VERMONT MENTAL HEALTH CRISIS RESPONSE COMMISSION

2023 Report to the Governor, General Assembly and Chief Justice, Vermont Supreme Court

The Mental Health Crisis Response Commission (MHCRC or Commission) is responsible for conducting reviews of law enforcement interactions that resulted in death or serious bodily injury and involved persons acting in a manner that created reason to believe a mental health crisis was occurring. 18 V.S.A. §7257a

The Commission is required to make recommendations based on its review of cases and to report its conclusions and recommendations to the Governor, General Assembly and Chief Justice of the Vermont Supreme Court. The charge of the Commission is:

1) to conduct reviews of law enforcement interactions with persons acting in a manner that created reason to believe a mental health crisis was occurring and resulted in a fatality or serious bodily injury to any party to the interaction;
2) to identify where increased or alternative supports or strategic investments within law enforcement, designated agencies, or other community service systems could improve outcomes;
3) to educate the public, service providers, and policymakers about strategies for intervention in and prevention of mental health crises;
4) to recommend policies, practices, and services that will encourage collaboration and increase successful interventions between law enforcement and persons acting in a manner that created reason to believe a mental health crisis was occurring;
5) to recommend training strategies for public safety, emergency, or other crisis response personnel that will increase successful interventions; and
6) to make recommendations based on the review of cases before the Commission.

In 2023, the Commission met as a body using the Zoom platform. Meetings of the Commission are outlined below:

January 13, 2023
March 10, 2023
April 14, 2023
May 19, 2023
June 9, 2023
August 11, 2023
September 15, 2023
October 20, 2023
November 17, 2023
December 15, 2023

Statutory Authority

18 V.S.A. §7257a(i) Notwithstanding 2 V.S.A. §20(d), the Commission shall report its conclusions and recommendations to the Governor, General Assembly, and Chief Justice of the Vermont Supreme Court as the Commission deems necessary, but no less frequently than once per calendar year. The report shall disclose individually identifiable health information only to the extent necessary to convey the Commission's conclusions and recommendations, and any such disclosures shall be limited to information already known to the public. The report shall be available to the public through the Office of the Attorney General.

The Commission

In 2023, the Commission's membership changed slightly. In January, Berlin Police Chief James Pontbriand joined the Commission as the representative of the Vermont Association of Chiefs of Police, replacing Hinesburg Police Chief Anthony Cambridge. Effective in June, Kate Lamphere chose to step down as Chair of the Commission and Allie Nerenberg was nominated to serve in this capacity. In July, David Soucy was appointed as one of the two regionally diverse at-large members of the Commission to replace John Campbell. Finally, Charlotte McCorkel joined the Commission for one case review (M.M.) as an interim replacement member for Kate Lamphere, who recused herself pursuant to the Commission's recusal policy outlined in this report and state statute.

Current Members of the Commission

- Allie Nerenberg, Chair, Vermont Department of Mental Health
- Kristin Chandler, Vice-Chair, Team Two (at large appointee)
- Erin Jacobsen, Vermont Attorney General's Office
- Lieutenant Anthony French, Vermont State Police
- Chief James Pontbriand, Berlin Police Department (Vermont Association of Chiefs of Police appointee)
- Mourning Fox, Department of Public Safety (Vermont Criminal Justice Council appointee)
- Kate Lamphere, Healthcare and Rehabilitation Services (Vermont Care Partners appointee)
- Charlotte McCorkel, Howard Center (interim replacement for Kate Lamphere on one case as Vermont Care Partners appointee)
- Lindsey Owen, Disability Rights Vermont
- Zachary Hughes, Vermont Psychiatric Survivors
- Chip Siler, National Alliance on Mental Illness, VT Chapter
- David Soucy, 2017-2018 Rutland State Senator (at large appointee)

Executive Summary

With several active referrals in 2023, the Commission began the year by developing specific policies and procedures to clarify its workflow and ensure consistency. The Commission defined a mental health crisis to guide the group in determining what level of review the Commission would undertake based on the facts of a case. The Commission discussed circumstances in which members would need to, or may choose to, recuse themselves. Finally, the Commission wrote a "Levels of Review" document to specifically outline the process of determining which cases would be screened out after a preliminary review or would receive a secondary and/or a full review by the Commission, and the differences. These policies are outlined in the first section of this report.

The Commission also reviewed documentary evidence for five cases and assigned each to a specific level of review based on the information received from the reporting entity. The Commission is using individuals' initials for cases that were either declined for full review, or are currently under review, with the goal of disclosing individually identifiable health information only to the extent necessary to convey the Commission's conclusions and recommendations.

After thorough discussion, review of evidence and records available, three of the cases (N.G., M.D., and J.W.) did not meet the statutory criteria for further commission review, either because the Commission found no evidence that either a mental health crisis was occurring, or that law enforcement had reason to believe that a mental health crisis was occurring. The remaining two cases (B.G. and M.M.) are currently being reviewed. A summary of the status of each case is provided in this report. Each case was reviewed by Commission members going through available documentary evidence, which could include, but was not limited to, the complete investigative reports, medical records, police cruiser video footage and audio recordings, as well as clinical records by mental health providers as applicable.

This report contains the Commission's conclusions and recommendations.

I. Case Review Policies and Definitions

For purposes of ensuring that the Commission is reviewing cases consistently and appropriately to the Legislative charge bestowed upon them, the Commission has created the following policies and definitions:

A. Mental health crisis:
   1) an event where a person is known to have recently expressed potential for causing harm to self or others and there is reason to believe that this is the result of a mental health condition. This may include suicidal ideation, plan, or intent or stated plan or intent to harm others prior to the interaction with law enforcement that led to the resulting injury or death; OR
   2) a situation where an individual's current behavior appears to be best attributable to a mental health condition rather than a crisis due to social, biological, or environmental factors, such as, but not limited to, a traumatic brain injury, an intellectual or developmental disability, substance use, or as a response to the presence of law enforcement.

B. Conflict/ Recusal:
   1) By statute, a Commission member shall recuse themselves from any review of a submitted case if the member is part of an organization involved in an interaction under review. The member shall not access or be privy to any Commission information related to the review. Pursuant to statute, the Commission may appoint an interim replacement member to serve the role of the recused member for review of that case.
   2) By Commission policy, if a Commission member is not a part of an organization involved in the interaction but believes that because of their relationship with either the parties involved or the agency involved, or because of the location or any other circumstances of the interaction itself, they cannot be fair and impartial, they shall be allowed to recuse themselves.

C. Levels of Review:

1) Preliminary Review (full or sub-committee*) – Entails a review of the records received from the Attorney General Office's (AGO) and any other information available, applying this Commission's definition of a mental health crisis. Records to review may include any or all of the following: witness statements, officer statements, body camera footage, Medical Examiners report, 9-1-1 call recording, etc. This could indicate that a full review is not warranted, or that more information is needed to determine if a full Commission Review is indicated.

   **If the review is conducted by a sub-committee, then it will be presented to the full Commission to determine next steps. If the individual sustained serious bodily injury, the Commission will seek their consent to proceed with further review and their consent will be taken into consideration when the Commission determines if further review is indicated.*

2) Secondary Review (full or sub-committee*) – This entails a preliminary assessment of available records as well as a review of further requested records and information (possibly mental health records, 9-1-1 transcripts if not already available, etc.). The results of the Secondary Review could be that the information provided indicates that a full Commission Review is not indicated, or it could indicate that the case is appropriate for a full Commission Review.

   **If the review is conducted by a sub-committee, then it will be presented to the full Commission to determine next steps.*

3) Full Commission Review –This will include all supporting documentation that is available including, but not limited to: any of the materials listed as part of the Preliminary Review and/or the Secondary Review; health care records from any known providers; media information, interviews with witnesses as indicated.

4) Notice:
    a) Upon beginning a Secondary Review, written notice shall be given to the injured or deceased person(s)' self or next of kin, in the following order: any spouse/domestic partner, adult children and grandchildren (both biological and adopted), parents or siblings.
    b) If no next of kin is known at the time the Secondary Review commences, but is discovered during any part of the review process thereafter, notice shall be provided within 30 days of discovery.

II. Cases Closed for Commission Review: N.G.

A. Commission Activities

March 2023: The Commission assigned one subcommittee to complete a Preliminary Review of N.G.'s case and return to the full committee meeting in April with a recommendation of whether or not to move this case to a Secondary Review.

April 2023: The Commission discussed the findings of the Preliminary Review and determined that there was insufficient evidence to suggest that this case met the definition of mental health crisis as outlined by the Commission.

May 2023: The Commission determined that it would close N.G.'s case review.

B. Evidence Reviewed*

1) Vermont Attorney General's Office Statement Regarding the Shooting of N.G. by Montpelier Police Officer and Vermont State Troopers
2) Channel 3 News broadcast
3) Judicial order issued by Judge Howard E. VanBenthuysen on February 16, 2018
4) Vermont State Police Affidavit of Subpoena
5) Autopsy Report

*Of note, the records indicated that, “other than the two Montpelier police cruiser cam videos, which do not show the shooting, they have no other video of the events before the shooting.” Records also noted that there was no audio recording of the incident.

C. Conclusion

After reviewing all available records regarding N.G., the Commission determined that they were not apparently experiencing a mental health crisis at the time of the incident. N.G.’s behavior appears to be best attributable as a response to the presence of law enforcement because of the crimes that had just been committed, rather than to an underlying mental health condition or a mental health crisis that began prior to the presence of law enforcement.

III. Cases Closed for Commission Review: M.D.

A. Commission Activities

May 2023: The Commission assigned one subcommittee to complete a Preliminary Review of M.D.’s case and return to the full committee meeting in June with a recommendation of whether to move this case to a Secondary Review.

June 2023: The Commission discussed the findings of the Preliminary Review. This discussion was not completed before the end of the meeting, so the Commission agreed to continue it at the next meeting.

August 2023: The Commission discussed the findings of the Preliminary Review. The Commission identified a need to determine where the reference to a “mental health crisis” in the discovery came from, with a plan for a specific Commission member to seek more information before the next meeting.

September 2023: The Commission continued discussion on the case and the need for additional policy documentation from the law enforcement entity involved.

October 2023: The Commission reviewed all information available and agreed to do one final subcommittee review of all the responding officer statements to confirm that officers were not told that a potential mental health crisis was occurring, and, if that remained accurate, to close the case for further review.

November 2023: The Commission confirmed that none of the evidence available reflects that the responding officers were informed that a potential mental health crisis was occurring. The Commission determined that it would close M.D.'s case review.

B. Evidence Reviewed

1) Vermont State Police OIS Investigation Case #22B1004362
2) Crime Scene Reports
3) Autopsy Report
4) Vermont State Police Interviews with law enforcement officers involved in the incident
5) Dispatch audio recordings
6) Axon body camera footage
7) Vermont State Police Investigative Reports
8) 20 V.S.A. § 2368 Standards for law enforcement use of force

C. Conclusion

After reviewing all available records regarding M.D., the Commission determined that this case did not meet the definition of a mental health crisis as outlined by the Commission. The only indication of a potential mental health crisis or mental health condition that may have impacted M.D.'s behavior was a statement in their alleged victim's Missing Person release from Massachusetts law enforcement, "There are recent concerning incidents, including a possible mental health breakdown of [M.D.] on Saturday, 7/9/22. [M.D.] has MA BOP including Assault to Kill,

ABDW [Assault and Battery with a Dangerous Weapon] and other similar incidents on [their] history." There is no indication that this potential concern was shared with any of the responding law enforcement officers, as it was absent from each of their interviews and investigative reports, as well as audio and video recordings of communications. M.D. was also not reported or heard in audio or video recordings reviewed by the Commission, to make statements that suggested that they were experiencing a mental health crisis at the time of the incident. This is a case where an individual was reported missing, and later found deceased by apparent homicide, with M.D. identified as the person of interest and with a known criminal history of violent crime. During the time M.D was engaged with officers during the search for them as the primary suspect in a homicide case, they did not act in a manner that created reason to believe a mental health crisis was occurring.

IV. Cases Closed for Commission Review: J.W.

A. Commission Activities

May 2023: The Commission assigned one subcommittee to complete a Preliminary Review of J.W.'s case and return to the full committee meeting in June with a recommendation of whether or not to move this case to a Secondary Review.

June 2023: The Commission discussed the findings of the Preliminary Review and determined that there was insufficient evidence to suggest that this case met the definition of a mental health crisis as outlined by the Commission. The Commission determined that it would close J.W.'s case review.

B. Evidence Reviewed

1) Vermont State Police OIS Investigation Case #22B1003716
2) Axon body camera footage
3) Vermont State Police Investigative Reports
4) Vermont State Police Interviews with witnesses and law enforcement officers involved in the incident
5) Department of Public Safety press releases regarding the incident
6) Dispatch audio recordings
7) Autopsy Report
8) Toxicology Report

C. Conclusion

After reviewing all available records regarding J.W., the Commission determined that J.W. was not apparently experiencing a mental health crisis at the time of the incident. Law enforcement had responded to a report of shots fired, resulting in an injury. Upon arrival, law enforcement took fire by J.W. It is not clear what led to J.W.'s behavior on the day of the incident, but there is a notable absence of any documentation in the discovery of a known mental health condition or observations prior to, or during, the incident that they were experiencing an acute mental health crisis at the time of their death.

V. Cases Currently Under Review: B.G.

A. Commission Activities

March 2023: The Commission assigned one subcommittee to complete a Preliminary Review of B.G.'s case and return to the full committee meeting in April with a recommendation of whether or not to move this case to a Secondary Review.

April 2023: The Commission discussed the findings of the Preliminary Review and determined that there was sufficient evidence to support the case proceeding to a Secondary Review.

May 2023: The primary subcommittee of the Commission was identified to continue active review of the case as more information was obtained and present it to the larger Commission at monthly meetings. The Commission agreed to seek treatment records from the Designated Agency documented to have provided services to B.G. prior to their death.

August 2023: The Commission discussed challenges in obtaining treatment records that would best inform consideration of ongoing case review. The Designated Agency identified as a recent service provider had noted that substance use treatment records are federally protected and cannot be shared in the way that mental health treatment records can be. The Commission agreed to amend the subpoena and seek records again.

September 2023: The Commission discussed the records received by the Designated Agency, most of which were heavily redacted, suggesting that B.G. may have received treatment primarily for a substance use disorder.

October 2023: The Commission agreed to ask B.G.'s next of kin for a release for the Designated Agency to share their full, un-redacted treatment records.

November 2023: The Commission discussed the case and had no new records to review. No response was received from the next of kin about sharing treatment records. The Commission agreed to make one additional attempt to contact them by mail prior to the next meeting.

December 2023: Following a second attempt to contact B.G.'s next of kin, the Commission did not receive a response. There was thus no authorization from B.G.'s next of kin to receive full treatment records. The Commission agreed to review Vermont State Police policies regarding pursuit of individuals who are under the influence from the time of the event and present, as well as relevant policies around interacting with individuals who appear to be experiencing mental health issues.

D. Evidence Reviewed

Section intentionally left blank pending completion of review.

E. Conclusion

Section intentionally left blank pending completion of review.

Cases Currently Under Review: M.M.

A. Commission Activities

June 2023: The Commission acknowledged the referral of M.M.'s case. Kate Lamphere identified that she would need to be recused from the case review. A plan was made to ensure that Kate did not have access to any Commission records or discussions. A replacement Commission member, Charlotte McCorkel, was identified as the Vermont Care Partners appointee on this specific case review, and a process was developed to divide future meetings and meeting minutes between Kate's and Charlotte's presence based on the cases reviewed. A subcommittee was identified to complete a Preliminary Review and present their findings at the next meeting.

August 2023: The Commission discussed the findings of the Preliminary Review and determined that there was sufficient evidence to support the case proceeding to a Secondary Review. The Commission agreed to seek records from the Designated Agency documented as providing services prior to the next meeting.

September 2023: The Commission discussed the findings of the Secondary Review and determined that there was sufficient evidence to support the case proceeding to a Full Commission Review. The Designated Agency who provided services had shared records, and some initial information from those was presented. The Commission began discussing potential witnesses, but agreed to wait to schedule interviews until all requested records had been received and reviewed.

October 2023: The Commission reviewed current information available, and identified additional records and evidence needed.

November 2023: The Commission noted that it had received all treatment records from the Designated Agency who provided services to M.M. Discussion focused around the role of the probationary supervision and information received from the Department of Corrections.

December 2023: The Commission discussed that it is awaiting some additional hospital records, but agreed that it has sufficient information to schedule interviews with at least a few witnesses in January. Specific Commission members were identified to schedule interviews and draft questions for the Commission to review in the January meeting.

B. Evidence Reviewed

Section intentionally left blank pending completion of review.

C. Conclusion

Section intentionally left blank pending completion of review.

Conclusions and Commission Recommendations

The Commission spent most of the year reviewing five cases, three of which (N.G., M.D., and J.W.) were closed for review after determining that the individuals involved did not appear to be experiencing mental health crises at the time of their death during interactions with law enforcement, and two of which are actively under review. The two cases under review (B.G. and M.M.) have initial information included in this report to reflect Commission discussions during the year. Case synopses and recommendations resulting from the case reviews will be shared in a 2024 report when the Commission has concluded its reviews.

The Commission has talked at length about the importance of understanding, to the greatest extent possible, the full array of systems involved in a case and how they interact with each other. One area of note to the Commission is that, of the

three cases reviewed that were determined not to meet the statutory criteria for the Commission, two cases (N.G. and J.W.) did not appear to have any reference to a mental health crisis occurring at all (J.W.) or prior to law enforcement's arrival (N.G.). The one case (M.D.) that included a reference to a potential mental health crisis is notable in that there is no evidence that this information was relayed to the responding Vermont law enforcement officers. Law enforcement thus responded with the goal of apprehending the primary suspect in a homicide. Information had been shared with law enforcement that M.D. had previously been convicted of violent crime, and this knowledge was reflected in interviews with three different law enforcement officers involved in the incident. The Commission underscores the importance of all pertinent information being relayed, as this can impact the nature of a response. The Commission acknowledges that even if this information were shared, given the dynamic and rapidly evolving nature of the situation, an alternative response may not have been possible.

Given that three of the five cases reviewed by the Commission did not meet the threshold for full review and thus fell outside its authority, and that the two remaining are actively under review, the Commission does not have formal recommendations to include in this report.

Respectfully submitted this 27th day of December, 2023,

Members of the Mental Health Crisis Response Commission