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Democracy Dies in Darkness

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Forest Haven Is Gone, But the Agony Remains

District's Elaborate System of Group Homes
Perpetuates Exploitation, Abuse of Retarded

BY KATHERINE BOO

Washington Post Staff Writer

Elroy lives here. Tiny, half-blind, mentally retarded, 39-year-old Elroy. To find him, go past the counselor flirting on the phone. Past the broken chairs, the roach-dappled kitchen and the housemates whose neglect in this group home has been chronicled for a decade in the files of city agencies. Head upstairs to Elroy's single bed.

"You're in good hands," reads the All-state Insurance poster tacked above his mattress — the mattress where the sexual predator would catch him sleeping. Catch him easily: The door between their rooms had fallen from its hinges. Catch him relentlessly — so relentlessly that Elroy tried to commit suicide by running blindly into a busy Southeast Washington street.

These days, reconciled to living, Elroy has fashioned ways to cope. He keeps private amulets against a misery he doesn't fully grasp. There's the leatherette Bible he

can't read; the Norman Rockwell calendar of family scenes he hasn't known.

And there's his strategy of groping his way down to the bare-bulbed basement again and again to wash the sheets from his violated bed, as if Tide could cleanse defilement. "God is a friend of mine," he says. But absent divine intervention, "you just gotta do what they say." Just got to add soap powder, and more soap powder, turn the dial to hot. "Gotta not let the worries pluck your nerves."

A decade ago, the District government, compelled by a federal lawsuit, carried out a celebrated rescue of some of its most vulnerable citizens. It closed Forest Haven, the notorious asylum for the retarded in Laurel, where Elroy had grown to adulthood. In its place, the city fashioned one of America's costliest reform efforts for the retarded: dispersing Forest Haven's 1,100 residents, and the other people subsequently committed to city care, into small, privately operated group homes scattered

throughout the District. This new, community-based system would provide sensitive, individualized care in homelike settings -- care monitored by a large network of city and federal protectors.

But today this reform is failing. In the 1990s, District and federal taxpayers have unwittingly financed a system marked by municipal ineptitude and private profiteering: a system that has fostered abuse and even death. An investigation by The Washington Post — which included visits to group homes and the therapeutic programs where the retarded spend their days, examination of tens of thousands of records, and interviews with retarded men and women — found:

More than 350 incidents of abuse, neglect, molestation or stealing have been documented in group homes and day programs in the '90s, according to the records of four District agencies and federal and D.C. courts. Those serious incidents involved companies that collectively run 70 percent of the city's group homes. Yet in that time, the District government levied not a single fine against a facility operator for maltreating the retarded.

A convicted embezzler, a psychologist who billed the government for treating the dead and a man who paid go-go dancers as "group home consultants" were among those paid by the District to run group homes and therapeutic programs for the retarded.

In the name of taxpayer-financed "day treatment," some of the District's retarded

wards were dispatched by the city to work for wages as low as 50 cents a week — work for which their day-program owners profited through private contracts. Other retarded people, in the name of therapy, shoveled manure at a group home operator's private farm. One man was locked for months in a "private treatment room." Others languished with no day treatment at all.

The District official responsible for overseeing such day programs for most of the '90s ran a travel business for the city's retarded on the side and bought a private home for the use of a treatment program operator he supposedly supervised.

The cost of this publicly funded system of care — group homes, day treatment, medical services — is about \$100,000 per person per year. Elroy is one of the system's 1,100 current beneficiaries: retarded people who, for financial, developmental or other reasons, aren't being cared for by relatives and can't live on their own. Each is assigned to one of the city's 150 group homes, most of which are run on a for-profit basis by health care entrepreneurs. Some of the homes offer competent and affectionate care, city records and home visits indicate. But behind the nondescript doors of other group homes lives a reminder of why Victorian reformers erected vast asylums in the first place: to prevent abuse and exploitation of the retarded in a community's darker corners.

Presented with The Post's findings, city officials professed ignorance of many specifics but acknowledged systemic short-

comings such as poor monitoring, miscommunication among agencies and a failure to fine companies that neglect or mistreat the retarded. "The situation didn't get this way overnight," said Department of Human Services Director Jearline F. Williams, who has overseen the agency since 1997. "And it's going to take some time to turn this around. But I assure taxpayers that there will be dramatic and visible improvements."

Elroy has endured the District's caretaking inadequacies since he was a toddler. The Post is withholding his last name for privacy reasons, because he has been sexually victimized. He lives in a group home run by entrepreneur Rollie Washington and his wife, Dorothy. Real estate records note that there are 11 bathrooms in the million-dollar Upper Marlboro "Manor Farm" where the Washingtons make their home. A city report recently noted that the home they provide for Elroy had no toilet paper. It did have vermin and broken furniture and, city records show, a long record of ill-serving its inhabitants. The Washingtons' company wasn't licensed to do business in the District from 1993 until late 1998, records show. Still, the city government paid their company millions of dollars over those six years for the services they provided Elroy and others.

The world of "simple" people is in truth a complicated place: Words elude, stories shift, times and places blur. But a tour of that world fixes one fact pretty firmly: Even people with IQs of 50 know this isn't the

way life is meant to be.

The Altruist's Dream

In 1991, when the District turned out the lights at the red-brick Laurel campus called Forest Haven, the impulse to reform was unassailable: The failures of the past were imprinted on the curved spines of the asylum's elderly, on the compulsively rocking torsos of its unheld young. No more large public institutions for the mentally retarded, the new social policy imperative held, conjuring a kinder, more familial form of care.

For some of Elroy's friends, the policy revelation arrived too late: They left by way of Forest Haven's basement morgue. But Elroy and a thousand others survived to reap the fruits of a federal lawsuit pressed since 1976 by the parents of several residents. In 1990, a judge began fining the city heavily to force a shutdown, and the Justice Department's Civil Rights Division joined the parents' suit, launching its own investigation of poor medical care at the asylum. Meanwhile, city and federal officials — recognizing that the retarded can't defend their own civil rights and that many have been abandoned by their best protectors, their families — erected a labyrinth of organizations and agencies to protect them.

Each retarded person would receive from the city an annual, individualized plan for therapy and services in a group home and in a separate day program. Ex-Forest Haveners would even be guaran-

teed a regular vacation. Court-appointed monitors and lawyers, trained personal advocates and other designated protectors would ensure that the city delivered this promised care.

But who exactly would take them in -- some drooling and vacant and crib-bound, a few given to eating their own clothes, none unmarked by their institutional experience? In the beginning, altruists stepped forward, as expected: groups like the religious, nonprofit Community of the Ark, which has operated two group homes in the District since the mid-'80s. In those Ark homes today, the walls blaze with the oil-paint issue of Saturday art classes at the Corcoran. A staff member flips flashcards to teach a resident her address. Another resident peels carrots and accepts congratulations on the second anniversary of his Arlington movie theater job. Then all gather for a pre-dinner prayer, at which well-groomed ex-Forest Haveners hold hands (and paws if you include the house cat, Milton) and sing:

*Giving me the things I need
The sun and the rain and the apple
seed.*

This is what deinstitutionalization's dreamers had in mind. But of the thousand-plus ex-Forest Haven residents, the Community of the Ark could take exactly eight.

While there were other well-motivated group home operators, the District's system swiftly came to be dominated by firms with an interest in profit. Today, more than 80

Hundreds of Abuses, Not a Single Fine

A man tied up after "making noises" and "asking for cookies." Another man locked in a "private treatment room" day after day. A woman scalded in the shower — by a staff member who then tried to cover up the wounds. Another woman starving because her for-profit group home wouldn't buy a few low-cost cans of a liquid supplement called Ensure.

These are a few of the more than 350 cases of abuse or neglect documented in District-funded facilities for the retarded in the last seven years. Thanks to a bureaucratic error, not a single fine has been levied against those who run the facilities.

A Washington Post review of tens of thousands of documents from the Department of Human Services, Department of Health, Medical Assistance Administration, Department of Consumer and Regulatory Affairs and federal and superior courts found:

190: cases of neglected medical or therapeutic treatment

80: cases of misappropriated funds

46: cases of physical abuse

44: cases of overdrugging

percent of the group homes are run by for-profit providers, some of them attracted by the city's decision — made under pressure of mounting federal court fines — to pay rates as high as \$500 a day per retarded cli-

ent, among the most generous pay schedules in the country.

In their effort to expand the network of group homes quickly, city officials entrusted most of the oversight of the new contracts to an obscure unit of the Department of Human Services: the Mental Retardation and Developmental Disabilities Administration. But that office had little monitoring staff to ensure that the claims of would-be providers had some basis in reality. Moreover, many of the caseworkers directly charged with safeguarding group home residents were former members of the Forest Haven staff — who, after years of spooning prunes or supervising calisthenics, had been haphazardly retrained and were now supposed to keep an accountant's eye on client funds and monitor medical treatment.

"In the early days, you could pretty much count on providers to be sincere about their commitment," recalls Vincent Gray, who headed the Department of Human Services when Forest Haven closed. "Then, as the dollars began to increase and the need for more homes began to increase, you began to see more people coming on the scene as a business venture. That became a serious problem. Those in it for financial gain needed much more sophisticated monitoring. But this was a system based on trust."

Running the system on trust reflected the philosophy of some advocates for the retarded, too. Desperate for the new system to succeed, they feared that criticism

of the group homes could be misconstrued as an endorsement of asylums. Betty Evans, mother of a young woman who died at Forest Haven and one of the lead actors in the federal suit, was one of many who urged restraint in publicizing troubles in the homes. "They may have problems," she recently told The Post, "but they're better than Forest Haven."

Into this fragile and forgiving civic infrastructure came entrepreneurs like Rollie Washington.

The Manor Farm

He sells stallions for a quarter million a mane. Wears a cowboy hat, collects Mercedes-Benzes. He had little experience caring for the mentally retarded. He did have experience making profits on the poor. In the '80s, he had a Department of Human Services contract to house the homeless in grim Southeast Washington apartments for which he charged the city \$3,000 a month apiece — until a city auditor objected.

As Forest Haven was closing, Washington applied for and received generous federal Medicaid funding to set up homes for retarded people with medical needs. But Medicaid officials started disputing the quality of his services and billing practices. So Washington turned to the D.C. Department of Human Services, which decided he was qualified to care for a dozen of Forest Haven's healthier cases, including mildly retarded Elroy.

The Washingtons' group homes claimed to provide special care for some

of the many ex-Forest Haveners who had emotional or behavioral troubles. But before long, records show, city health inspectors were expressing dissatisfaction with what they saw of that care: poor physical conditions the Washingtons were slow to correct and required treatments the residents weren't getting. So, in early 1996, city health inspectors urged that Elroy's home and another one Washington and his wife run be closed because of care so inadequate that its residents were judged to be in danger.

Over the following two years, a federal court monitor urgently petitioned city agencies to protect the residents. But it wasn't until late 1998, 2½ years after health inspectors requested the closure, that city enforcement lawyers met with a representative of the Washingtons' company to discuss problems at the homes. The District's lawyers subsequently declared past concerns allayed — just days before health inspectors, prompted by The Post's inquiries, returned to the homes and found and reported a level of neglect and squalor they termed "life-threatening."

In interviews, Rollie Washington declined to review documents calling his homes "deplorable" and said the city hadn't complained to him about problems in them. While he refused to discuss the specifics of his contracts, he said he provides services that meet or exceed city requirements. "If I wasn't doing what I should be doing," he said, "why would they have done business with me all these years?"

The Department of Human Services acknowledged that "it is conceivable" that it gave the Washingtons contracts while "failing to scrutinize or question the absence of other documentation," such as licenses to do business in the city. But the department did more for the Washingtons than pay their company at least \$4 million during the six years it wasn't licensed. Year after year, the department has also decided that the best "therapeutic vocational training" for several of the city's dependents is mucking out the stables and mowing the lawns at the Washingtons' "manor farm," where the couple breeds thoroughbreds to sell or race at a Bowie track. With the department's permission, these retarded farm workers last year earned, for five-hour days, five days a week, \$5 or less a day.

City records show that last year, the Washingtons received an additional \$180,000 in public money for providing this "day program."

Under the law, mentally retarded workers may be paid less than the minimum wage for work done as part of a treatment or job-training program. But in the early '90s, Human Services officials raised questions about the possible exploitation of the Washingtons' farm workers and the accuracy of claims about the therapies for which they were billing. A 1994 department investigation called for immediate improvements in services and conditions. Agency records indicate that trained monitors never returned to see whether improvements had been made. Instead, the gov-

ernment relied for information about the well-being of the workers primarily on the monthly reports of a therapist paid by the Washingtons. Rollie Washington declined to say how often the therapist was on the farm.

"I believe in reality therapy," said Washington, who notes that he recently confiscated one of his ward's shoes to keep him from running away. "If you do something wrong, you are going to have to be dealt with."

Reality: a bone-chill morning at the Washingtons' estate. At the manor house, up past the paddocks, Rollie Washington is talking with his lawyer. Down another road, Elroy's housemate DeWitt Stith labors beside a deaf-mute man who lives in another group home run by the Washingtons. They are cleaning stables in unsupervised silence. Startled by visitors, the deaf man brandishes his shovel. But gray-haired Stith sprints over, shedding his dung-smearred gloves. Stith, 52, has been laboring at this farm since 1991, despite his thick-tongued objections: "Work too hard." "Mr. Washington play too rough."

City officials say that Stith needs to be isolated at the farm because he behaves inappropriately in social settings and that he is receiving socialization therapy while training for free-market work as a stable hand. But therapists aren't in evidence. And the career ladder is equally hard to perceive: Stith has "apprenticed" at shoveling and other menial tasks five days a week for seven years. In those seven years, city

officials have noted frequently in case files their plans to find Stith better day program options. They declined to produce for The Post any documents showing that such options have been pursued. Department of Human Services officials acknowledge that, because of budget and staff cuts, they have not monitored the farm program, or many other day programs for the retarded, for four years.

In minutes, Rollie Washington will speed to the stables and order Stith back to his low-paid labor. But for now, Stith believes that the visitors have come to liberate him from the farm — free him to go, instead, to a sheltered workshop he's heard about. Elroy, he hopes, will work there, too. Together, they'll learn to make furniture. At the idea of this imaginary rescue, a toothless smile breaks over Stith's face.

"Today," he says happily, inaccurately — "today is my last day on the farm!"

Elroy's Despair

"You drop a fish into the tank who suddenly eats all your other fish up. That's pretty much how it was." The residential director of Elroy's group home, Tom Roberson, is describing life in the house for most of last year. The piranha: a heavyset Forest Haven graduate who, after being sexually abused as a youth, developed a history of sexually predatory behavior.

In 1997, D.C. Medicaid officials decided he wasn't sick enough to rate the expensive treatment he had theoretically been getting at a home operated by a nonprofit com-

pany. So the Department of Human Services sent the man to the Southeast home, where monitors and inspectors regularly decried a lack of services and therapy.

Before long, in the bathtub, in the basement, in bedrooms across the house, the man regressed to compulsive sexual behavior, according to city records and interviews with residents, staff and Rollie Washington. "He'd even come after people when they went to use the bathroom," Washington says. "The whole house went crazy."

Elroy, besieged by constant demands to participate in what the new housemate called "digging," couldn't even escape during the day. The predator, as city documents call him, worked beside him in a job-training program at a nursing facility. Elroy grew suicidal, telling staff and relatives that he was going to get AIDS and burn in hell. In 1995, while in the group home's care, he had been run over by a car on Minnesota Avenue, breaking an arm and a leg. Now, announcing his desire to die, he flung himself into the middle of the street on purpose.

He put a fist through a windowpane. He smashed his own glasses, without which — given blindness in one eye and glaucoma in the other — he was virtually helpless. Worried about his self-destructive behavior, his day program suspended him from its apprentice cleaning crew, a job that the meticulous Elroy had loved. He spent the next six months, while the city looked with little apparent urgency for a new day pro-

gram, riding around the District in a van that delivered his housemates to their day programs. Then he went home to sitcoms and some strange televised proceedings regarding Bill Clinton and "Monica Melinsky."

The Absent Protectors

How did a system with multiple layers of oversight — city inspectors, federal courts, social service caseworkers — fail Elroy and his housemates so completely?

The Mental Retardation and Developmental Disabilities Administration is the city agency chiefly responsible for making Elroy's world safe. But records turned over to The Post indicate that there were only two visits to Elroy's home by monitoring staff between 1995 and 1998. City officials privately note that there was a practical reason for casting a blind eye: During the District's mid-decade budget crises, those who served the retarded were often viewed as non-priority creditors. The Washingtons and other companies had to wait months for their promised payments, giving the District little leverage in demanding quality care.

The Department of Health also was supposed to look out for Elroy, investigating complaints and enforcing minimum safety and treatment standards at his and other group homes. But as the men suffered, their putative inspectors were otherwise engaged. Department of Health officials say that in 1997, they detailed most of the inspectors of homes for the healthy

1990: The End of Institutionalization

For decades, most of the mentally retarded in the District's custody lived at Forest Haven, a large asylum in Laurel. Care and conditions in the institution deteriorated until 1990, when a federal judge under pressure from the Justice Department forced the institution to close.

In one of its most expensive social reforms, the District relocated Forest Haven residents to privately operated group homes and set up an elaborate system to ensure that they received more compassionate care.

1999: Community-Based Care

The structure: The District now cares for 1,100 mentally retarded residents in a network of 150 group homes run by nonprofit or for-profit companies. In the last decade, the city has spent more public money on community care, per capita, than anywhere else in the country.

The residents are divided into two categories based on their needs:

Medically fragile: Most of the District's retarded — about 700 — need special medical care for conditions that range from mental illness to cerebral palsy. Their treatment is funded by the federal Medicaid program. They are housed in group homes known as intermediate care facilities run by 26 contractors; the rates per patient vary according to needs — from \$134 to \$415 per day per resident. During the day, these needy clients go to Medicaid-funded treatment programs. The price tag for these programs is \$80 million per year, about \$112,000 per retarded person.

Healthy: About 400 retarded residents are considered physically capable of living in community residential facilities. The District contracts with private vendors to run these less-specialized group homes and offer therapeutic services or jobs.

mentally retarded to child-care centers, following a Post report about life-threatening conditions in those facilities. For more than a year, Health Department officials acknowledge, many of the 33 group homes for the high-functioning retarded — as well as the city's 170 group homes for the mentally ill and the elderly — went virtually unmonitored.

Even when agencies do investigate reports of abuse in group homes, they often don't get very far. Homes often attribute bruises and bloody lips to accidents or self-mutilation. Rapes get described as consensual sex. Those explanations may in some cases be accurate. But when they aren't, the few clients competent enough to describe what happened may choose, as Elroy does, not to make waves. "I don't think on the negative stuff," he says. "Although I might get hit by a car sometimes," he adds with what sounds like hope.

Advocating on behalf of a reluctant or incapable client: This is where certified personal advocates were supposed to come in. District law mandates that a trained volunteer be assigned to every retarded person in the custody of the city: to visit the group homes and day programs regularly, to listen to the retarded and to convey what they see and hear to city and court authorities. But the once-vibrant advocates program has foundered. There are currently 148 certified advocates, which works out to about one for every seven retarded wards. And many of those certified advocates are inactive. (Two-hundred of the District's

group home residents aren't promised an advocate at all because they haven't been officially committed to the city's care; they've been "assigned" to the system by relatives or have entered voluntarily.)

"When you have a system with so many structural problems," says John Connelly, a veteran lawyer for the retarded, "it's even more critical to have people with a genuine interest in the retarded coming in, looking with fresh eyes. But I haven't seen an advocate in years."

In addition to individual advocates, the federal court employs a nonprofit group as a "special monitor" to make sure that Elroy and the other surviving Forest Haveners are getting the services promised to them when the institution closed. Since 1995, that monitoring agency — the District of Columbia Arc Inc. (not to be confused with the Community of the Ark) — has sent Human Services officials, health inspectors and court representatives numerous urgent missives about the Washingtons' homes, detailing "serious questions of institutional neglect" and "serious concern" for the health and safety of residents. These chronicles of maltreatment do not include the havoc created by the sexual predator, about which the monitoring agency failed to learn.

But city officials are often slow to address the quality problems the monitor finds. And while the federal court can fine the District for failing to provide decent services, the plaintiffs in the Forest Haven case have pressed the court much harder

on the issue of timely payments to providers, some of which are shoestring nonprofits. In the '90s, judges have fined the city stiffly for being late with payments to operators such as Rollie Washington. But they've never assessed a fine for poor treatment of the retarded.

The staff of Elroy's group home didn't inform city authorities of a crisis at the home until about six months after the predator's arrival, city records show. Residential director Tom Roberson says the staff initially considered the sex consensual. Then, he says, "we waited to see if [the predator's behavior] was an aberration." The home finally informed the Department of Human Services in April 1998, but the city took no action to rescue Elroy and his housemates. Nor did it in May, when city records indicate that the predator's behavior had become so uncontrolled that he had to be taken to D.C. General Hospital's Emergency Psychiatric Response Unit — where he was evaluated and returned home to the room next to Elroy's. For the next two months, the acts that city officials summarized as "threats to harm himself and others, and persistent sexual advances" escalated. They also increasingly targeted Elroy, according to a graphic report the group home submitted to Department of Human Services officials.

But the department did not notify residents' families or court-appointed attorneys of the damage the predator was inflicting. And it waited until Aug. 31 to move him out of the home — nearly a year

after the attacks began, and five months after city officials learned there was a problem. One staff member describes those months like this: "so terrible, so sexualized, I dreaded going into the house."

Roberson concurs, laughing: "I mean, he was incessant. He could go forever. I told people, man, I want a prescription for whatever this guy's taking. This stuff is better than Viagra!"

Victim or Perp?

As Elroy sank into despondency, the agitation of his emotionally troubled friend DeWitt Stith spiraled. Earlier in the year, Stith had been disturbed to find rats in his bedroom. Now the predator was in there, too.

Stith repeatedly tried to escape from the home and his labor at the Washingtons' stables by standing in the street and faking seizures. Several times, these performances got him into a hospital, where he basked in the care of nurses until the group home staff found him and took him home. Once, he made his way to a police substation on Pennsylvania Avenue SE, where he lay on the ground by the entrance in the hope of getting an officer's attention. He was found, not by officers, but by a group home staff member. Returned, he grew defiant, violent — once beating his roommate so badly the elderly man had to be hospitalized.

He was treated with the "reality therapy" of the farm, where — despite his passionate protests during his annual assessment hearing last fall — the city assigned

him for another year.

The predator who hounded Stith now has a new residence: a home on 13th Street NW, where his room is down the way from a retarded man with stomach cancer.

Stith has a new residence, too: the D.C. jail. In January, he escaped the van that was taking him to the farm and traced a familiar arc of sexual abuse: The victim became an alleged perp. He was arrested a day later on a charge of molesting a 12-year-old retarded boy.

'We're All Scattered Now'

"RETARDS" reads a slash of paint on a door of the Forest Haven cottage where Elroy, Stith and the other "kids" used to live. The abandoned gym where they danced the mashed potato is now white with asbestos frost. About this ghost-place, a thousand case files lie discarded. Here is Elroy's. Here is Stith's, and the predator's — clinical case jottings about subjects who once were children.

Elroy, that bit of a boy in outsize glasses, proudly leading the canteen cleanup crew.

DeWitt Stith, whom the other children chose on May Day to be the flag bearer. Who, asylum colors streaming, grinned and high-stepped his way across the grass.

Those kids are gone.

In the years after the asylum, some of Elroy and DeWitt's friends were helped, loved — even transformed — as were a retarded couple named Ricardo and Donna Thornton. After release from Forest Haven, they hooked up with one of the city's sav-

viest advocates, a D.C. government retiree named Shirley Rees who sometimes walks the city's rougher neighborhoods looking for ex-Forest Haven residents who have chosen steam grates over group homes. She had the experience to truth-squad the system; the Thorntons had enough mental capacity to take advantage of opportunities called to their attention. Nowadays, the couple lives a life as beautifully dull as any other working couple's. They finish their jobs at a hospital and a public library and head home to a tidy subsidized apartment and their non-retarded 12-year-old son, Ricky, whose warmth and brightness have stretched their minds further.

The Thorntons have tried over the years to help lower-functioning Forest Haven friends squeeze similar help from the city. Tried to believe official assurances that life for the retarded would get better. But hope is sometimes hard to hold.

"We're all scattered now," Donna says. "More than likely, people are scared."

Donna starts many of her sentences

with "more than likely." Retarded people can't always be certain that things are the way they seem. She wonders whether smarter people can make sense of what happened to the retarded after their liberation from Forest Haven.

A Saturday: Jittery Elroy travels across Southeast from his group home to the D.C. jail. A red pass lets you see a retarded man in an orange jumpsuit who sits in a fortified white cage.

Elroy has brought a greeting card for his friend DeWitt Stith. The guys in the house did their best to sign it. Its front, for some reason, is a smiley face.

Elroy and Stith converse disjointedly across a bulletproof divide. DeWitt doesn't mind the jail — hash browns for breakfast, large-screen TV, no horse manure. Elroy does mind. It has taken his friend. In this mystifying world, he is even more alone.

Stith returns to his cell.

Elroy returns to his. Bible to stare at. Bedsheets to wash.

THE CITY'S GUARANTEES

As part of the federal court action that led to Forest Haven's closure, the District guarantees former asylum residents:

Small, well-kept group homes offering personalized care.

Day programs providing stimulation, therapy or work opportunities.

Comprehensive annual assessments of psychological, physical and emotional needs.

City government caseworkers able to provide individual attention.

Annual vacations.

THE HOMES

Group homes for the retarded are scattered across the region and vary widely in quality, size and cost. But city inspectors have never fined an operator for poor care. In the last four years, the corporation counsel's office, the agency charged with taking legal action against program operators, has filed only a single case, which is pending.

Group homes are supposed to be licensed and inspected annually by the city's Department of Health. But many of the homes for the healthy retarded went unmonitored in 1998, as their inspectors were detailed to day-care centers.

THE CONTRACTORS

An investigation by The Washington Post shows that in some cases, the city awarded contracts for services to the retarded without scrutinizing the companies' performance in other states or carefully monitoring their operations in the District to ensure the health and safety of the residents.

Washington & Washington

This company is run by Rollie Washington and his wife, Dorothy. In 1996, city inspectors urged that two of their homes be closed because the residents were judged to be in immediate danger from inadequate care. At that time, and for nearly three years

afterward, the Washingtons' company wasn't legally authorized to do business in the District, as they had failed to file basic information about the business with the government. Still, the Department of Human Services paid the couple about \$4 million over those years to run group homes.

D.C. Family Services

A company owned by dentist Arthur Stubbs and his partner Sheila Gaither operates 14 group homes, including one in which a 57-year-old man died in 1997 after being drugged, and several others where medical neglect has been found. The company was paid \$6.3 million in federal funds last year, records show. The city also awarded Stubbs and Gaither a \$6.6 million welfare reform contract.

Rolli-Dot Manor Farm

The city paid Rollie and Dorothy Washington \$180,000 last year to let retarded residents work as stablehands at their \$1 million Maryland "Manor Farm." The Washingtons paid each retarded worker approximately \$5 a day to muck stalls and perform other menial tasks. Rollie Washington calls the work "reality therapy."

Brice Warren Corp.

Owner Carl Peterson ran four group homes and received around \$2.5 million in Medicaid funds a year to care for 24 clients. Peterson was found guilty in May 1997 of stealing \$430,000 in federal funds for the mentally retarded in Ohio. Auditors now can't find the books that show how he spent money the District paid him. His group homes are now operated by a new corporation, RCM, which is owned by Peterson's longtime deputy and his former partner.

Individual Development Inc.

This company collects nearly \$9 million in federal funds a year to provide care for the most-impaired mentally retarded. Under its former name, We Care Inc., it declared bankruptcy in 1995 as its officers charged each other with mismanagement of funds and sexual harassment. It is currently out of bankruptcy.

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Residents Languish, Profiteers Flourish

While Deaths and Abuse Go Unexamined,
For-Profit Operators Milk a Lax System

BY KATHERINE BOO

Washington Post Staff Writer

Frederick Brandenburg carried a Bible and lisped through ill-fitting false teeth. He loved country ballads and, unfortunately, sang them — his voice could knock starlings from the sky. His life at a Wisconsin Avenue NW group home passed about as normally as life passes for a retarded person in the care of the D.C. government. Until one winter morning.

“Alert, smiling,” noted his doctor in the last week of Brandenburg’s life, declaring the 57-year-old free of a cold. “Active and talkative,” reported a health inspector who happened, the same week, to be doing an annual inspection at the home — one of 14 facilities for the mentally retarded run by a for-profit company called D.C. Family Services. But the inspector was jarred on the second day of her visit. Brandenburg was in the throes of what she termed “a major change”: lethargy so pronounced

that she suspected he’d been drugged. The guy with opinions on everything — why University of Virginia football mattered, why old black-and-white movies are better than candy-colored new ones — could this January 1997 morning barely rise from his bed.

When the inspector inquired, a group home staff member said that Brandenburg had been sedated with Ativan, a potent tranquilizer, to calm him down for a morning appointment at George Washington University Hospital — an appointment, the staff member said, the clinic had suddenly canceled. Health inspectors later learned that the group home itself had canceled the appointment. Brandenburg remained so heavily sedated at dinner time that it took two staff members to hold him up to sip a Coke.

The next day, still lethargic, Brandenburg started sweating, breathing slowly, according to a subsequent D.C. Health Department report obtained by The Post.

No one called a doctor. No one recorded his vital signs. And the following morning — 48 hours after being drugged, and without recovering from the sedation — Fred Brandenburg was dead in his bed.

A decade ago, when retarded people died in the District's asylum called Forest Haven, in Laurel, they were removed to shallow graves in an unmarked field, from which the overflow of a nearby creek would sometimes disinter them. But in 1991, with the aid of a federal lawsuit and the U.S. Department of Justice, Brandenburg and his peers were rescued from the place that had become national shorthand for the inhumanity of large institutions for the mentally disabled. They were requited for their suffering by what was designed to be one of America's most compassionate social policy reforms. Forest Haven shuttered, they were brought home to the District and the presumptive safety of their community's watchful eye.

Today, the District's mentally retarded population is among the most deinstitutionalized in the country. More than 1,000 people under city care are scattered among 150 homelike facilities run by private contractors in neighborhoods from Chevy Chase to Congress Heights. The services the retarded receive — in their group homes, and in therapy, skills training or work programs they attend daily outside the home — cost as much, per person, per year, as four years at Harvard.

A decade into reform, however, a Washington Post investigation has found

that the ideal of compassionate care and municipal accountability has yielded to a reality of profiteering and fraud, facilitated by city agencies that have for years demanded little accountability and little human decency in return for a vast outlay of public money. For corporate wrongdoers, the consequences for cruelty and neglect have been negligible. For the city's retarded men and women — men and women who are politically, and sometimes literally, voiceless — the consequences have been swift, direct and sometimes fatal.

A review of tens of thousands of documents from four city agencies and the federal courts revealed more than 350 incidents of abuse, neglect and robbery of retarded residents in the '90s. A sampling: A man tied up after "making noises" and "asking for cookies." Clients so drugged by their caretakers they kept falling down. A woman starving because her for-profit group home wouldn't buy her what a doctor and a nutritionist were begging for — a few cans a day of a liquid supplement called Ensure. Yet none of these and other documented reports of abuse led to fines or criminal penalties against the offending group home operators.

The group home and day program operators treated with such lenience included a convicted embezzler and a D.C. nightclub owner on his way to prison. A high-level city official responsible for monitoring the quality of day programs bought a private home for a contractor he was overseeing — a popular treatment provider

who, court records allege, billed Medicaid for thousands of treatments she didn't actually deliver to the retarded in her care.

And then there are the dead. Fifty-three group home residents have died in the last three years. When retarded people died at Forest Haven during its final years, the Justice Department rushed in to investigate whether poor treatment had contributed. But of the 53 recent deaths, only three have received even cursory inquiry from the city or federal government.

Frances Bowie, administrator of the Department of Human Services agency that serves as custodian of the District's retarded wards, says the deaths are a demographic inevitability: The average group home resident is over 40, with "a lot of medical problems." But her agency refused to release the names or ages of the dead, or even summary information about how and where they died, citing privacy concerns. The Washington Post identified Brandenburg only after dozens of inquiries within the community where he died.

Operating without public scrutiny, city officials have routinely closed death cases with no more than a brief account written by an employee of the group home or day program — the entities that might be liable if poor treatment were found to have contributed. A paid representative of D.C. Family Services Inc. probably would have written the story of the death of Fred Brandenburg, too, except for happenstance: A health inspector had witnessed the prolonged sedation that preceded his death.

The Health Department's conclusions about Brandenburg's death were dark. It found that the group home staff had not only lied about one missed medical appointment, but also had withheld previous key medical treatment. Although Brandenburg had a history of heart disease, the home had failed to carry out orders by his cardiologist to increase his heart medicine and to obtain lab tests to ensure that the treatment was working.

The report didn't note a fact contained in health inspectors' own files and in the files of D.C. Medicaid monitors assigned to safeguard the federal funds spent for care of the city's sickest retarded people: In the previous two years, poor medical care had been found repeatedly in homes that D.C. Family Services runs across the city. Just three weeks before Brandenburg's death, for instance, health inspectors cited a D.C. Family Services home for delaying medical treatment to a profoundly retarded man who had received two head injuries over the course of a few days -- and who had been physically restrained by what health inspectors called "hostile staff."

Sheila Gaither, co-owner of the company, declined to comment on Brandenburg's case. Her partner, Capitol Hill dentist Arthur Stubbs, did not return repeated phone calls.

Last year, D.C. Family Services received \$6.3 million in public funds to run its group homes, records say. And last November — about the time that health inspectors cited another case of medical

neglect at Brandenburg's old home — the Department of Human Services awarded \$6.6 million to another company run by Gaither and Stubbs, this one to help welfare recipients get jobs.

Fred Brandenburg didn't even get the autopsy that, records say, his doctor requested from the city. The D.C. medical examiner didn't perform one. "If we had known the full circumstances, there probably would have been an autopsy," said Jacqueline Lee, the deputy chief medical examiner.

Health inspectors didn't refer their findings to the U.S. attorney or anyone else; they say they haven't referred a group home death to higher authorities in five years. The death certificate read: heart disease. The case was filed away. After a life of not quite being there, Fred Brandenburg was gone altogether. And the Department of Human Services assigned another retarded person to his bed.

City officials, responding to The Post's findings, acknowledged systemic failures that have hurt the well-being of the retarded after the closing of Forest Haven: poor monitoring they attributed in part to budget cuts, miscommunication among agencies and a failure to implement regulations that would allow companies that mistreat the retarded to be fined.

On documents turned over to The Washington Post under the Freedom of Information Act, city officials -- citing the privacy of the retarded -- expunged the name of Fred Brandenburg and thousands

of his peers with heavy swaths of black ink. The symbolism sears. This is a story of lives and deaths that, even in the midst of communities, remain invisible.

Swollen Into a Moon

In the red-light district around Fifth and K streets NW, a neon martini glass marks the gilt-trimmed doorway of the 360 Club. At this nightclub, or upstairs with the exotic dancers at a club called The Rogue, one could frequently find the caretaker of some of the neediest men and women who had been released from Forest Haven. Charismatic Carl Peterson, owner of the 360 Club and four group homes for the retarded, embodied two sad realities of the District's post-asylum age: the kind of entrepreneurs attracted by the city's generosity toward the retarded and the incapacity of the city to deal with them.

Peterson came to Washington in the early '90s with a PhD in physics, a dissertation on a technical aspect of quantum chemistry called "valence bond calculation" and a wandering entrepreneurial eye. It fell on the former residents of Forest Haven.

Peterson already ran a few group homes for the retarded in Ohio. And as Forest Haven closed, the District was paying some of the country's highest rates for caring for the retarded, as much as \$500 a day. Care for the city's 700 or so medically needy retarded brought in the most money: federal Medicaid funds for day treatment and residential care. The 400

healthy retarded received lower-cost, city-financed housing and treatment. Peterson chose the sick, adding a string of D.C. homes to his holdings.

He entered the District's system at a time when the role of for-profit operators was exploding. From 1985 to 1998, the number of private group homes in the District grew from a few dozen to about 150 — 80 percent of them run by for-profit companies. Some of those companies ran only a home or two; some ran more than a dozen. Peterson soon had four.

The rates that providers like Peterson receive are set by negotiation with the local Medicaid office and are theoretically based on the cost of client care. Shortly after Peterson opened his D.C. homes, Medicaid memos indicate, he requested and obtained additional money to address his clients' expensive needs. It was a tactic he had used in Ohio, whose attorney general later found that one reason his costs were high was that he was skimming off hundreds of thousands of dollars for his personal use.

By 1997, Peterson's company, Brice-Warren, was receiving \$2.5 million a year in federal funds to care for 24 D.C. clients. Meanwhile, city records show, money was disappearing regularly from his clients' private accounts — usually tiny Social Security checks that Peterson and his staff were entrusted to manage. Medicaid officials would make Peterson's company put the money back. Then the money would disappear again. (A 1998 Department of

Human Services audit of client accounts in group homes across the city noted that deductions had frequently been made from such accounts without the requisite documentation.) Meanwhile, in another corner of the city bureaucracy, health inspectors charged with surveying the homes and investigating complaints were compiling report after report of abuse and neglect in the Brice-Warren homes.

In the summer of 1996, a resident of a Peterson home on 11th Street NW arrived at her day treatment program aching, her face swollen into a moon. Beneath her clothes, 36-year-old Irene was a map of contusions. The day program staff members called the health inspectors, who went to 11th Street to look more closely at the lives of the six men and women who lived there. What they found was startling. In the same week as Irene's beating, according to their subsequent report, a neighbor reported seeing a staff member hit a woman after she declined to take a bath. Another staff member was seen chasing a retarded man down the street, threatening him with a stick and warning him of punishment with a belt. Sticks and belts weren't the only implements of discipline in the house, an employee later told investigators: One staff member preferred to give clients a blast in the face from a "chemical spray."

A week after Irene's injuries, another resident began to suffer seizures. City records say that the staff didn't dial 911 until eight hours after the first convulsion.

Health inspection records note that a year before Irene was hurt, a different neighbor of the home called the Department of Human Services to complain that clients were being abused. The agency can locate no record of an investigation. But even when agencies do earnestly investigate abuse allegations in group homes, they often don't get very far, records show. Homes often attribute wounds — the cigarette burns on one man's back, the bruises on many arms, legs and pelvises — to accident or self-mutilation. Sometimes those explanations may be truthful. And when they aren't, the clients competent enough to explain what actually happened may decline to criticize the group home staff that may be the closest thing to family they have.

Nor could the inhabitants of Peterson's homes count on the court-appointed personal advocate the District's generous protection laws mandate: a trained volunteer, assigned to each retarded ward, who visits the client's home and day program and fights to get what he or she needs. The program to recruit and train such volunteers, which is run out of D.C. Superior Court, has foundered: There are currently 148 certified advocates for nearly 1,000 wards.

The retarded did have, when Irene was hurt, diligent health inspectors on their side. Those inspectors eventually documented that four of 11th Street's six residents had been beaten or otherwise abused by their caretakers, who had also failed to

report many serious incidents and injuries in the home. But all the inspectors could do was ask Peterson for "corrective action," as they routinely ask providers when they find problems. Only when providers fail repeatedly to undertake corrections can the city revoke Medicaid funding, something that hasn't happened to a group home for the retarded in years. Nor could inspectors slap a fine on Peterson's company, like the \$100,000 penalties that can be levied on nursing homes that neglect their patients. That's because the District — whose laws permit strong monetary sanctions on facilities that maltreat the retarded -- has never promulgated a schedule of fines that would allow the penalties on the books to be imposed.

Because Peterson's funding came from the federal Medicaid program, the District's Medicaid office also was charged with monitoring his finances and program quality. But it had only two fraud detectors to monitor a budget that is bigger than that of the D.C. public schools — \$840 million today. As for the Department of Human Services, many of the caseworkers assigned to protect the well-being of group home residents were haphazardly retrained Forest Haven staff members, who were further demoralized by mass department layoffs.

There was no broad inquiry into Peterson's operations in the wake of the findings of abuse at the 11th Street group home. In fact, the Medicaid office, which is supposed to audit company billings annually, hadn't audited Brice-Warren once since it started

its D.C. operations in 1991.

If there had been an inquiry, it might have discovered that, months before Irene's injuries, Peterson had been indicted in federal court in Ohio for stealing \$430,000 in federal money intended for that state's mentally retarded — and spending those stolen funds on jewelry, go-go dancers listed as “group-home consultants” and an elaborate sound system for a Columbus strip club called Dancers and Dreamers. In May 1997, Peterson was found guilty in Ohio and sentenced to prison.

By the time Medicaid officials finally tried to examine seven years of multimillion-dollar payments made to his D.C. homes, his company had been dissolved; his books had vanished. Peterson, contacted in federal prison, declined to comment.

Marcus Veazey, supervisor of a new unit of the FBI called the D.C. Health Care Fraud Squad, says the District is a particularly difficult place to catch Medicaid corruption: “There haven't been a lot of audits of providers because the city regulators are understaffed. So you end up with providers who know they're not being looked at. Those who want to get involved in criminal activity will because they don't think they'll get caught.”

Today, a new for-profit corporation, RCM, runs the former Peterson homes. But inspection reports from the facilities ring familiar. In 1998, records

Death Among the Mentally Retarded

Over the years, there has been a lessening in the level of public interest and response when a mentally retarded ward of the District dies. In the past three years, 53 mentally retarded group home residents have died, but only three of these deaths have received even cursory investigation by the Department of Health. The Department of Human Services refused to release further information about the other deaths, citing privacy concerns. Who these people are, where they died and whether care was a factor remains a public mystery.

That stands in stark contrast to the way such deaths were probed at the beginning of the decade, when mentally retarded wards were housed at Forest Haven, a large asylum run by the District. Concerned about conditions there, Justice Department lawyers and medical consultants catalogued conditions surrounding virtually every death between 1989 and 1991, concluding that substandard medical care contributed to at least eight deaths at Forest Haven. The findings helped bring about the closing of Forest Haven in 1991 and a city settlement of \$1 million to relatives of those who died there.

Today, the Department of Health investigates the death of a retarded ward only when it perceives something unusual after reading “incident reports” about the circumstances of the death, which are usually written by the operator of the group home or day treatment program where the ward died. In one case where suspicious causes were found, health officials requested an autopsy from the District's medical examiner. But no autopsy was performed. The medical examiner's office says it was never made aware of the details of the death.

Even when the Department of Health finds that poor medical treatment is involved in a retarded person's death, it cannot fine the group home operator. It can only refer the case to the U.S. attorney's office for criminal prosecution or to the District corporation counsel's office for civil action. In the last decade, not a single case has been referred.

note a client molested by another resident who remained in the home; a patient burned as a result of staff negligence; clients given psychotropic medication without the requisite psychiatric approval; and money missing from client accounts. RCM's director, Marsha Brevard, says the company has recently poured funds into physical improvements and quality control -- efforts that have thus far staved off city attempts to penalize the homes for poor quality.

Brevard notes that Carl Peterson calls collect from time to time, from prison. The owners of the new company are Amy Brooks, Peterson's longtime deputy, and Brevard, his old partner in, among other businesses, the now-bankrupt 360 Club.

Friendly Oversight

Not far from the 360 Club, in an old school on O Street NW, sits defense headquarters for the city's retarded men and women: the Mental Retardation and Developmental Disabilities Administration of the Department of Human Services. As the group home business burgeoned, the agency was meant to provide a regulatory counterweight — to protect the retarded against indifferent providers. Sometimes, however, the agency's bureaucrats were not just bantam counterweights. They were closely involved with the profiteers. Consider what might be called the tale of two Smiths.

Every retarded person under the mental retardation administration's aegis

receives an annual assessment of what he needs to maximize his physical and mental well-being: a road map to his care. Enter Smith One: psychologist Denise Braxtonbrown-Smith, with whom the city contracted after Forest Haven's closing to help do these annual assessments. Like many of those who served the retarded after Forest Haven closed, she was an entrepreneur as well as a psychologist. Besides doing assessments, she ran her own treatment companies — which sometimes provided the very therapies she recommended for the clients she was assessing. One of those companies, Better Treatment Center, was soon charging \$175 a day per client served, by far the highest rate for day treatment in the city.

Last October, the D.C. corporation counsel charged in a civil action that from 1995 to 1998, Braxtonbrown-Smith's companies filed \$10 million in false and inflated claims for services. Taxpayer funds paid for the alleged psychoanalysis of 70 retarded people, even though the profoundly retarded are implausible candidates for analysis, and even though there are few records to indicate that clients actually saw a psychotherapist. Taxpayers also financed services rendered to clients who were hospitalized or dead, according to the District's court pleadings. In January, Smith's chief financial officer, Kenneth Strachan, pleaded guilty to criminal conspiracy in a case stemming from the false-claims scheme. He said in court papers that he helped Smith bilk Medicaid and pocket

the profits.

Braxtonbrown-Smith declined repeated requests for comment. No charges have been filed against her.

The city official charged with safeguarding the retarded in such programs was, during most of the '90s, Smith Two: Arnett Smith, the mental retardation administration's chief of day programming and no relation to the psychologist. No family relation, anyway. In 1994, real estate records show, Arnett (who was married and lived elsewhere) bought a home on Columbia Road NW for the use of Denise.

Arnett Smith says of Braxtonbrown-Smith, "I treated her like everyone else." He declined through his lawyer to answer questions about his purchase of the home where Braxtonbrown-Smith lived, which he later sold.

Arnett Smith also had a business on the side: He sold travel packages to group homes for the mentally retarded, hiring other employees of his agency as his private company's staff. The nonprofit St. John's Community Services was one of several providers that complained to Smith's superiors that they felt pressured to buy these travel packages or lose their clients and contracts. Nevertheless, Smith ran his business with city permission until he retired in 1996 — after which he went to work as a paid consultant to Braxtonbrown-Smith.

Today, he receives city funding to run a Southeast group home for the mentally ill.

A 42-year-old named Charlie John-

son was one of the retarded clients reliant on the two Smiths' care. At long tables at a 13th Street NW storefront, he and other retarded people spent several hours a day folding washcloths — labor for which Braxtonbrown-Smith earned income through contracts she negotiated with private companies. By law, people like Johnson may be paid less than the minimum wage if their work is part of a treatment or job training plan. Last fall, after the city sent Johnson to one of its better group homes, the Community of the Ark, a staff member thought to check his pay stub to see exactly how much less than the minimum wage he was getting for his labor.

Over one two-week pay period, Johnson earned 85 cents.

As Braxtonbrown-Smith's programs grew large with city money, some respected, low-cost programs for the retarded lost their clients and contracts. For instance, by the mid-'90s, Rehabilitation Opportunities Inc., a nonprofit sheltered workshop, wasn't even getting clients the city had already paid for. "For the last years, we hardly ever saw a monitor or a caseworker," said Executive Director Rory Brett, whose group now serves only Maryland clients. "There was no benefit to running a good program and no penalty for running a bad one." Arnett Smith did visit occasionally, Brett recalls — not to check on the retarded, but to drop off brochures about his travel agency.

And even when city officials do trip over a bad program, they may be forgiving.

The mental retardation administration continued to pay Braxtonbrown-Smith to care for Johnson and other retarded people for six months after being notified that the District's own lawyers were suing the psychologist for fraud.

'Work Cut Out for All'

As part of what an internal D.C. government memo calls "a media strategy to reduce the impact of [The Post's] sensitive story," city agencies have in recent months sent crews of monitors and inspectors into homes where The Post found problems. They say that important steps already have been taken to rectify systemic failures, and that more are on the way: more monitoring and quality-assurance mechanisms at the mental retardation administration; more legal action against bad providers taken by the corporation counsel, which has filed only one enforcement case involving the mentally retarded in the last four years; and more fraud-detection efforts at the Medicaid office, which last year began ratcheting down the District's high provider payments. More health inspectors to monitor group homes are also promised, although officials can't say when those inspectors will be deployed.

City officials also told The Post they will finally promulgate the necessary fine schedules so that the city can punish abuse and neglect of the retarded.

"We've got our work cut out for all of us," says Department of Human Services Director Jearline F. Williams.

One of the first jobs will be getting agencies to trade information — to begin identifying patterns of abuse or corruption that now get missed. The need for that broader view is illustrated by the recent history of the District's largest nonprofit group home provider: a company called D.C. Community Services. In the '90s, its managers have included a convicted embezzler and six others found guilty in Massachusetts of diverting money meant for the retarded to personal use.

Embezzling officers were not the nonprofit's only recurring problem. Consider the experience of a mute, severely retarded woman named Angela, who in 1997 was sent by the city to one of D.C. Community Services' 12 group homes. There was a vacancy at this Northwest Washington home because a previous resident had fallen out of the home's van and, caught in the door, been dragged face down on the pavement. A month after moving in, Angela, too, came to harm in the van. According to health inspectors' documents, a staff member pounded her head and upper body because she unfastened her seat belt. A woman driving behind the van, herself the mother of a disabled child, bravely intervened. Health inspectors substantiated her account of the beating. But bloodied Angela remained at the home.

Videotape shot at her day program two months after the incident shows her slumped and oblivious, day after day. In March, health inspectors cited D.C. Community Services for improperly drugging

her — a citation that came, as always, with no fine.

Meanwhile, the Mental Retardation and Developmental Disabilities Administration, Angela's official caretaker, was seemingly unaware of her suffering: Records it provided to The Post show that trained monitors visited her home once between 1994 and 1998. Angela's caseworker did drop in after her beating and the drugging, records show. Noting no unusual incidents involving his client, the caseworker pronounced her living situation "good."

Running D.C. Community Services at the time of Angela's injuries was a man named Steven Pullman, who had been named to the job after the previous executive director had been convicted of defrauding the government and the nonprofit's board of directors. But Pullman himself had been convicted in the late '80s of bilking the Town of Vienna in his role as its chief financial officer. He stole the money, he told the judge, to finance a \$500-a-day cocaine habit. Pullman, who declined to be interviewed, resigned from D.C. Community Services last summer — shortly after its board of directors learned that the company no longer owned many of the homes where its clients live. A civil lawsuit filed by the board alleges that, through a series of unauthorized maneuvers, Pullman converted many of the nonprofit's homes, vans and other assets to his own name. Pullman says in a counter-suit that the deals were approved by the board president, the

director of a Capitol Hill nursing home, and were appropriate.

As those charges of impropriety played out in court last year, D.C. Community Services collected about \$5 million in city and federal money.

This year, D.C. Community Services has a new executive director, Nathaniel Jenkins, who has run programs for the retarded in Maryland. He said, "I have observed personally that the care going on is excellent." He declined to comment about Angela, whose home — one of the few D.C. Community Services still owns -- appeared earlier this month in a tiny notice in the Washington Times. It was scheduled for auction because the nonprofit hadn't made its mortgage payments.

A World Without Words

Fred Brandenburg's retarded friends grieved. In his Wisconsin Avenue group home, in the day program where he played checkers and made popsicle-stick crafts, in group homes across the city where ex-Forest Haveners remember — in some quarters, there were tears long after Fred's body was taken away.

But outside the claustal realm of the retarded, his death didn't resonate much. Perhaps that was evitable: The opinionated, off-key 57-year-old retarded man wasn't a fully functioning member of society, or even one of the docile disabled who sweep up stray french fries at McDonald's. But from a certain angle, there is particular tragedy in being born with very little

and losing some or all of that.

In being 22-year-old, retarded, paraplegic Robert, who has legs the length of rulers, feet short some toes, chronically sopping Huggies — and a mind uncannily able to recall every song in the hymnal.

Given up by his birth mother, then a foster one, he now has been sent by the city to his first group home. And he, who grew up without the shaping scars of Forest Haven, whose smile says, Stay and talk: He represents whatever hope there is.

“Where do you live?” Robert asks a rare visitor, fingering his bib. “Do you love me?” He allows that he has learned his address and his ABCs. But his attempts at dinner-table conversation are interrupted. His profoundly retarded housemates have forsaken their chicken noodle soup to hurl

themselves against the living room walls.

There are benevolent laws on the books. There is money in the budget. There is magic in this lonely, miniature man. But District officials have placed him in a world without words.

One of his housemates bangs his head mutely. Another howls and pounds in need or anger. Two aides silently intervene. And Robert freezes, orange jello trembling on his spoon.

*O beautiful, for spacious skies
For amber waves of grain. . . .*

Urgently, exquisitely, Robert tries to do what his city hasn't done for him. He comforts himself. He sings, until the heads hitting drywall overwhelm.

The Washington Post

Democracy Dies in Darkness

SUNDAY, DECEMBER 5, 1999

Invisible Deaths: The Fatal Neglect of D.C.'s Retarded

System Loses Lives and Trust

Since 1993, at least 116 people have died in D.C.'s costly system of group homes for the mentally retarded—many under troubling circumstances. In 34 of the deaths, The Post found delayed treatment, neglect, false reports or other flaws.

BY KATHERINE BOO

Washington Post Staff Writer

The corpse measured 66 inches from blue toes to jutting ears. In a beige house on Tenley Circle, a dentist-entrepreneur lugged this cargo down the stairs into the basement and laid it to rest by the washer.

The body in plaid pajamas was that of a 57-year-old retarded ward of the District of Columbia. On the streets outside the city-funded group home where he had lived and died, kids sometimes called him Retard-O. Inside, he sweetened the hours by printing the name his mother gave him before she gave him up. Frederick Emory Brandenburg. He blanketed old telephone directories with that name, covered the TV Guides the home's staffers tossed aside. He

glutted the flyleaves of his large-print Living Bible. The immensity of the effort made his hands shake, but the habit seemed as requisite as breath. In this way Brandenburg, whose thick-tongued words were mysteries to many, impressed the fact of his existence on his world.

In January 1997, that existence was obliterated by his caretakers.

In one of 14 group homes for which the city pays dentist Arthur Stubbs and his partner, Sheila Gaither, \$6 million a year, Brandenburg was tranquilized in a staff mix-up, grew acutely ill and, surrounded by caretakers, slowly died without treatment. His body was washed, moved by Stubbs into the basement, and cremated without autopsy. The White Pages emblazoned with his name were dispatched to a trash can out

back. His caretakers altered the time and circumstances of his death in records they submitted to the city, house documents show. Government officials who were supposed to ensure his safety kept evidence of wrongdoing from the police. And this summer, after The Washington Post asked questions, Brandenburg's city case manager shredded records on his death. Today, in the name of the privacy and dignity of the retarded, top city officials say they can't publicly acknowledge that a man named Fred Brandenburg was ever in their care.

This erasure of a life was not an exceptional event in what was supposed to be America's most compassionate and costly effort to deinstitutionalize the mentally retarded.

As the 1990s began, a historic reform moved the District's mentally disabled wards from a large, exurban asylum called Forest Haven into a web of small, privately run group homes and therapeutic programs in the heart of the city—programs funded by more than 1 billion public dollars. But in those intimate settings, a Post investigation has found, corporate misrepresentation and city complicity have concealed the facts of dozens of troubling deaths.

In 86 cases from 1993 through September 1999 in which The Post could ascertain a cause of death, it found documentary evidence in 34—more than one-third—of delayed treatment, neglect, falsifications in reports or other lapses.

Among the dead were:

- Profoundly retarded, elderly Calvin

Nielson, fatally scalded in a home owned by a prominent developer. An aide left him alone in an overheating shower about which city inspectors had repeatedly complained.

- Herbert Scott, 43, whose decaying corpse was discovered by his caretakers only when the odor snaked under his door into a hallway.

- Antonio Silva, 16, who choked and died when counselors at his day program—the same program where 12 months earlier a boy died unattended in a hallway—couldn't locate paperwork they said they needed in order to suction his pneumonia-ridden lungs.

- Reginald Lovette, 28, who was strangled by his 250-pound roommate. For a year, his repeated pleas for protection had been disregarded by the convicted criminals who served as his group home counselors.

For these four cases, the city's Department of Human Services—the municipal custodian of D.C.'s retarded wards—produced, in seven months, exactly one record: a note from the organization that cared for Herbert Scott saying that his body had been found.

Although DHS officials told The Post earlier this year that many of the deaths had been investigated, a study of records shows that in the face of ample evidence of neglect, DHS hasn't investigated a single death of a retarded person since at least 1993. Only 14 received an autopsy—and six of those autopsies were left unfinished.

Government officials routinely closed death cases on the basis of phoned-in or brief written accounts by group home and day-program officials—accounts that, The Post found, were frequently false.

Today, city records on many of those deaths have vanished. In April, using the Freedom of Information Act, The Post requested the records of all retarded persons who died in the city's care since 1993. In June 1999, DHS released heavily edited records documenting a total of 11 deaths. Pressed, DHS officials combed files and surveyed group home operators and by October had documented 69 dead. DHS Director Jearline F. Williams said last month that she could not explain why there were no records on 47 other deaths found by The Post.

Two days ago, DHS officials turned over death certificates that they said represented 114 deaths, at least 45 more than they had previously disclosed. Most of the details on the certificates had been whited out—giving no indication of who had died, where, how or under whose care.

Among public health researchers, fatalities of wards of the state are sometimes tagged "sentinel events": Like lifeless canaries in the pit of the mine shaft, they warn of perils that may await the living. But the D.C. government has for years resisted inquiry—by the press, by a federally funded advocacy group and even by the U.S. Department of Justice—into deaths within its taxpayer-funded network of care.

"We have a sacred trust to ensure the

Scores of Deaths, No Investigations

After searching its files for seven months, the D.C. Department of Human Services, the municipal custodian of D.C.'s retarded wards, was able to document that 69 of approximately 1,190 retarded individuals in its residential care system died between January 1993 and September 1999. A Post investigation identified 47 additional wards who died during that time. The Post also found evidence of delayed treatment, neglect, falsification of circumstances or other lapses in 34 cases — well over one-third.

116 DEATHS identified by the Post investigation

69 NUMBER OF DEATHS the Department of Human Services documented by November.

8 AUTOPSIES COMPLETED by the D.C. medical examiner

0 INVESTIGATIONS DOCUMENTED by the Department of Human Services

NOTE: Studies of the mortality of the mentally retarded in community programs have found that a surge in the death rate is common in the first year after deinstitutionalization. In order to provide the least inflated analysis of death in the District in the 1990s, The Post studied deaths that occurred from January 1993, 14 months after the closing of Forest Haven, to September 1999.

well-being of our most vulnerable clients," Mayor Anthony A. Williams said in July, after blind, retarded Patrick Dutch died of heat exhaustion when his caretakers forgot him for seven hours in a locked and stifling van. But the city's own records reveal a system that, buffered from public scrutiny, failed that trust.

The Post investigation used District medical examiners' records, DHS and Department of Public Health documents, funeral home and cemetery databases, Social Security death records and more than 200 interviews with retarded people and their caretakers, families and doctors to develop an accounting of who died and how.

In interviews, top officials of DHS, D.C. police, the health department and the medical examiner's office did not attempt to defend their agencies' handling of deaths among the retarded. "The system is broken," said Jearline Williams in response to The Post's findings. "The families of the dead have my sympathy, they have the District government's sympathy."

Williams and other agency heads said that, with the help of the District's inspector general and the U.S. Department of Health and Human Services, they were working frantically to initiate structural changes and investigate abusive contractors and negligent city employees. "We can't sit back and cover up things," said Williams. "It took a long time to get to this state, and it is going to take time to fix. But I promise that there will be radical changes, starting now, to ensure that those

still in the group homes are safe. This will never happen again."

Some of the city's unrecorded dead lie in a Northeast cemetery: numbered discs, silted over, in rows by a chain-link fence. Others rest elsewhere, in unmarked group graves or plastic cartons. A tour of these shadowlands might begin with Fred Brandenburg. Although his body was cremated before burial, interviews and extant city records allow an account of his death to be exhumed.

At Forest Haven, where Brandenburg grew up, a child-size wheelchair is draped in reindeer moss. A stand of scrub oaks is shrouded in yellow steam, the off-venting of a nearby juvenile jail. If Brandenburg had died at this remote Laurel asylum in the final years before its court-ordered 1991 closing, the Justice Department would have sent in medical experts to find out why. A federal suit filed by residents' families had exposed so much medical neglect that Justice's civil rights division had joined the action, investigating every fatality.

But a 1997 death inside a D.C. Family Services house in Tenleytown—where the court rescue had eventually deposited Brandenburg—would be a far more secretive affair.

Stubbs, co-owner of D.C. Family Services, told The Post early last month that he was too busy to answer questions about Brandenburg's death, or other deaths in his homes, and did not return subsequent

phone calls. His partner, Gaither, who is the company's executive director, also did not return repeated calls. Last week, Stubbs and Gaither, through their lawyer, declined to comment.

Employees observe that Stubbs doesn't often visit the 14 homes for the retarded that had helped him buy his own million-dollar home off Foxhall Road. But on Jan. 10, 1997, his presence was required.

For two years his company's nursing staff had failed to carry out a cardiologist's orders for medicating Brandenburg's long-standing heart condition, health department records show, while improperly medicating one of his housemates with Valium. On Jan. 8, Brandenburg, who was rarely sedated, was tranquilized, too. And something went wrong.

That morning, a staff nurse gave him an injection of Ativan without the required doctor's orders, city records indicate. The nurse did so, group home records show, in the belief that another staffer would be taking him to a minor medical test that might frighten him. Brandenburg would not make it to any test. For the next two days, records show, Brandenburg couldn't stand without assistance and could barely open his eyes. He sweated and shook; staffers trying to make him eat saw bread fall from his lips, unchewed. But group home officials did not call a doctor or dial 911.

Nor did a health department inspector who happened to come to the house Jan. 8 for an annual survey of the home's quality of care. She found Brandenburg in

a stupor on a back-room couch. The home's records indicate that staff members sought to hide the extent of his incapacity. They weren't successful. Over the next two days, records show, the inspector diligently documented Brandenburg's poor condition—and her discovery that the staff had lied to her about the circumstances surrounding the tranquilization. But she left the house without taking action to secure treatment for him.

Early the next morning, his stupor ended.

House logs and other records say that counselors checked Brandenburg every 15 or 30 minutes in the early hours of Jan. 10. Then at 5:30 a.m., his breathing suddenly grew labored, they said, so they dialed 911.

But ambulance records and staff interviews indicate that paramedics who arrived four minutes after the 911 call found a body already cold. Brandenburg had been dead for hours.

Police officers arrived soon after the paramedics, as they do for sudden deaths in private homes. Officers didn't note the discrepancy between house logs and a stiff corpse, records show. Nor did they learn of the tranquilization and the discrepancies surrounding it from health inspection officials who joined them at the house, records and interviews indicate. The subsequent police report would instead cite Elliot Gersh, a pediatrician under contract with the group home company. City records show that Gersh arrived at the house three hours after the 911 call and told officers

what he would later record on Brandenburg's death certificate: that the 57-year-old had probably died of heart disease.

Gersh—who had examined Brandenburg the day before the drugging and described him in medical records as “alert, smiling” and recovered from a cold—said in an interview that health inspectors and group home officials hadn't informed him of the two days of sickness following tranquilization. He filled out the death certificate, he said, at the request of group home officials.

By law, bodies of those who die unexpectedly in private homes must be sent to the morgue for examination. To prevent evidence tampering, police are supposed to guard the body in the home until a medical examiner arrives. Gersh ordered the autopsy as required. But by noon—many hours before the pathologist appeared—police officers had departed the scene, group home records and interviews show.

In the interval, Stubbs appeared. With the help of a house counselor, group home records show, he moved Brandenburg's body from the scene of death, his second-floor bedroom, to the basement. At some point after the death, internal Family Services reports indicate, Brandenburg's body was washed, for unknown reasons.

“Totally inappropriate,” said Chief Medical Examiner Jonathan L. Arden, who assumed his position last year. He reviewed the case at the request of The Post. The file was slim: Health inspectors had not passed on what they knew about the tranquiliza-

tion and its aftermath. “This office should have been told,” Arden said.

“I am outraged, hearing this,” said Ivan C.A. Walks, the new director of the Department of Public Health, of his inspection unit's failure to intervene when the oversea-
dation was discovered or to report what it knew to police after Brandenburg's death. “I can't defend these actions.”

“We're going to have to reopen this investigation,” said Executive Assistant Police Chief Terrance W. Gainer, who also examined police records at The Post's request.

Reopening the case will be difficult. Brandenburg's body was released from the morgue and cremated without an autopsy. In an interview earlier this year, DHS official Frances Bowie, who until recently headed the department's developmental disabilities unit, explained why: Brandenburg's two sisters had refused to permit an autopsy. DHS officials said the sisters, who they said were Jehovah's Witnesses and would not identify, had religious objections to the practice.

The Post located the sisters. One of them, Gloria Donovan, is a longtime member of All Saints Catholic Church in Manassas. The other, Juanita DeButts, worships and teaches Sunday school at the First Baptist Church of La Plata. “We're not Jehovah's Witnesses, and we were never asked about an autopsy,” said Donovan, whose brother had just spent the Christmas holidays at her home. “It didn't happen.”

Bowie today says she cannot recall the source of her information about the refused autopsy, and DHS Director Williams acknowledges that agency officials have no records to support their previous assertions. Williams also confirmed that this summer, after Post inquiries about the death, case manager Dwayne Franklin shredded his records on Brandenburg's death. On Nov. 4, Franklin was fired for the shredding.

In an interview, Franklin, who had been rated "excellent" in a job evaluation this year, admitted destroying some documents and otherwise not acting on what he considered obvious and suspicious inconsistencies surrounding Brandenburg's death. But Franklin said that DHS officials, fearing bad publicity, were making him a scapegoat for doing what superiors consistently encouraged case managers to do: "hush up problem deaths and other screw-ups."

"Sad to say, our division didn't care who died or when or how, so they didn't give us the tools to investigate," Franklin said. "The truth is that the agency was sloppy from the top on down, and clients paid for it in illnesses, rapes and deaths."

The city delivered another client to Brandenburg's empty bed, records show. Stubbs and Gaither kept collecting \$6 million a year in public money to care for the retarded. And none of the many city officials who knew about the tranquilization, the slow death and the evidence of corpse-tampering breathed a word to the family

members whose names Brandenburg had struggled to record beneath his own in the leaves of his Living Bible.

"This is devastating." The voice of Brandenburg's sister Gloria breaks. "They all told us Fred died in his sleep."

It was meant to be a decade of recompense, with progressive laws and ample funding marshaled to the mission. After Forest Haven, in group homes from Cleveland Park to Capitol View, long-warehoused individuals would realize their potential to live, learn and work under the protection of their community's watchful eye. A Post series in March chronicled how, when profit-minded entrepreneurs flocked to a suddenly lucrative field, taxpayer-financed protections succumbed to crasser interests. A muddy stretch of Section T in Northeast's Glenwood Cemetery offers a useful vantage from which to view the reform effort's least revocable failure.

Here, shadowed by sweet-faced marble angels and 19th-century mausoleums, lie the District government's unmonied or unclaimed dead: pressed-wood or aluminum coffins packed tight in narrow lots, for reasons of municipal economy. A plastic disk numbered "192" marks the grave of James Scott, a man whose December 1994 death has carved a particular trace in the minds of the retarded men and women who survived him.

He passed the days as a food-service trainee at a for-profit company, PSI, that runs the city's largest day program for the

retarded. He didn't say much, this bald 55-year-old with autistic tendencies and off-brand sneakers, while packing tuna-on-white into plastic wrap. He wasn't too much trouble, either, former counselors recall, until the lunch time when his caretakers fatally injured him.

As Scott's retarded peers watched, PSI therapists physically "restrained" him after he became "agitated" and threatened a program mate, according to reports staffers wrote at the time. Their attempts at restraint dislocated his spine and paralyzed him, according to reports that D.C. General physicians wrote later. But after injuring him, PSI records show, staffers attributed his "rag doll" stance and his guttural cries of "Arm, arm!" to "behavioral hysteria."

Nearly two hours passed, PSI and ambulance records show, before his caretakers dialed 911. Hospitalized in intensive care, Scott died four weeks later. And one by one, the agencies that had been assigned to protect him averted their gaze.

The police vowed to investigate a death that the medical examiner's office, after an autopsy, classified as homicide. Five years later, Assistant Chief Gainer examined the file and expressed dismay: "This case got lost in never-never land."

DHS officials said, after Scott's death, that they would investigate whether PSI was using excessive force on some of the disabled people it receives \$10 million a year to care for. But court records show that DHS's chief overseer of day programs at the time, Arnett Smith, was busy with pri-

vate side deals with numerous group home operators (including Stubbs, who hired Smith as a consultant when he applied for public funding for his new group home network). Smith, who declined to comment, was recently indicted on federal conspiracy charges after The Post reported that he bought a private home for another day program operator—a psychologist now charged with Medicaid fraud—while he was supposed to be monitoring her.

Reports of at least 18 other PSI injuries accumulated in government files: a woman beaten with a baseball bat by counselors, for instance, and another woman injured, as Scott had been, when staff members restrained her. The promised investigation never materialized. "It appears we didn't do one," said DHS spokeswoman Madelyn Andrews.

Each retarded ward has a court-appointed lawyer designated to represent his interests. Records show that DHS officials didn't locate Scott's. Each former resident of Forest Haven gets an extra level of protection: a federal court monitor assigned to make sure he gets the services the city has promised him. DHS didn't inform the monitor of Scott's death until this September, five years after the fact. And DHS delegated the task of notifying his relatives to the owner of his group home, an entrepreneur named Carl Peterson who had previously pocketed his clients' small disability checks, health inspection records show. He would subsequently go to federal prison, convicted of spending public funds

meant for the retarded on go-go dancers he called "group home consultants."

No relatives were found. No criminal charges or administrative fines were levied against employees or officials of PSI. And the city appropriated Scott's savings—the disability payments that hadn't been stolen—to finance his funeral, which was held at a mortuary owned by a DHS caseworker's husband. Scott helped pay as well for his own interment beneath a numbered plastic disk.

Questioned recently by The Post, PSI President Elizabeth Abramowitz responded in writing that Scott had not died of injuries caused by her staff. After being told of autopsy and police reports, Abramowitz said she was unable to discuss Scott's death or other injuries at PSI because to do so would violate the privacy rights of the retarded.

The realm of the retarded dead resounds with such silences in part because of a 1978 law backed by well-intentioned advocates. In mandating that the city keep extensive records on the health of its retarded clients, the law stipulates that details of those records be kept private to preserve dignity. The District cites that privacy clause to withhold information about deaths—a policy that most recently slowed a Justice Department civil rights investigation sparked by The Post's March series. For months, District officials refused on privacy grounds to turn over records to Justice and have since obtained a temporary court seal to keep the results of the

federal investigation from the public.

The incomplete records District agencies released to The Post suggest that the interests being protected weren't strictly those of the retarded. Officials had inked out not just the names of the disabled dead but the names of companies paid public money to care for them, city caseworkers and health inspectors charged with monitoring them—and occasionally even high-level government officials. But the heavily blackened records are, in their own way, revealing. They show that the failure to investigate deaths was a systemic, multi-agency breakdown:

- At DHS, the first line of defense for the retarded, caseworkers filed away many cases suggestive of neglect—the middle-aged woman who died of a urinary tract infection, for instance. But they did refer several troubling cases to the agency's internal investigative unit. The investigators were unable to document, after months of inquiries, that they had done more than simply obtain death certificates and close the files.

- The city's Medicaid office was assigned to investigate deaths in the 80 percent of city group homes and day programs that receive federal funds, a total of about \$80 million a year. That office was able to document two death investigations. The first, from 1994, was a brief description of a scene of a murder. The second was an investigation ordered by the mayor last summer, after the highly publicized death of Patrick Dutch, who was left for hours

in the group home van. The investigation found that the house manager and van driver "appeared not to remember many of the details that might give someone a better understanding why this tragedy happened."

• Inspectors at the Department of Public Health, charged with making inquiries when suspicions are brought to their attention, did a few death investigations, too. The record shows they averaged one per year. When they found wrongdoing, they asked the group home for "a plan of correction," as they did in Brandenburg's case. They couldn't assess a fine—such as the \$100,000 penalty that can be levied on District nursing homes for neglect—because the city's attorneys have never done the administrative work needed to enforce an existing law that allows monetary sanctions on group homes. Inspectors could have referred death cases to the police. They haven't done so in more than a decade.

If individual cases are grim, the aggregate is startling. While the exact number of retarded people who died since 1993 is unknown, the 116 that The Post counted would give the District a death rate far higher than that of similar jurisdictions.

The study of mortality among the deinstitutionalized retarded is still in its academic infancy: Data sets are small, government numbers vary in reliability, and medical issues differ among populations. Still, the District has had more than

three times the number of deaths found in a roughly equivalent New Jersey population and twice as many as found in a Pennsylvania population. The District's death rate significantly exceeds that of California's troubled group home system, where University of California-Riverside faculty members have been extensively researching mortality in community-based care.

"I wonder somewhat," said Wesley Vinner, a high-functioning retarded man who grew up at Forest Haven. "It's like we're dying left and right in programs that say they protect us."

One reason, The Post found, is that city officials repeatedly failed to recognize and correct disturbing patterns of neglect.

In 1990, when examining deaths at Forest Haven, Justice Department investigators spotted one particularly alarming trend: Residents were dying of aspiration pneumonia, which sometimes occurs when the bedridden are fed inexpertly and fluids build up in their lungs. A prominent D.C. law firm, acting pro bono, sued the city on behalf of six dead Forest Haven residents, alleging delayed and inadequate treatment. The District settled for more than \$1 million.

The Post, reviewing death certificates and hospital records, identified 10 aspiration-related deaths since 1993 in group homes scattered across the city. None of those deaths prompted an investigation by city officials, records show.

Tony Snider, age 26. Sheila Payne, age 32. Steven Vasquez, age 39. Midway down

THE NAMES OF THE DEAD, 1993-99*:

Josephine Gaines	Phyllis Mallory	Tony Snider
Majorie Haas	Female, full name unknown	Helena Taylor
Earl Veit Donzer	David Abney	Male, full name unknown
Ray Fonville	Stephen Sellows	Charles Rowley
Marie Dickens	Dorothy Simmons	Kermit Gleaton
Vernon Brown	David Wyatt	Gary N. Thomas
Dora Mae Christian	Full name unknown	William Hillery
Deborah Lynn Key	Peter Chipouras	Full name unknown
Theodore Turner	Grace Marie Arnold	Michael Gilliland
Ruth Mae Boaze	Antonio Silva	Full name unknown
Richard Smallwood	Eugene Robinson	Antonio Lucas
Cheryl Ann Bush	John Wesley	James Fairfax
Patrick Wyman Dixon	Hanna Clara French	Male, full name unknown
Robert Allen Watts	Levander Johnson	Lemeka Edon
Nancy Williams	Unknown female	Eleanor Gleason
Joanne Marie Curtain	Male, full name unknown	James Smallwood
Alonzo Fouch	Eduardo Echaves	Full name unknown
Helen Andrews	Kenny Holmes	Male, full name unknown
Calvin Nielson	Female, full name unknown	Margaret Marie Bicksler
Joyce King	Female, full name unknown	Hilda Redman
Richard Julius Braddy	Emma Williams	LaVon Green
Joshua Brooks	Cassandra Cobb	Christopher Lane
Viola Tillyer	James Henry Wilson	Thelma Goldberg
Ernest Durity	Henrietta Green	Henry Laker
Kevin Paul Turner	Kenneth Arnold Gavin	Dennis Edward Jackson
Marguerite Spaulding	Denise Allison Smith	Carlis Spears
Brugiere Palmieri	Steve Edward Moore	Nannie Jones
Steven Vasquez	Melvin Seymore	Reginald Murray
Cecil Gobble Lee	Fred Brandenburg	Desmond Brown
Robert Shipman	Freddie Deperini	Hazel Pinkney
Isaac Lloyd Williams	Francis Hanfman	A. Rowe
Male, full name unknown	Sheila Payne	Geraldine Howell
Daniel Bern	Louis Parnell	Patrickk Dutch
James Scott	Gloria Marie Davis	James Dean
Reginald Lovette	Roy Calloway	Joseph Addison
Antonio McCullers	John Motika	Annie Williams
Betty Tunstall	Raynard Olds	V. Bennett
Lawrence P. Toney	Herbert Scott	Female, full name unknown
Hazel Harris	Sara Walford Martin	

*City records regarding the mentally disabled contain a variety of spellings for certain names.

the aspiration death list is Gloria Davis, a much-loved competitor in the ball-toss at the Special Olympics, who died at age 33.

Profoundly retarded people such as Davis can't articulate pain, which is one reason their caretakers, the good ones, are remarkable to watch. They develop a hyper-perception that lets them scent an infection, read pain in the blinking of an eye. Davis, nonverbal and nonambulatory since birth, had been placed, after Forest Haven, in what was supposed to be a bastion of such sensitivity. The Astor Place SE group home where she lived is one of 34 in the District owned or managed by Voca, a division of a Louisville-based corporation, and supported by \$25 million a year in federal funds. Its direct-care workers earn as much as \$12 an hour, and its foyers are fresh from the broom. But troubling deaths happened in Voca's homes, too.

One evening in 1997, the company's records show, Gloria Davis started spewing mucous from her nose and mouth—the hallmark of a major aspiration. Davis alerted caretakers to her distress the only way she could—by shaking her bed. This cry for help was heard at 10 p.m., house records show. But her caretakers didn't dial 911. They dialed group home administrators. Records show that a series of conversations ensued—about the fact that Davis was struggling to breathe, that “the situation was getting worse,” that an ambulance should be called. But 70 minutes passed before anyone actually called one. Too late. Davis arrived at the hospital a few minutes

before midnight and was declared dead.

Voca's initial accounts of the evening understated by 40 minutes the interval between Davis's distress signal and the call to 911, company records show. Cleveland Corbett, vice president of Voca, said that the inaccuracy was an inadvertent error on the part of harried caretakers and that he “wouldn't second-guess the staff's judgment” on the 70-minute delay.

A month after Gloria Davis's death, at a home run by Voca in Northeast, 42-year-old Raynard Olds had a seizure so propulsive that his head left a hole in his bedroom wall. His neck was critically injured on impact. A caretaker came immediately to find him on the floor, fully conscious. I can't get up, Olds explained. Ambulance records show he didn't arrive at the hospital for an hour and a half after his violent fall. He died a month later from his injuries. Voca's Corbett described the time lapse between injury and hospitalization as “appropriate given the professional judgments involved.”

Kenny Holmes, who lived in a Voca home three blocks from Olds's, also had to wait for care. He swallowed three small plastic bags while his counselor enjoyed a “fish and bread” dinner.

Profoundly retarded, Holmes interpreted the world through his mouth, like an infant, but with the dangerous coordination of an adult. He swallowed whole corncobs, ate his own shoelaces. Unable to speak, he couldn't call for help when help was required. That's why Voca was paid

\$90,000 in public funds per year to keep him safe.

One August night, caretaker Linda Bowers settled in with her dinner on the couch.

According to an account she wrote of the evening—an account Bowers described in an interview with The Post as accurate—when Holmes emerged from his bedroom and obtained her attention, she sent him back inside and continued eating. He retreated but then came out again. Go back to your room, she told him more firmly, not leaving her meal. Again he did as he was told. Back in his room, he finally got her attention—by issuing a great and stomach-turning gurgle, turning blue and thrashing on the floor. Bowers panicked and neglected to perform the Heimlich maneuver she had been trained to do, Voca records show. When Holmes got to the hospital, there was little to be done. He was declared dead of asphyxiation.

Voca's "discharge summary" to DHS omitted Holmes's attempts to obtain Bowers's attention and said Bowers called an ambulance 40 minutes before ambulance records show she did. Corbett called Bowers a caring employee and said, "I believe the staff provided the information as they knew it at the time."

If Holmes had died five blocks east, in Maryland, the government would have sent a registered nurse to the scene to interview staff. A physician would have scoured his medical file, and a University of Maryland professor of pharmacology

would have studied the drugs he had been taking—their adequacy and interactions. By governor's fiat, Maryland's state health department investigates every death in group homes except those of residents who have been diagnosed as terminally ill.

If Holmes had died in Delaware, the questioning of staff would have been led by a state long-term care official who is a former FBI investigator.

If Holmes had died in Missouri, his group home might now be shuttered. Four months after Holmes's death, a retarded man in a St. Louis facility swallowed rubber gloves and choked to death in his bedroom as a caretaker sat nearby. State officials conducted a months-long investigation, identified systemic shortcomings and closed the home.

But Kenny Holmes died in the District of Columbia. Voca executives carried out the only review done on his death. Bowers, those officials concluded, required a training session in "calmness." She remains a caretaker with the company, about which Corbett can say accurately, "The city has never had a problem with us about deaths."

Breast cancer. Massive cardiac events. The complex medical conditions associated with Down syndrome. Some deaths The Post found were inevitable, and a few—at the nonprofit Kennedy Institute, at the for-profit Metro Homes—were thoroughly, even mournfully, documented by group home officials. But some of the deaths that weren't, like that of

Helen Andrews, had consequences that resonated beyond group home doors.

Eating her morning Cheerios, climbing a single flight of stairs—even the basics seemed to tax her. Languid outings with her day program sometimes left her gulping for air, which was discomfiting to a 70-year-old with good manners. The high-functioning Andrews lived in a caring home run by the nonprofit Black Leadership and Christ's Kingdom Society, whose staffers regularly delivered her to the internist with whom it contracted for residents' care. Group home records show that in April 1994, Fumikazu Kawakami, observing that Andrews had been "deteriorating significantly" for six months, diagnosed her condition: She was suffering from arthritis and depression.

Twelve days after he wrote her a prescription for an antidepressant called Zoloft, records show, she was dead of treatable, contagious tuberculosis.

Kawakami did not return a reporter's phone calls. City officials turned over to The Post a single document on Andrews's death, after inking out every fact but the date and the cause of death: "Tuberculous."

TB deaths, rarities in the metropolitan area, tend to make headlines and inspire mass testings, as the pernicious airborne bacteria can be passed to others in as little time as it takes an elevator to go from the first floor to the fifth. Fortunately, the vast majority of those infected can be cured with a low-cost course of antibiotics—if they learn they've been exposed.

"I'm appalled," said Tom Wilds, president of St. John's Community Services, where, until she grew too weak to attend, Andrews was in a day program with a dozen other retarded people. "Our clients and staff were exposed, and I am just learning this now?"

A short story and an old one: In the 1980s, an entrepreneur named Weldon Ferguson opened a home for the retarded on 14th Street NW. In 1987, a doctor examining one of Ferguson's residents found evidence of what he termed "sexual violation." And in 1988, six retarded men who had lived at the home told a Channel 9 reporter that Ferguson had been molesting them in their bedrooms for years and that DHS officials had—also for years—ignored their pleas for help. The story aired, the police swept in, and Ferguson pleaded guilty to assault with intent to sodomize, for which he got a short suspended sentence.

The end. Almost.

One of the deaths for which DHS lost records was that of LaVon Green, who'd been among those who told a grand jury he'd been a victim of Ferguson's assaults. Channel 9 reported that Green contracted HIV while living at Ferguson's house. He died of complications from AIDS last year. Weldon Ferguson, who said in an interview he did not have HIV, was never ordered by the court to take an AIDS test.

Asked whether other former residents of Ferguson's house had died similarly,

DHS spokesman Andrews said: "We can't find the answer. We just don't know."

They were unlikely money magnets, the refugees from Forest Haven, with their trash bags of clothes and stuffed animals. But as \$1 billion flowed into D.C.'s group homes to pay for their care, charitable agencies were supplanted by entrepreneurs—in pronounced contrast to the situation in other states. To keep the new providers honest, DHS had a handful of social workers who had come to the city to be part of a nationally celebrated reform. But city officials acknowledge that much of the task of analyzing medical records and challenging the accounts of the new businesses was delegated to workers who had previously given sponge baths and spooned applesauce at Forest Haven.

Some of those new case managers cared deeply about clients they'd watched grow up, but DHS officials had a vested interest in never training them to investigate deaths. These officials had weathered blistering criticism for conditions at Forest Haven and then, under court-imposed deadline, had personally chosen the group home operators who would supplant the asylum. If these new homes were found wanting, where would the residents go?

Today, the impulse to extenuate the circumstances of death is quickened by a fear of liability. As city officials note, some low-income families see a death by scalding or by broken neck as an opportunity for windfall litigation. Because retarded

people have little lost-earning potential, big settlements are rare. Still, one mother contacted by The Post about her son, who died this year, asked "America to know my pain" and a reporter to find her a lawyer. She last visited her son, she later noted, in 1989.

DHS's unwillingness to investigate is facilitated by a city agency that should be the last bulwark of accountability: the medical examiner's office. Many jurisdictions require an autopsy on all deceased public wards who did not have documented organic diseases. D.C.'s Chief Medical Examiner Arden previously worked in New York City, where autopsies are performed on approximately 90 percent of retarded wards. The District has no such policy mandates. Only one in 13 got a completed autopsy, The Post found. In several cases, bodies sent to the morgue were left unexamined, without explanation, by city pathologists.

"If you're going to point fingers, point here," said Arden. "We didn't investigate when we should have. We didn't do right by these men and women."

Then again, the vast majority of the retarded dead never arrived at the morgue in the first place. City records show that, even when signs of neglect had been documented, DHS officials consistently failed to request autopsies for retarded people without families—people for whom the agency served as the de facto "next of kin."

And sometimes, as with a woman named Betty Tunstall, they closed the file

with even fewer formalities.

As the decade began, Tunstall embodied the transforming promise of the group home system. Today, hers is a life twice lost.

After Forest Haven, where she had lived since the Truman administration, Tunstall was placed in a Southeast group home owned by a company called We Care, whose director was a former aide to Marion Barry. We Care received \$154,000 per client per year, one of the highest Medicaid rates in the country. After Chapter 11 bankruptcy reorganization, six settled sexual harassment suits against its director and allegations of misspent funds, the organization has been renamed Individual Development Inc. and is chaired by David Wilmot, one of Barry's longtime personal attorneys. "I don't know what those guys were doing, frankly," said Wilmot, who said his homes, which are managed by Voca, now provide excellent care.

There was a robust cocaine trade in Betty Tunstall's new front yard, former staffers recall. Nonetheless, deinstitutionalization would suit her.

Nonverbal, said the Forest Haven records.

"Pork chops and fries," Betty Tunstall said one night at the sight of her favorite dinner, rendering her caretakers bug-eyed at the stove.

After 40 years, Tunstall was pushing boundaries, finding words. "Look," she

demanded, as she turned on the house radio by herself. She mastered the essential pronoun of communal living: "mine." This was the miracle that reformers had worked to witness—what they dreamed their legacy would be.

For five years now, this miracle has been buried in an unmarked plot in Prince George's County that even the cemetery director gets lost trying to find. How Tunstall got there, DHS records do not say. She was interred at age 50 but never officially declared dead. City officials shelved her case without a death certificate.

It's illegal in the District to bury a person without certifying death. "Very unusual," said Urbane Bass, head of D.C.'s vital records agency. "It's a crime." Also a mystery. What happened to the \$70 monthly disability checks that, Social Security Administration records show, group home administrators kept receiving in her name for months after her unrecorded death?

It would be easy, given cases such as Brandenburg's and Tunstall's, to paint life inside group homes in the hue of Clockwork Orange. The reality is subtler: an incremental coarsening of sensibility. Take the big white house on Maple Street NW—the one with Christmas garlands bedecking the portico—where lived gentle, 28-year-old Reginald Lovette.

Lovette's roommate, a 250-pound retarded man named Bernard Eaton, had his grievances, as roommates do. He

thought Lovette touched his television, snored too loudly, got preferential treatment from the staff. Eaton sometimes registered his protests by attacking Lovette while he slept. When Lovette was awake, police documents show, Eaton frequently attempted to strangle him.

Lovette, who city records say had come into government care after a violent childhood with a psychotic father, repeatedly asked staff members to shield him from what they would later describe as "constant abuse." But Lovette was left to share a room with Eaton. And DHS left uninvestigated a series of reports by the home's neighbors. Residents were wandering the streets, confused and unattended. Residents were in the back yard, chilled and naked, with none of their caretakers in sight.

And then one night just before Christmas 1994, Eaton succeeded in an act he'd been edging toward all year. He strangled Lovette with a baby-blue bedsheet.

Police reports describe the battleground: bed and nightstand askew, pillow gory, body in checkered pajamas splayed on floor. The scene comported with what Eaton confessed. Not long after midnight, he had a prolonged fight with Lovette before getting the sheet to strangle him. But the employees in the home—charged with checking hourly on Lovette and his housemates—didn't rush to the rescue. Police and health department records show they were missing in action all night and didn't find Lovette's body until after 7 a.m., by which time rigor mortis had set

in. After discovering the killing, health inspection records show, staffers did nothing. Only when a member of the morning shift appeared 20 minutes later did someone decide to call the police.

Health inspectors subsequently arriving on the scene noted a tangential oddity: There was no food in the house for the residents to eat. As the group home's owner, Samelia Green, would later explain to inspectors, the staff supervisor had probably falsified grocery store receipts and pocketed the cash meant to finance a week of clients' meals.

Who exactly were Lovette's caretakers in the house on Maple Street? A check of District and Maryland criminal records indicates that they included a convicted cocaine dealer, a convicted crack dealer and a twice-convicted thief and crack user who had just been released from jail.

To care for the retarded in, say, Florida, one must pass a criminal background check, secure an FBI clearance and attest in writing to exacting standards of moral character. The District recently put a similar law on its books, but city administrators have yet to do the necessary paperwork to enforce it. No effective curb on criminal caretakers. No trace of a response to panicked neighbors. No protection for a young man in bed. And after Lovette's killing, little change.

Eaton, who under D.C. law could not be held responsible for the homicide because of his mental deficiencies, went to live with his mother in Northeast

Samelia Green, who declined to comment, continued collecting her public money. Felons went on caring for the survivors. And DHS officials didn't supply a single record on the case.

Desmond Brown's fingers curled inward like rams' horns. His slender torso was a permanent L. He was retarded. He was blind. And what of it? He cranked his favorite Santana tape and decided he could dance on his knees. If fate had played a trick on him, he seemed to get the joke. Among so many limits, said his presence, there may still be so much life.

Two years after city and group home officials concealed the truth of the death of Fred Brandenburg, 38-year-old Desmond Brown was in another home owned by dentist Arthur Stubbs.

One rainy day in January, Brown, who had cerebral palsy, got wet. In city files, there is one version of what happened next: a 10-sentence memo, titled "Investigation," by Stubbs's partner, Sheila Gaither. It says Brown came down with a cold but quickly recovered. When his "cold symptoms" returned a week later, group home officials whisked him to the hospital.

City records and the accounts of his group home and day program caretakers provide a painful counter-narrative. From late January to late February 1999, Brown's care supervisor, Patricia Thorpe, repeatedly petitioned superiors to give the "sick," "unresponsive" Brown treatment stronger than Sudafed. "He was distressed, and I

felt we shouldn't take chances," Thorpe said in an interview. But company officials declined to take Brown to a doctor.

"They'd say, he's fine, just give him soup, give him water," recalled Genevieve Ruffin, a veteran aide at Brown's group home and one of four DCFS staffers who noted that dialing 911 without authorization can get a person fired. "When Desmond couldn't eat, they said it was a 'behavior problem,'" Ruffin said. "I mean, even I could tell by looking at him—it was pneumonia."

As Brown was wasting away, residents of other DCFS homes were hurting, too. Health inspectors found that one woman had been improperly treated for respiratory distress, two others had been repeatedly and improperly tranquilized, and many more weren't getting medical treatments that had been ordered by their doctors. Meanwhile, crucial day-to-day care was being handled by a crew of minimally trained welfare recipients. DHS had given Stubbs and Gaither a multimillion-dollar contract to help D.C. welfare mothers find jobs. Until it was discovered that a DHS official involved in awarding the contract lived in a home owned by Stubbs, the deal gave the dentist and his partner a double windfall: bonuses from their welfare-reform contract for placing workers in jobs and tax credits at the group homes for hiring welfare recipients. Somewhere near the bottom of the incentive structure ranked the life of one Desmond Brown.

"Saving money, saving money: That's all we heard," said Thorpe, who eventually

took a job in the Maryland group home system.

Brown couldn't negotiate a similar exit.

"Step out!" he'd regally gesture when his guardians irked him—a stylish cover for a physical fact: Brown himself was trapped. He grew sicker, until one Friday night his labored breathing and shaking left his caretakers almost as distraught as he was. But as with Brandenburg, the problem was kept inside the house. Sweat poured off Brown's emaciated body, records and interviews show. He tore at his clothes in anguish. He gasped for air. But DCFS supervisors decided that he didn't require the services of a doctor. Brown was "doing fine" that Friday evening, says the brief DCFS "investigation." He was desperately ill, say interviews and city records. In the house ledger, Ruffin and a co-worker detailed more than Brown's unremedied suffering. They recorded his horrified recognition.

"I am dying," a retarded man informed his caretakers. "I am going to die."

It was as if, in that moment on the last night he ever spoke, the blind man could see what lay ahead. The Saturday morning when Gaither granted permission to take him to Providence Hospital. The emergency tracheotomy. The immediate dispatch to intensive care, where yellow ghosts attended in isolation gear. The silvery balloon for his 39th birthday, hovering above a tangle of plastic tubes. And then a casket crammed alongside 11 other

caskets in a single cemetery plot.

Like so many others failed by the government that promised to save them, Desmond Brown in the end received a group grave with a plastic marker.

On that marker, another joke Brown might have gotten. No name, just the digits 137. A number, as if someone were counting.

Staff researchers Alice Crites and Heming Nelson contributed to this report.

CORRECTION: In yesterday's front-page article about fatal neglect at the District's homes for the mentally disabled, nearly two paragraphs were dropped on Page A33 in some editions because of a production error. The complete story can be read on The Post's Web site, www.washingtonpost.com. The missing text, which dealt with the failure to do an autopsy on Fred Brandenburg, is as follows:

Reopening the case will be difficult. Brandenburg's body was released from the morgue and cremated without an autopsy. In an interview earlier this year, DHS official Frances Bowie, who until recently headed the department's developmental disabilities unit, explained why: Brandenburg's two sisters had refused to permit an autopsy. DHS officials said the sisters, who they said were Jehovah's Witnesses and whom they would not identify, had reli-

gious objections to the practice.

The Post located the sisters. One of them, Gloria Donovan, is a longtime member of All Saints Catholic Church in Manassas. The other, Juanita DeButts, worships and teaches Sunday school at the

First Baptist Church of La Plata. "We're not Jehovah's Witnesses, and we were never asked about an autopsy," said Donovan, whose brother had just spent the Christmas holidays at her home. "It didn't happen."

Changes Demanded on Group Homes

City Officials Acknowledge Problems in Protecting Retarded Residents

**BY VANESSA WILLIAMS
AND KATHERINE BOO**

Washington Post Staff Writers

"We can no longer make excuses," D.C. Council member Sandy Allen (D-Ward 8) yesterday told officials of the Department of Human Services and Department of Health, expressing outrage at the neglect and abuse of mentally retarded people in the District's care detailed in a Washington Post investigation that appeared in the paper Sunday and yesterday.

City officials at the hearing acknowledged "severe" deficiencies in their monitoring of care given to the city's retarded and said that they would work diligently to reverse the damage of "decades of inattention."

Allen, chairman of the Committee on Human Services, responded sharply when one Human Services official said reforms would be implemented in "one or two years."

"One or two years?" she said. "How many vulnerable people are going to be hurt in those one or two years? I don't even want to hear another study. We need to see

it yesterday."

Allen said she would request additional dollars for the department to hire more monitors and caseworkers. The department, she said, needs to increase the frequency of its site inspections and client visits to ensure residents are getting quality services.

Allen, who has chaired the committee for 1½ years, said she had received anecdotal information about abuse and neglect but was surprised by the large number of allegations of abuse.

In other reaction to the series, a Department of Human Services spokesman said yesterday that Mayor Anthony A. Williams had called the head of the agency on Sunday to demand an accounting of the group home situation.

Council member David Catania (R-At Large), the only other member of the five-member committee to attend yesterday's discussion, accused officials of passing the blame. Catania was incredulous that officials were unable to explain what steps are taken to protect the clients' personal funds.

"I think we can agree the system you have in place now is a failure," Catania told

the officials. The council member challenged Williams to commit the resources to improve oversight of the group homes. "I want these people taken care of, I want their money protected and I want those who abuse them to be thrown in jail," he said.

After the hearing, Wayne Casey, deputy director of the Department of Human Services, reiterated his argument that the agency doesn't have the resources to do its job.

"When we had our budget reduced in 1995 and '96, at a number of council meetings I said this will be a devastating impact

on human services for all our clients by the year 2000. And this is where we are," Casey said.

Frances Bowie, administrator of the Mental Retardation and Developmental Disabilities Administration, said the council members' questions were "fair."

"We have providers who are bad apples and may have taken advantage of the inability of government to properly monitor them," Bowie said. She went on to insist that the agency has already identified its shortcomings and developed an action plan that includes the hiring of additional monitors.

The Washington Post

Democracy Dies in Darkness

THURSDAY, MARCH 18, 1999

D.C. Evacuates Two Homes For Retarded *City Had Ignored Perilous Conditions*

**BY KATHERINE BOO
AND MICHAEL H. COTTMAN**
Washington Post Staff Writers

D.C. Mayor Anthony A. Williams yesterday ordered the evacuation of two group homes for the mentally retarded where neglect and life-threatening conditions had been ignored by city officials for years. The removal of residents from the homes was one of several steps the District government took yesterday to address problems in the city's group homes for the retarded.

"I ordered patients put in the right facility regardless of what the impact will be on the facility itself," Williams said yesterday.

"This is something we've been working on for some time," he said. "We believe that the responsible thing to do was to work as we did to get those patients into the right place, and we needed to act decisively, and that's what we've done."

The actions came after a Washington Post investigation that found 350 docu-

mented cases in this decade of abuse and neglect in the city's expensive group home system, as well as financial mismanagement by group home owners poorly monitored by several city agencies. Between 1990 and today, the city failed to issue a single fine against a company found to have mistreated the retarded.

Department of Human Services Director Jearline F. Williams said that she and Mayor Williams had asked the D.C. inspector general to launch inquiries into the Mental Retardation and Developmental Disabilities Administration, as well as the providers that serve the agency. The city also requested the help of the U.S. Department of Health and Human Services in accelerating the pace of reform.

The Minnesota Avenue homes closed yesterday were operated by longtime city contractor Rollie Washington and his wife, Dorothy. In its series, The Post found that city officials had known for at least five years about life-threatening conditions and what federal court monitors called

“serious” neglect of retarded residents of the Washingtons’ homes. In that time, the Department of Human Services paid the Washingtons \$4 million to run group homes. The Washingtons were not licensed to run a business in the District.

The Washingtons also received Department of Human Services funding to run a day program for the retarded at their Manor Farm in Upper Marlboro. Human Services officials assigned some of the city’s retarded wards to shovel manure and haul hay at the farm for wages of \$2.50 to \$5 a day.

Yesterday, the Department of Human Services said that no more retarded workers would be sent to the farm.

“We have terminated our relationship” with the Washingtons, said Human Services Director Jearline Williams, who emphasized that other contractors identified in The Post’s series were now receiving careful and regular monitoring.

At the Minnesota Avenue homes yesterday, Rollie Washington said that the city had given him no reason for closing his homes. In earlier interviews, Washington said the services he provided clients met or exceeded what the city required of him.

Meanwhile, D.C. police officers supervised as city officials and staff packed up the residents’ clothes and 10 years’ worth of possessions in trash bags to be moved.

Jearline Williams said the residents would be transferred to other homes temporarily, while social workers assess their mental and physical conditions and determine what treatment they need.

Mayor Williams said that the Mental Retardation and Developmental Disabilities Administration “has been involved in the legal process of trying to close this facility [Minnesota Avenue] since 1996, and is in fact still attempting to do so.

“But the urgency of the situation at this facility made it necessary to circumvent the red tape in favor of the well-being and safety of the patients involved. This move is reflective of a proactive agenda being implemented by [Human Services] to ensure the safety of the citizens it serves.

“When measured on a scale, the quality of life of District residents will always outweigh the need to maintain the bureaucratic process.”

One resident of the homes — a nearly blind man who, according to city records, tried to kill himself last year after months of harassment by a fellow resident — was surprised to learn that he would have a new place to live.

“Change is a nervous question,” said 39-year-old Elroy, “but it’s not upsetting, it’s nice. I would say it’s an interesting thing.”

The Washington Post

Democracy Dies in Darkness

TUESDAY, MAY 4, 1999

INVISIBLE LIVES: D.C.'s Troubled System for the Retarded

U.S. Probes District's Homes for Retarded

BY KATHERINE BOO

Washington Post Staff Writer

The U.S. Justice Department has begun a special probe into the quality of care at District government-funded facilities for the mentally retarded.

The inquiry, by the department's Civil Rights Division, was sparked by an investigation by The Washington Post published in March that found 350 documented cases of abuse and neglect as well as profiteering in the city's 150 taxpayer-financed group homes for the retarded.

"We take all allegations of abuse and neglect very seriously and certainly follow up to determine whether allegations warrant additional federal action," said Bill Lann Lee, acting assistant attorney general for civil rights. "That's what we're doing in this case."

Lee has commissioned Tony Records, a nationally known expert on services for the retarded, to help with the division's investigation.

In recent weeks, the Justice investigators have gone into about a dozen group

homes across the District, including homes run by the city's largest service providers, Voca and D.C. Family Services. Investigators plan to visit a broad cross section of the city's homes and day programs in the weeks ahead, interviewing nearly 100 retarded residents and scouring their medical and treatment records.

As a party to *Evans v. Washington*, a 23-year-old federal lawsuit that helped deinstitutionalize the District's mentally retarded population, the Civil Rights Division periodically has taken actions to prod the District toward better services. "But I don't think we've ever looked at this many homes this quickly," said a Justice official involved in the case, citing a "sense of urgency" regarding the allegations.

The civil rights inquiry into the District's system is relatively unusual in its focus: examining the treatment of retarded people in community-based settings that have become a central component of reform efforts across America, not in the large asylums upon which Justice attorneys have concentrated their legal efforts

in recent decades.

Justice undertakes the inquiry in the District in its capacity as a "plaintiff-intervenor" in the still-open Evans case, whose consent decrees are supposed to offer special protection to the retarded men and women who were moved from a troubled city-run asylum in Laurel into smaller facilities in the District. Results of the new investigation are expected by June. Justice may use the findings to press for remedies through the ongoing federal court case or other means.

In a separate criminal investigation, the FBI's Washington field office is examining allegations of corruption and Medicaid fraud against several providers of services to the District's retarded. An FBI spokesman declined to comment on the investigation.

The District's taxpayer-funded programs for the retarded are among the most expensive in the country, with an average cost per patient of more than \$100,000 a year. The Washington Post found that, with minimal oversight by city agencies and the D.C. Council, the care of the retarded and millions of dollars in public funds had been entrusted to a convicted embezzler, a nightclub owner and several companies with long histories of abusing or neglecting their wards. Documented abuse went unpunished: From 1990 to 1999, the city failed to issue a single fine against a company found to have mistreated a retarded person. And 50 deaths in the last three years went unexamined by city officials.

On Sunday, another retarded person in the District's care, Desmond Brown, 39, died at Providence Hospital. He was sent to Providence's intensive-care unit after developing an advanced case of pneumonia at a network of for-profit group homes repeatedly cited for medical neglect.

Justice Department intervention was instrumental in building the District's current privatized, community-based system.

In the 1970s, the Civil Rights Division joined a federal lawsuit filed by parents of retarded men and women housed at the District-run asylum called Forest Haven in Laurel; the division's subsequent documentation of Forest Haven's poor medical treatment helped force its closing in 1991. The transfer of residents to group homes and treatment programs within the District was considered a historic reform effort at the time, as the city's retarded population became one of the most deinstitutionalized in the country.

Jearline F. Williams, director of the D.C. Department of Human Services, which oversees care for the retarded, said her agency welcomed the civil rights and FBI investigations and was cooperating fully with Justice officials. After The Post's series, Williams joined D.C. Mayor Anthony A. Williams (D) in ordering the immediate closure of two homes and a farm-labor program whose poor conditions and abused residents had been featured in the series. She also removed the chief of the Mental Retardation and Developmental Disabilities Administration,

which has direct responsibility for group home oversight, and requested the aid of the U.S. Department of Health and Human Services in accelerating reform.

Of her department's "massive over-

haul" of its services to the retarded, Williams said, "We've got a lot of partners in this, from the community and from the federal government. I see real change ahead."

The Washington Post

Democracy Dies in Darkness

THURSDAY, DECEMBER 9, 1999

D.C. Official Suspended In Probe Of Homes

Records of Deaths Allegedly Shredded

**BY KATHERINE BOO
AND PETER SLEVIN**

Washington Post Staff Writers

Viola Keyes, the chief investigator in the D.C. Department of Human Services, was placed on administrative leave yesterday while the city's police and inspector general investigate charges that she ordered her staff to destroy records about deaths in city-funded group homes for the mentally retarded.

Police guarded the DHS investigations office into the night after a team from the inspector general's office, acting on a tip, secured files and interviewed staff.

"I take all allegations of this nature seriously," said DHS Director Jearline F. Williams, who suspended Keyes pending further inquiry.

Keyes, a city employee for more than 25 years, is the head of the DHS office responsible for examining abuse and fraud among agency employees and city contrac-

tors, including the city's group homes.

The Washington Post reported Sunday that DHS had lost or concealed records regarding dozens of deaths in its group home system, and that one case manager, Dwayne Franklin, had shredded documents about a suspicious death after The Washington Post asked questions. Franklin was fired last month. The Post examination revealed hundreds of instances of neglect in the community-based system and 116 deaths of residents since 1993.

D.C. Mayor Anthony A. Williams this week pledged full cooperation with federal and local investigators. Williams announced personnel changes and promised strong oversight of the city's 150 group homes, saying government employees "from top to bottom . . . will be held accountable."

Police officials, meanwhile, have assigned the investigation to the major crimes unit of the department and have

met with the U.S. attorney's office, the FBI and the D.C. corporation counsel.

Although DHS officials had told The Post that deaths had been routinely investigated—and that certain deaths were referred to Keyes's office for special inquiry—Keyes's unit was unable to document, after months of inquiries, that it had completed a single investigation between 1993 and September 1999.

Jearline Williams questioned Keyes yesterday about whether she had ordered the destruction of several dozen case files, DHS officials said. Williams subsequently placed Keyes on administrative leave for the duration of the investigation. Keyes did not return repeated telephone calls.

Keyes, 55, has long been a controversial figure at DHS. A licensed social worker with master's degrees from Howard University and American University, she sued supervisors and the District government repeatedly in the past 12 years, alleging that she was a victim of age and sex discrimination and suffered retaliation for being outspoken.

In a 1993 affidavit filed in D.C. Superior Court, Keyes said she endured "atrocious, extreme and outrageous conduct." Asserting that she was wrongly removed from her job during a 1991 downsizing, then rehired at a level unsuitable to her skills, she maintained that the actions of the city and senior managers caused her "much emotional distress, embarrassment

and humiliation."

Keyes sought \$8 million. A Superior Court judge dismissed the case.

In an earlier case described by her attorney in court records, Keyes said she was demoted improperly in November 1987. She filed a complaint with the Equal Employment Opportunity Commission. With her federal trial underway, the District rehired her at her original level, wrote lawyer Robert Bell.

Outside the mayor's office last night, members of Capital Area Adapt, a disability rights group, placed candles and flowers in front of cardboard cutouts shaped like tombstones. On each cutout appeared the name of a retarded person who had died under the District's care, written in black ink.

"I knew most of these people who died," said Bernard Briggs, 40, a former group home resident. "It was a nightmare then, and it's still happening."

He wiped tears from his face.

Among other vigil-keepers, members of the District's Center for Independent Living program protested the deaths, which they said could have been prevented.

"I feel my brothers and sisters who died in the District programs did not get the respect they deserved," said Hannah Pittsgalmore. "I expect them to get quality care now."

Staff writer Emily Wax contributed to this report.

Files on Retarded Out of Reach

Advocates Frustrated by Lack of Cooperation From D.C. Superior Court

BY PETER SLEVIN; KATHERINE BOO

Washington Post Staff Writers

Sixteen months after advocates for retarded District residents sought access to D.C. Superior Court files—and four months after an exasperated federal judge took the rare step of intervening on their behalf—the local court has not complied.

The records are essential to hundreds of former residents of the District's decrepit Forest Haven asylum. In a broken system of care, defenders of the retarded want to know which of them have attorneys and which do not, which ones are competently represented and which are not.

Much of the information has always been within reach, in the file rooms of Superior Court. But gaining access to the records has proved impossible for advocates and now for a U.S. District judge who wants to resolve a 23-year-old class-action lawsuit.

The duel over the court files illustrates how the fate of the District's retarded people often hinges on small details and decisions.

Many months into the dispute, for example, Superior Court clerks told attorneys that they could retrieve only four files

each day, despite the need to review 760 cases. One Superior Court judge said the effort would cost more money than the court could afford: \$2,675.

At another point, Superior Court Chief Judge Eugene N. Hamilton promised a response within days. Weeks went by, but Senior U.S. District Judge Stanley S. Harris said he never heard from Superior Court again.

A recent Washington Post investigation found 350 documented cases of abuse and 116 unexamined deaths of group home residents in an industry pocked by corporate fraud and government neglect. The District's network of homes and day programs, which spends about \$100,000 annually per client, is among the costliest in the nation.

The dispute over the court files appears emblematic of the way D.C. authorities have failed the onetime residents of Forest Haven. What Harris terms the "unwillingness" of Superior Court to provide essential information adds a district judge's voice to the chorus of local and federal players who have recently criticized the court for poor performance and ineffective leadership.

Defenders of the retarded hope to improve conditions by ensuring that each

person is represented by an attorney who is aware of the rights and guarantees defined in the 1976 class-action lawsuit now before Harris. Legal appointments are made by Superior Court, which is responsible for overseeing the commitment and treatment of the District's mentally retarded population.

"We suspected that the Superior Court cases were not as active as they should be and that attorneys were probably not checking on people's placements and doing the advocacy that the statute allows them to do and requires them to do," said Kelly Bagby, a lawyer with University Legal Services, a federally funded advocacy group. "We began discovering more and more cases of [retarded people] who were committed but had no attorney. No one had shown up at the house for years."

Family Court Presiding Judge Zinora Mitchell-Rankin said in an interview yesterday that Superior Court has been slowed by financial troubles and an overtaxed staff but is working to fulfill Harris's demand.

In February, Harris requested a report on the Superior Court advocacy system. That meant locating the lawyers, who can earn \$1,300 or more a year representing the interests of the retarded.

A federal court monitor had been working since August 1998 to find the same information, according to a detailed ruling by Harris. Letters went unanswered by Charles Gaines, chief of Superior Court's mental health and mental retardation branch. Gaines later offered a series of explanations for being unable to deliver,

Harris said, but eventually delivered an incomplete list of lawyers' names.

When court monitor Lydia Williams contacted the lawyers, she discovered that many no longer accepted court appointments—some because they were frustrated with the court's slow payment habits. Others knew nothing of their clients' special rights under the federal lawsuit—or even that the class-action case existed. Only one-third of the wards appeared to have a working attorney.

A series of fruitless dealings and petty frustrations followed.

When Family Court's Mitchell-Rankin explained that the court's files were not automated, the attorneys volunteered the services of law students. The judge rebuffed them, citing crowded courthouse work areas and worries that the volunteers would breach confidentiality rules.

As efforts stalled, Harris interceded.

Mitchell-Rankin stood him up once without explanation, he said. Then she said it would take 168 hours of overtime to review the 760 files and explained that Superior Court—which has an annual budget of \$121 million—could not afford the \$2,675 cost. Harris, declining to underwrite the expense, said the volunteer law student idea "seemed eminently feasible."

Mitchell-Rankin promised to confer with Chief Judge Hamilton and report back. She never did. Harris then spoke with Hamilton, who said he was aware of the issue and would contact Harris within a few days. Hamilton never got back in touch.

When Forest Haven class-action attorneys sought to review the files one by one, Superior Court officials denied them access, contending that only the individual attorneys—whose very names the lawyers were seeking—could review the material. Harris called the court's policy "wholly illogical."

On Aug. 20, Harris expressed his "acute disappointment" and ordered Superior Court to make the files available. He called the history of the dispute "rather remarkable."

"To me, this is like a non-issue," Mitchell-Rankin countered in an interview yesterday. "We've never been obstreperous. We've said from the very beginning that we're prepared to provide the information. Hopefully, with one more day of overtime, we will be completed."

Court oversight of the District's retarded wards was not meant to depend so heavily on lawyers. Under city law, Superior Court was supposed to appoint for each ward a "certified personal advocate": a trained volunteer to visit the ward in the group home and day program and convey his or her needs and concerns to court authorities. But fewer than 25 percent of the city's wards have an advocate today.

Mitchell-Rankin attributes the city's failure to comply with the law to a lack of public interest and a limited budget for recruiting and volunteer retention. She said a successful program costs "in excess of \$12,000 to \$15,000. That's not a terrific amount of money . . . but it's not chump

change."

Tracy Dacosta, a 28-year-old legal assistant, sees things differently. In March, after reading a Washington Post series about unchecked abuse and neglect in city's group homes, she signed up to be an advocate and quickly completed the three-hour training course needed for certification.

Today, nine months later, she is still waiting to be assigned. "They're supposedly begging for volunteers, but it's been a bunch of runaround trying to be one," said Dacosta, thumbing through a detailed chronology of deferment.

Superior Court informed her this summer that she would be assigned to a 51-year-old woman named Mary Ann. Then the court hearing at which Dacosta was to be appointed was canceled. The city social worker and the lawyer had failed to show.

Through the autumn, Dacosta peppered the court and the lawyer with phone calls, but the hearing was never rescheduled. She recently learned that Mary Ann's annual review had been conducted without her.

"I wonder if the problem is that the city and the group homes don't want advocates snooping around," said Dacosta, who reported that the bureaucratic obstacles have only strengthened her sense of mission.

"One of these days I am going to get to meet her," she said of Mary Ann. "And we'll be laughing, saying, 'It's about time.'"