department of Mental Health; and the Department of Adult Protective Services. The conditions, not only continue to exist, but have worsened. Not too long ago, I was told by a person at the Department of Adult Services that as long as [REDACTED] is not "a danger to himself or to others," there is not much they can do. I believe that the unhealthy and unsanitary conditions constitute a public nuisance and pose an imminent danger to [REDACTED] and to his adjacent neighbors.

I would also mention that I have known and been friends with [REDACTED] for approximately 50 years, and that he has no family in the District. I am in contact with his family in Mississippi.

I do not believe that it is or ever was the intent of your administration to allow such conditions to exist in the District, and would appreciate your assistance with this matter.

Respectfully submitted,
[REDACTED]

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From: [redacted] (DCOA)
Sent: Wednesday, June 23, 2010 5:34 PM
To: [redacted] (DMH); [redacted] (EOM); [redacted] (DCOA); [redacted] (DPW); [redacted] (DCRA); [redacted] (DCOA); [redacted] (DCOA); [redacted] (EOM); [redacted] (EOM); [redacted] (DCRA); [redacted] (DCRA); [redacted] (DHS); [redacted] (DPW); [redacted] (DPW)
Cc: [redacted] (DMH); [redacted] (DMH); [redacted] (DMH); [redacted] (DMH)
Subject: RE: Potential Hoarder on [redacted]
Importance: High..

Great!! Thanks [redacted], I thought that they had visited the site, my mistake.

[redacted] and staff – We need your help!!

From: [redacted] (DCOA)
To: [redacted] (DCOA); [redacted] (DPW); [redacted] (DCRA); [redacted] (EOM); [redacted] (DCOA); [redacted] (DCOA); [redacted] (DCRA); [redacted] (DCOA); [redacted] (EOM); [redacted] (EOM); [redacted] (DCRA); [redacted] (DCRA); [redacted] (DHS); [redacted] (DPW); [redacted] (DPW); [redacted] (DMH); [redacted] (DMH)
Cc: [redacted]
Sent: Wed Jun 23 15:54:36 2010
Subject: RE: Potential Hoarder on [redacted]

Hi Everybody:

This case has been troublesome from the start. It looks like a good idea to involve [redacted] in this case. I suggest that if no resolution can be accomplished by the end of this week, that we have a meeting to work on a division of labor—"who will do what and by what date" kind of meeting. If the ADRC building is good we could meet here—or any other location that seems better-suited/located. I am no longer at Barney Neighborhood House—now at ADRC. See you all soon. [redacted] Social Worker

From: [redacted] (DMH)
Sent: Wednesday, June 23, 2010 5:24 PM
To: [redacted] (EOM); [redacted] (DCOA); [redacted] (DCOA); [redacted] (DCOA); [redacted] (DPW); [redacted] (DCRA); [redacted] (DCOA); [redacted] (DCOA); [redacted] (EOM); [redacted] (EOM); [redacted] (DCRA); [redacted] (DCRA); [redacted] (DHS); [redacted] (DPW); [redacted] (DPW)
Cc: [redacted] (DMH); [redacted] (DMH); [redacted] (DMH); [redacted] (DMH)
Subject: RE: Potential Hoarder on [redacted]

That's for including us in the loop ☺ However, the DMH Mobile Crisis Services (MCS) have been up and running for well over a year and have a lot of experience in working with potential and real hoarders. [redacted] LICSW, is the Director of MCS, and [redacted] and [redacted] are the team leaders. They're the team that almost always takes the lead on these cases unless there's a hiccup in staffing patterns, which would then necessitate our involvement.

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From: [REDACTED] (EOM)
Sent: Wednesday, June 23, 2010 6:27 PM
To: [REDACTED] (DMH); [REDACTED] (DCOA); [REDACTED] (DMH); [REDACTED] (DCOA); [REDACTED] (DPW); [REDACTED] (DCRA); [REDACTED] (DCOA); [REDACTED] (DCOA); [REDACTED] (EOM); [REDACTED] (EOM); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DHS); [REDACTED] (DPW); [REDACTED] (DPW)
Cc: [REDACTED] (DMH); [REDACTED] (DMH); [REDACTED] (DMH); [REDACTED] (OAG)
Subject: Re: Potential Hoarder on [REDACTED]

The next step is gaining access to the inside of his home. Previous attempts have proven ineffective - [REDACTED] is firm and intent on keeping everyone out. We need either an agency with legal authority to enter a home regardless of the owner's consent (on the basis hazard of health and safety of self or others), or an administrative search warrant. I am looping OAG with this email. This situation is becoming increasingly time sensitive. I appreciate your due attention to this matter.

Regards,

[REDACTED] Mayor's Office of Community Relations| Ward 4 Liaison | [REDACTED]

From: [REDACTED] (DPW)
Sent: Friday, June 25, 2010 11:34 AM
To: [REDACTED] (EOM); [REDACTED] (DMH); [REDACTED] (DCOA); [REDACTED] (DMH); [REDACTED] (DCOA); [REDACTED] (DPW); [REDACTED] (DCRA); [REDACTED] (DCOA); [REDACTED] (DCOA); [REDACTED] (EOM); [REDACTED] (EOM); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DHS); [REDACTED] (DPW); [REDACTED] (DOH); [REDACTED] (FEMS)
Cc: [REDACTED] (DMH); [REDACTED] (DMH); [REDACTED] (DMH); [REDACTED] (OAG)
Subject: RE: Potential Hoarder on [REDACTED]

Good Morning to All,

First, I would like to ask have we establish a time frame when we will meet on this matter? Secondly, you mentioned previous attempts were ineffective, at that time was it a group of representatives, if so, which representatives were present? or if a one-on-one conversation took place with [REDACTED]? If in fact a group of representatives were present, it may have petrified him. It may be important to reach out to him independently if in fact this has not taken place. In conference with [REDACTED] family, [REDACTED] retired last year from the federal government after 40 years of service, as an Analysis for the Executive Suite of the White House, clearly something went wrong here. I have reached out to DC Fire, [REDACTED] and [REDACTED] of DOH to assist in this matter.

Best regards,

[REDACTED]

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From: [REDACTED] (DCRA)
Sent: Wednesday, June 30, 2010 2:05 PM
To: [REDACTED] (OAG); [REDACTED] (EOM); [REDACTED] (DPW); [REDACTED] (EOM); [REDACTED] (DCRA)
Cc: [REDACTED] (OAG)
Subject: RE: Potential Hoarder on [REDACTED]

[REDACTED]

Thanks for all your help.

[REDACTED]

Please see if you can arrange for all the stakeholders to meet at the site tomorrow at approx. 2pm to execute the warrant. In particular I think we will need someone from the CPEP program from DC Gen Hosp. I believe that the DOH folks can put you in touch with them. MPD will be the ones to actually serve the warrant; so they will need to be on hand as well. DCFD to make the fire danger call.

Has any contact with the relatives been made? They should at least be made aware of the activity that will be happening.

Any questions please feel free to give me a call.

From: [REDACTED] (OAG)
Sent: Wednesday, June 30, 2010 12:39 PM
To: [REDACTED] (EOM); [REDACTED] (DPW); [REDACTED] (EOM); [REDACTED] (DCRA); [REDACTED] (DCRA)
Cc: [REDACTED] (OAG)
Subject: RE: Potential Hoarder on [REDACTED]

Hello All. [REDACTED] came to the office this morning, and a search warrant was obtained. The warrant is for DCRA's access to the premises. It cannot be used for other agencies to have unlimited access. In light of the situation, of course, it is essential to have other pertinent and required members present to 8/18/2011

From: [REDACTED] (EOM)
To: [REDACTED] (DCRA)
Cc: [REDACTED] (DCRA); [REDACTED] (DCRA)
Sent: Wed Sep 01 12:37:34 2010
Subject: [REDACTED]

Good Afternoon [REDACTED]

Have we made any moves on [REDACTED] to fix [REDACTED] toilet? If not, what immediate steps can we take to resolve this issue? [REDACTED] continues to defecate and urinate outside of his home and on his porch.

Thank you,

[REDACTED]

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-----Original Message-----

From: [REDACTED] (OAG)
Sent: Wednesday, September 08, 2010 10:59 AM
To: [REDACTED] (DCRA)
Subject: RE:

I recall this property. Has anyone gone by again and attempted to gain access voluntarily by the homeowner? I assume you all want access to see whether he has water in the home. The last I recall is that he does in fact have water, and his bill was extremely low because he did not use water. Additionally, after executing the warrant, reportedly an abatement team was supposed to work with the homeowner, so I am curious to know first the basis for needing access (outside of him using the bathroom outside, which he was doing previously) and the status of the abatement team and efforts to work with this individual.

[REDACTED]

From: [REDACTED] (EOM)
Sent: Monday, January 31, 2011 11:11 AM
To: [REDACTED] (DCOA); [REDACTED] (DCOA); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DPW); [REDACTED] (DHS); [REDACTED] (DMH); [REDACTED] (DCRA)
Cc: [REDACTED] (EOM); [REDACTED] (DCRA); [REDACTED] (DCRA)
Subject: [REDACTED]

Good Morning All,

A few months ago, we worked together to address the concerns listed below from [REDACTED] regarding his neighbor [REDACTED]. Apparently, his habits have not changed and there is an ever-present concern that he poses a risk to himself. I am hoping that we can come together and find a solution for this case.

At last look, I had requested an update from DCRA [REDACTED] regarding the repair of [REDACTED] toilet in his home. I am not sure this is the point from which we can pick it back up, but any insight or assistance you can provide would be greatly appreciated.

The email below includes some summary background information on the case.

[REDACTED]

Executive Office of the Mayor
Mayor's Liaison to Community Relations and Services - Ward 4
1350 Pennsylvania Avenue NW, Ste 327
Washington, DC 20004-3003

c: [REDACTED]
[REDACTED]

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From: [REDACTED] (EOM)
To: [REDACTED] (EOM)
Cc: [REDACTED] (EOM)
Subject: Re: [REDACTED]
Date: Wednesday, February 02, 2011 8:13:52 AM

In this specific case, how do we normally handle this situation?
Do we go out with the psychiatrist or just let them handle this?

Any input?

[REDACTED]
Mayor's Office of Community Relations and Services
Ward 4 Liaison
[REDACTED]

From: [REDACTED] (EOM)
To: [REDACTED] (DOH); [REDACTED] (MPD); [REDACTED] (EOM); [REDACTED] (EOM); [REDACTED] (DHS); [REDACTED] (DHS)
Cc: [REDACTED] (DCRA); [REDACTED] (MPD); [REDACTED] (MPD); [REDACTED] (DMH)
Sent: Wed Feb 02 07:58:22 2011
Subject: Re: [REDACTED]

We also kindly ask DMH to please re-evaluate the client.

From: [REDACTED] (EOM)
To: [REDACTED] (DOH); [REDACTED] (MPD); [REDACTED] (EOM); [REDACTED] (EOM); [REDACTED] (DHS); [REDACTED] (DHS)
Cc: [REDACTED] (DCRA); [REDACTED] (MPD); [REDACTED] (MPD); [REDACTED] (DMH)
Sent: Wed Feb 02 07:49:18 2011
Subject: Re: [REDACTED]

Thanks, [REDACTED]. We appreciate DHS assistance in this matter.

From: [REDACTED] (DOH)
To: [REDACTED] (EOM); [REDACTED] (MPD); [REDACTED] (EOM); [REDACTED] (EOM); [REDACTED] (DHS)
Cc: [REDACTED] (DCRA); [REDACTED] (MPD); [REDACTED] (MPD); [REDACTED] (DMH)
Sent: Wed Feb 02 07:36:51 2011
Subject: RE: [REDACTED]

[REDACTED]

[REDACTED] (included) with APS has an outstanding team that may be able to assist.

[REDACTED] Bureau of Community Hygiene | Rodent and Vector Control Division | HRLA DC Department of Health | Government of the District of Columbia

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From: [REDACTED] (EOM)
Sent: Tuesday, February 01, 2011 7:33 PM
To: [REDACTED] (MPD); [REDACTED] (EOM); [REDACTED] (EOM)
Cc: [REDACTED] (DCRA); [REDACTED] (MPD); [REDACTED] (DOH); [REDACTED] (MPD); [REDACTED] (DMH)
Subject: Re: [REDACTED]

Thanks, [REDACTED] Anything we can do to end his practice.

From: [REDACTED] (MPD)
To: [REDACTED] (EOM); [REDACTED] (EOM); [REDACTED] (EOM)
Cc: [REDACTED] (DCRA); [REDACTED] (MPD); [REDACTED] (DOH); [REDACTED] (MPD); [REDACTED] (DMH)
Sent: Tue Feb 01 19:30:46 2011
Subject: RE: [REDACTED]

Thanks [REDACTED] – have we asked the office of aging to assist in this matter for outreach ...apparently DMH has stated he is NOT in need of mental health services.... What is it that u are asking MPD to do – for we would not arrest this subject due to him defecating in his house – we can go talk to him and see what is going on ([REDACTED] are u familiar with this citizen)

[REDACTED] when was last time DMH went to house ... and was MPD with you for there is nothing we can do to remove him if he is NOT a harm to himself...

[REDACTED] has DCRA received complaints on this property as nuisance/hazard... what can be done legally to address this for not a criminal act... but is PUBLIC Health issue to neighbors vs Public Safety

From: [REDACTED] (EOM)
Sent: Tuesday, February 01, 2011 4:12 PM
To: [REDACTED] (EOM); [REDACTED] (EOM); [REDACTED] (MPD)
Subject: Fw: [REDACTED]

FYI- can MPD help on this matter once again.

From: [REDACTED] (DDOE)
To: [REDACTED] (EOM)
Sent: Tue Feb 01 16:09:19 2011
Subject: FW: [REDACTED]

FYI

From: [REDACTED] (DDOE)

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Sent: Tuesday, February 01, 2011 11:29 AM

To: [REDACTED] (DDOE)

Cc: [REDACTED] (DDOE)

Subject: RE: [REDACTED]

Hi [REDACTED]: I read the letter from the neighbor, [REDACTED], and the situation sounds very sad. However, in order for us to have jurisdiction, [REDACTED] must handle a "hazardous waste" as defined by RCRA and our regulations. I did not see anything in the email traffic suggesting that [REDACTED] has handled a hazardous waste. Even if the conditions justify an emergency action, it is MPD, not DDOE, that carries out emergency actions. Apparently, MPD has done this in the past at [REDACTED] house.

[REDACTED]

[REDACTED]

[REDACTED]

Environmental Protection Administration
District Department of the Environment
1200 1st Street, N.E., [REDACTED]
Washington, D.C. 20002

[REDACTED]

<http://green.dc.gov>

From: [REDACTED] (DDOE)

Sent: Tuesday, February 01, 2011 10:33 AM

To: [REDACTED] (EOM); [REDACTED] (DMH); [REDACTED] (EOM); [REDACTED] (DDOE)

Cc: [REDACTED] (DOH); [REDACTED] (DOH); [REDACTED] (DOH); [REDACTED] (DCRA); [REDACTED] (DDOE)

Subject: RE: [REDACTED]

[REDACTED] – I'm looping in [REDACTED] Deputy Director for Environmental Services, to look into this matter.

From: [REDACTED] (EOM)

Sent: Tuesday, February 01, 2011 10:21 AM

To: [REDACTED] (DMH); [REDACTED] (EOM)

Cc: [REDACTED] (DOH); [REDACTED] (DOH); [REDACTED] (DOH); [REDACTED] (DCRA); [REDACTED] (DDOE)

Subject: RE: [REDACTED]

Dear [REDACTED]

Thank you for your help.

Can DOH please fine this individual? Will DCRA fix his toilet even though he refused? What about DDOE? Can DDO enforce under the hazardous materials clause?

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From: [REDACTED] (DMH)
Sent: Monday, January 31, 2011 11:32 AM
To: [REDACTED] (EOM)
Cc: [REDACTED] (EOM)
Subject: RE: [REDACTED]

For us to have someone detained for emergency hospitalization (FD-12) we must assess them to be likely to injure self/and or others as a result of a mental illness. And if we are able to prove this, the individual would be transported by law enforcement to CPEP or a community hospital that accepts involuntary patients (currently: United Medical Center, Providence Hospital, Washington Hospital Center, or Psychiatric Institute of Washington). The psychiatrist at the psychiatric facility then assesses the individual to see if they need to stay for treatment. We can have our MCS psychiatrist come with a team to assess [REDACTED] again whenever the time is appropriate.

[REDACTED]
Comprehensive Psychiatric Emergency Program
DC Department of Mental Health
[REDACTED]

From: [REDACTED] (EOM)
Sent: Monday, January 31, 2011 11:16 AM
To: [REDACTED] (DMH)
Cc: [REDACTED] (EOM)
Subject: RE: [REDACTED]

Thanks [REDACTED]. MCU has evaluated on a number of occasions and has "cleared" him. What kinds of strategies or solutions are available to evaluate him based on his environment (for example, hoarding behavior) and/or his hygienic practices?

Thanks,

[REDACTED]
Executive Office of the Mayor
Mayor's Liaison to Community Relations and Services - Ward 4
1350 Pennsylvania Avenue NW, Ste 327
Washington, DC 20004-3003
[REDACTED]
Ward 4 Help Desk: [REDACTED]

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From: [REDACTED] (DHS)
To: [REDACTED] (EOM)
Cc: [REDACTED] (DHS)
Subject: Hoarding Workgroup
Date: Monday, February 28, 2011 12:49:51 PM

Greetings!

It is my understanding that you are seeking whether APS will participate in the Hoarding Workgroup scheduled for March 18th, from 10-11:30. We just learned of this workgroup and would be delighted to attend. In FY 2010, APS received a significant number of hoarding cases. We certainly can benefit from the discussion. As requested, please forward all specific information pertaining to the workgroup. I will be certain to have representation present. Thank you for inviting APS.

All the best,

[REDACTED]
Chief, Adult Protective Services
Department of Human Services
Family Services Administration
645 H Street, N.E. 3rd Fl.
Washington, D.C. 20002
[REDACTED]

From: [REDACTED] (EOM)
Sent: Tuesday, February 08, 2011 11:53 AM
To: [REDACTED] (DCRA); [REDACTED] (EOM)
Cc: [REDACTED] (MPD); [REDACTED] (MPD); [REDACTED] (DCRA); [REDACTED] (OAG); [REDACTED] (DMH); [REDACTED] (DHS); [REDACTED] (MPD); [REDACTED] (DOH); [REDACTED] (EOM); [REDACTED] (DHS); [REDACTED] (DOH); [REDACTED] (DOH)
Subject: RE: [REDACTED]

Thanks, [REDACTED]

Can OAG please assist with this matter?

[REDACTED]

From: [REDACTED] (DCRA)
Sent: Tuesday, February 08, 2011 11:45 AM
To: [REDACTED] (EOM)
Cc: [REDACTED] (MPD); [REDACTED] (MPD); [REDACTED] (DCRA); [REDACTED] (OAG); [REDACTED] (DMH); [REDACTED] (DHS); [REDACTED] (MPD); [REDACTED] (EOM); [REDACTED] (DOH); [REDACTED] (EOM); [REDACTED] (DHS); [REDACTED] (DOH); [REDACTED] (DOH)
Subject: RE: [REDACTED]

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DCRA would have to go through the Office of the Attorney General to obtain a warrant. The last time we inspected this property the owner allowed us entry so we didn't need a warrant.

[REDACTED]
Department of Consumer and Regulatory Affairs
1100 4th Street, S.W.
Washington, D.C. 20024

[REDACTED]
www.dkra.dc.gov
Twitter: @dkra

From: [REDACTED] (EOM)
Sent: Monday, February 07, 2011 1:19 PM
To: [REDACTED] (DMH); [REDACTED] (DHS); [REDACTED] (MPD); [REDACTED] (EOM);
[REDACTED] (DOH); [REDACTED] (EOM); [REDACTED] (DHS); [REDACTED] (DOH);
[REDACTED] (DOH)
Cc: [REDACTED] (DCRA); [REDACTED] (MPD); [REDACTED] (MPD); [REDACTED]
(DCRA); [REDACTED] (OAG)
Subject: RE: [REDACTED]

Good Afternoon All,

At this juncture, it seems we will have to get an administrative warrant to address and evaluate the concerns of [REDACTED] and the conditions of his home. I am hoping DCRA can take the lead on this, as they did so very well last time, to put a definite end to this behavior of defecating and urinating on his porch and disposing of it in the alley and his trash receptacles.

What options do we have to bring this case to a close? I know we had considered meeting tomorrow, but it seems we will meet insurmountable resistance from [REDACTED] without some legal backing.

Regards,

[REDACTED]
Executive Office of the Mayor
Mayor's Liaison to Community Relations and Services - Ward 4
1350 Pennsylvania Avenue NW, Ste 327
Washington, DC 20004-3003
[REDACTED]

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From: [REDACTED] (DHS)
Sent: Thursday, March 24, 2011 5:00 PM
To: [REDACTED] (EOM)
Cc: [REDACTED] (DHS); [REDACTED] (EOM); [REDACTED] (DMH); [REDACTED] (DMH); [REDACTED] (DCOA); [REDACTED] (DCOA); [REDACTED] (DCOA); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DPW); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DCRA)
Subject: [REDACTED] case

Hi [REDACTED]

Here's an APS Update-

APS met with DMH Mobile Crisis Unit and their psychiatrist, [REDACTED] last month in February to assess [REDACTED]. However he refused to be evaluated fully by [REDACTED] and refused mental health services from Department of Mental Health. APS has also consulted with our Attorney, [REDACTED] regarding guardianship. [REDACTED] reported that APS cannot proceed with guardianship due to [REDACTED] being able to make knowing and voluntary decision to refuse services. APS also requested this month for DMH Mobile Crisis Unit to visit [REDACTED] after a concern from a neighbor. DMH visited [REDACTED] and assess him and he was not a threat to self or others and continues to refuse mental health services. [REDACTED] also has not adhered to DCRA assistance or directives.

From: [REDACTED]
Sent: Monday, June 13, 2011 2:26 PM
To: [REDACTED]
Subject: [REDACTED]
Attachments: 023.jpg; 024.jpg; 01062011326.jpg; 01062011327.jpg

Dear [REDACTED] I hope all is well for you. FYI, as of to date there has been no other dumping behind this property.

The other major problem is my dear neighbor [REDACTED]. [REDACTED] is an elderly gentleman who is unable to maintain his property in side or out. This is beginning to affect my property in that now the rats have eaten their way over to my home. An exterminator has found holes in the adjoining wall to [REDACTED] home. [REDACTED] uses the bathroom on his front porch (see pictures). I dont know if he does not have running water or if he has problems with his plumbing. I have seen the city over at [REDACTED] to clean his yard and porch. The rodent problem is very bad and the family staying in my home (they have not been very clean) has attracted this problem to my home. An exterminator's charge is about \$350.00 (money I dont have) to eradicate the problem.

I have tolerated this for a number of year now. This is unsanitary, not healthy and is an eye soar for me, and is bring the property market value even lower. My assessment however is still high though. I just dont know where to start. I have contacted the Health Department in the past. They (HD) indicated that they were addressing the issues and that other neighbors had called about getting [REDACTED] some help.

I have other pictures and will send to you when i find them.

[REDACTED]

APPENDICES

From: [REDACTED] (DHS)
To: [REDACTED] (EOM); [REDACTED] (DOH); [REDACTED] (EOM); [REDACTED] (DMH); [REDACTED] (OAG); [REDACTED] (FEMS); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DHS)
Sent: Tue Jun 14 18:27:50 2011
Subject: RE: [REDACTED]

Greetings,

This case is known to Adult Protective Services. We have collaborated with several sister government agencies to address the issues of [REDACTED]. Further, we have addressed the client's issues with our attorney who indicates that the circumstances surrounding this case cannot be addressed by APS. APS has attempted to have the client assessed for mental capacity and he refused to allow the psychologist to conduct the assessment. Consequently, APS has been unable to determine capacity. Because we have been unable to determine capacity, this decreases our ability to petition the Court for guardianship.

Regards,

[REDACTED]
Department of Human Services
Family Services Administration
645 H Street, N.E. 3rd Fl.
Washington, D.C. 20002
[REDACTED]

From: [REDACTED]
Sent: Thursday, June 23, 2011 1:54 PM
To: [REDACTED] (DMH); [REDACTED] (FEMS); [REDACTED] (DCRA) ([REDACTED]); [REDACTED] (DCRA); [REDACTED] (DOH); [REDACTED] (DCOA) ([REDACTED]); [REDACTED] (OAG)
Cc: [REDACTED] (EOM) ([REDACTED]); [REDACTED] (EOM) ([REDACTED])
Subject: Request for Meeting: Hoarding Workgroup Case Assessment *INTERNAL AND CONFIDENTIAL*
Importance: High

Good Afternoon All,

Since the advent of our initial meetings of the Hoarding Workgroup, I have been referred four hoarding cases. I thought it may be helpful if we reengaged each other as a workgroup and meet to assess these cases:

- [REDACTED] NW (resistant to assistance, stalemate with repairs, neighbors now reporting)
- [REDACTED] (new, self-referral)

APPENDICES

[REDACTED] (time sensitive, apartment managers are being unresponsive on date of next inspection)
[REDACTED] (Leave voicemail weekly, constituent has not returned call – may be nonworking number?)-

It is my hope that we can all devote some time to flesh out a plan for each of these cases, schedule inspections with each according to an appropriate timeline, and create an action plan to see these cases through. They are each unique in their own special ways, with idiosyncrasies all their own. At the suggestion of OAG, please also request the attendance of your respective General Counsels.

It is of critical importance that we meet before the end of next week. Monday or Tuesday morning work on my end. Please Reply-All if either of these work for you.

Many thanks!!

[REDACTED]
Executive Office of the Mayor
Mayor's Liaison to Community Relations and Services - Ward 4
1350 Pennsylvania Avenue NW, Ste 327
Washington, DC 20004-3003
[REDACTED]

From: [REDACTED]
To: [REDACTED] (DMH); [REDACTED] (FEMS); [REDACTED] (DCRA); [REDACTED] (DCRA); [REDACTED] (DOH); [REDACTED] (DCOA); [REDACTED] (OAG)
Cc: [REDACTED] (EOM); [REDACTED] (EOM); [REDACTED] (DCRA)
Subject: RE: Request for Meeting: Hoarding Workgroup Case Assessment *INTERNAL AND CONFIDENTIAL*
Date: Monday, June 27, 2011 12:22:21 PM
Importance: High

Good Afternoon Partners,

I am reengaging a second time to schedule a meeting for the hoarding workgroup. I am also imploring your assistance in the case of [REDACTED] – I need FEMS' support specifically – for our inspection on Thursday.

I have engaged this group on a number of cases, and overall hear back from one or two agencies. **We do it better together**, and you are an essential piece of our puzzle. Please review the email below and let's schedule this meeting as soon as possible – we are time and patience constrained and there are people depending on us.

[REDACTED]
Executive Office of the Mayor
Mayor's Liaison to Community Relations and Services - Ward 4
1350 Pennsylvania Avenue NW, Ste 327
Washington, DC 20004-3003
[REDACTED]

APPENDIX 3

(Template for D.C. Superior Court “Report of Examiner.” In particular, the reader should note that if he determines a subject is incapacitated, the examiner is asked to specify the nature of the incapacity, e.g., “the subject lacks the capacity to take actions necessary ... to provide personal hygiene and other care without which serious physical injury or illness is more likely to occur.”)

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

PROBATE DIVISION

In re: _____ INT _____
_____ IDD _____

An Adult

REPORT OF EXAMINER

EXAMINER'S INFORMATION

Name: _____

Address: _____

Phone: _____ Fax: _____ Cell: _____

Discipline:

- Physician (please list specialty)
- Nurse Practitioner
- Social Worker
- Psychologist
- Other: _____

List any certification, experience, area of specialization or other qualifications relevant to your examination of the subject and preparation of this report.

EXAMINATION INFORMATION

[Attach additional information, as needed.]

Date(s) of subject's examination: _____

Place(s) of examination: _____

Length of time spent with subject: _____

APPENDICES

List diagnostic tools used, if any, (e.g. Mini Mental Status)

- See attached medical records.

Please list other people interviewed in connection with this examination. Include names, relationship to the subject, and any available contact information.

BACKGROUND INFORMATION

(Subject's demographic history, available medical history, present situation)

Gender _____ Age _____

- See attached medical records.

[Please use a format appropriate to your professional specialty area. Attach additional pages or documents as needed.]

ASSESSMENT OF CAPACITY OR INCAPACITY

1. The subject **does not have a mental or physical impairment** which affects his or her ability to receive and evaluate information effectively or to communicate decisions regarding assets, property, and finances or to meet his or her essential physical health, safety, habilitation, or therapeutic needs.

Indicate any facts that might support a contrary assessment:

OR

2. The subject **has a mental or physical impairment**, but **presently has the capacity to** receive and evaluate information effectively or to communicate decisions regarding assets, property, and finances, or to meet his or her essential physical health, safety, habilitation, or therapeutic needs.

Describe the specific nature of the impairment and the basis for this assessment. Indicate any facts that might support a contrary assessment:

OR

April 2010

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APPENDICES

3. The subject **has a mental or physical impairment** and because of the impairment(s) the subject of this proceeding is an adult whose **ability to receive and evaluate information** effectively or **to communicate decisions is impaired** to such an extent that:
- a. the subject lacks the capacity to take actions necessary to obtain, administer, and dispose of [check all that apply]
- real and personal property, intangible property, business property,
 - benefits and income.

Describe the specific nature of the incapacity and the basis for this assessment. Indicate any facts that might support a contrary assessment:

- b. the subject lacks the capacity to take actions necessary [check all that apply]
- to make health care decisions,
 - to provide health care,
 - to provide food, clothing, and shelter,
 - to provide personal hygiene and other care without which serious physical injury or illness is more likely than not to occur.

Describe the specific nature of the incapacity and the basis for this assessment. Indicate any facts that might support a contrary assessment:

- c. the subject lacks the capacity to meet all or some essential requirements for his or her habilitation or therapeutic needs.

Describe the specific nature of the incapacity and the basis for this assessment. Indicate any facts which might support a contrary assessment:

If the subject is incapacitated, assess his or her potential for regaining some or all capacity:

If the subject is incapacitated, identify any factors which would argue against this Court's intervention on the subject's behalf (e.g. community or family support systems):

APPENDICES

Other Comments or Recommendations:

Signature of Examiner

Date

License # and State

Court-appointed examiners must serve a copy of this report by first class mail upon all persons listed on the order appointing the examiner.

CERTIFICATE OF SERVICE

I hereby certify that on the _____ day of _____, 20____ this report was sent by first class mail, as is required by Superior Court, Probate Division Rule 326, and,

- faxed
- served in hand

upon the following persons entitled to receive service in this case.

- See attached Service List
or list persons served here:

Signature of Examiner

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
PROBATE DIVISION

In re: _____ INT _____
 _____ IDD _____

_____ An Adult

SERVICE LIST

[List names and addresses, of persons entitled to service. See Superior Court, Probate Division Rule 326. Phone and fax numbers may be included, if known.]